Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 29 November 2018 at 10.00 am
Main Hall, Didcot Civic Hall, Britwell Road, Didcot, Oxon OX11 7JN

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Neil Owen

Councillors:	Mark Cherry	Mike Fox-Davies	Laura Price
	Dr Simon Clarke	Hilary Hibbert-Biles	Alison Rooke
District Councillors:	Nigel Champken-Woods	Monica Lovatt	
	Sean Gaul	Susanna Pressel	
Co-optees:	Dr Alan Cohen	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *7 February 2019*

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

Yvonne Rees
Chief Executive

November 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 - 24)

To approve the minutes of the meeting held on 20 September 2018 (**JHO3**) and to receive information arising from them.

For ease of reference when considering the Matters Arising from the 20 September 2018 meeting, a list of actions is attached at **JHO3**.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 25 - 28)

10:15

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

6. Health Visiting and School Nursing Services (Pages 29 - 50)

10:20

This item covers the following (**JHO6)**:

- the impact of changes to children's centres on provision of health visiting service;
- scrutiny of the newly commissioned service for 0 – 5 years health visiting services;
- the impact of school health nurses in secondary schools and future service plans;
- the recommissioned services.

7. Healthwatch Oxfordshire (Pages 51 - 56)

11:40

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) will be present to report on the views gathered by HWO and its latest activities (**JHO7**).

8. Chairman's Report (Pages 57 - 64)

11:50

The Chairman's report is attached at **JHO8**. It includes an update on Health and Social Care liaison and the MSK Task Group.

9. New Governance of the Health & Wellbeing Board (Pages 65 - 116)

12:00

With the recent reorganisation of the Oxfordshire Health & Wellbeing Board in mind, the Committee will ask the following:

- how effective will the Board be to drive forward health, public health and social care integration?
- Is there effective governance in place to deliver this?
- How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for greater integration?

A progress report is attached at **JHO9**.

10. Clinical Commissioning Group - Update (Pages 117 - 120)

12:30

This item provides a report (**JHO10**) on the key issues for the OCCG and outlines the current and upcoming areas of work, including an update on Cogges Surgery.

11. Review of Local Health Needs (Pages 121 - 134)

12:40

The Committee will receive an update (**JHO11**) from the Oxfordshire Clinical Commissioning Group and Oxford Health Foundation Trust following the recommendations put forward at the last meeting on 20 September (Minute 47/18 refers), including proposals for the resumption of services and any necessary consultation on services at Wantage Community Hospital.

Two reports are attached entitled 'Planning for Future Population Health and Care Needs' and 'Planning for Population Needs – Wantage' (**JHO11**).

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.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 September 2018 commencing at 10.00 am and finishing at 3.10 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair District Councillor Neil Owen (Deputy Chairman) Councillor Kevin Bulmer Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Laura Price Councillor Alison Rooke District Councillor Nigel Champken-Woods District Councillor Sean Gaul District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Jeannette Matelot (In place of Councillor Mike Fox-Davies)
Co-opted Members:	Dr Alan Cohen, Dr Keith Ruddle and Anne Wilkinson

Officers:

Whole of meeting	Strategic Director for People; J. Dean and S. Shepherd (Resources)

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

39/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Jeanette Matelot attended for Councillor Mike Fox-Davies.

The Chairman took this opportunity to welcome new members Cllr Hilary Hibbert-Biles and Cllr Sean Gaul to the Committee.

40/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Cllr Hilary Hibbert-Biles declared a personal interest in Agenda Item11 – 'Annual Report of the Director of Public Health 2017/18' on account of her former office as Cabinet Member for Public Health and Education.

41/18 MINUTES

(Agenda No. 3)

The Minutes of the last meeting were approved and signed as a correct record subject to the following:

- Minute 34/18 – 'Update on implementation of recommendations from the Oxfordshire Health Inequalities Commission', page 14, paragraph 5, line 3 to add in the words 'health issues' after the word 'familiar';
- Minute 35/18 – 'Stroke Rehabilitation' Services – Pilot Report' – page 15, paragraph 3, line 1, to add the words 'along with the local MP', after 'Committee';
- Minute 36/18 - 'Transition of Learning Disability Services' – page 17, paragraph 2, line 7, to delete the word 'Leader's' and to add 'Leader'.

There were no Matters Arising.

42/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The following requests to speak had been agreed:

- Cllr Brenda Churchill, speaking as a patient of Cogges Surgery and as Mayor of Witney (Agenda Item 8);
- Cllr Rosa Bolger, speaking as local Member for Witney East (Agenda Item 8);
- Julie Mabberley – speaking on behalf of the Wantage Hospital Campaign Group (Agenda Item 9);
- Councillor Jenny Hannaby, speaking as a local Member for Wantage – Agenda Item 9; and
- Joan Stewart speaking on behalf of 'Keep our NHS public (Agenda Item 9).

43/18 FORWARD PLAN

(Agenda No. 5)

The Committee gave consideration to the latest Forward Plan, as amended since the last meeting (JHO5).

With regard to the item 'School Health Nurses' - this was amended to 'The impact of school health nurses in ***primary and*** secondary schools and future service plans'

A member suggested that the Committee look at the County Council's response to the Green paper. The Chairman agreed to take this forward to the Planning Group.

44/18 UPDATE BRIEFING - EVALUATION FRAMEWORK & BEST PRACTICE EXAMPLES

(Agenda No. 6)

In April 2018, following a presentation on the progress of work being carried out in response to the CQC Local Area Review, this Committee had asked Oxfordshire System Leaders to develop an evaluation framework to measure how actions taken in response to that review would improve outcomes for people who accessed services.

At the June meeting of HOSC Oxfordshire System Leaders had reported that there was no national framework for measuring the performance of actions plans developed as part of the CQC's programme of local system reviews. Similarly, the Department of Health & Social Care had not yet developed a performance framework for measuring a health and social care system in its entirety. It was also noted that a number of performance indicators were already being measured and reported on and it was from these that a performance framework would be drawn together.

Also at the June meeting the Committee had received a presentation highlighting some innovative approaches to delivering services, together with an example of how Oxfordshire was learning from best practice elsewhere. The Committee had requested that System Leaders returned to this meeting with some additional examples of how best practice was being incorporated into the work.

The Committee welcomed Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG); Kate Terroni, Director for Adult Social Services, Oxfordshire County Council (OCC); and James Underhay, Director of Strategy & Communications & Deputy Chief Executive Officer (South Central Ambulance NHS Foundation Trust) to the meeting.

Kate, introducing the item, stated that since the CQC inspection, discussions had been underway on how to draw together the Action Plan and how to evaluate it in order to allow its scrutiny; and what proposals to take forward to the newly created Oxfordshire Health & Wellbeing Board on 15 November 2018 to allow the delivery of a new HWB vision. She added that there were many actions which are to be done differently with regard to the pathways, the culture and the narrative of the system. Kate stated that all leaders had worked together and through more joint roles in order to make the experience better for patients and residents of Oxfordshire. Kate stated that although the targets set in the paper presented appeared conservative, these were et centrally and locally. Moreover, the system was working towards a more ambitious progress.

Examples given by the presenters of changes made included:

- Following a two - day event, a proposal was made to create the first system post, that of a single Winter Director with a single team;

- For the workforce, best practice had been followed and funding had been awarded to develop a system of care certificates which would be portable across agencies, particularly targeting the under 24's;
- The Ambulance Service was working nationally with NHS England, putting together a home delivery plan, which would comprise of therapists who were better equipped to pull together and deliver the best service for patients. This work had been piloted in Reading;

Louise Patten reported that the CQC were returning to Oxfordshire on 5 November 2018 to undertake a follow up review. In all 20 reviews had been undertaken, looking at how patients moved through the system and the CQC were keen to return to visit 3 systems to hear about what had been achieved and where it was heading: Oxfordshire had been chosen as one of these. She added that ministers were pleased with Oxfordshire's progress. It had been suggested that the visiting team might wish to meet with the Chair of Performance Scrutiny Committee or HOSC, but this was to be confirmed.

In response to a comment from a Committee member about the need for the newly formed Health & Wellbeing Board to recognise the need for openness and public transparency, Dr McWilliam responded that the members of the Board had taken the thrust of the CQC recommendations very seriously which was to work as one system to oversee its Strategy and to hold it to account. To this end the Board had taken on a programme of organisational development, the process for which had involved independent facilitators to assist them to define its role. The next meeting of the HWB would take place in public as usual. He added that one of the proposals for its new organisational development was to hold a Reference Group which would comprise of workshops for the public to engage with and discuss key issues in the HWB programme. The public will be able to see the emergence of this at the November 2018 meeting. Louise Patten added that the Health & Wellbeing Board would be measuring progress, not merely signing it off.

Responses to a series of questions from members of the Committee included the following:

- The latest DTOC statistics for Oxfordshire were at 79 against nationally set targets. Assurance was given to the Committee that there would be no complacency. Reference was made to the HART (Home Assessment Reablement Team) team administered by the Oxford University Hospitals Foundation Trust (OUH) which had been created specifically to assist people with a high level of needs to receive assistance within their home environment;

- With regard to the issue of 'Oxford Weighting', Louise Patten stated that lobbying was in progress for equal weighting with London. She pointed out that Oxford Health and OUH were already offering incentives for clinical and nursing staff. Kate Terroni added also that the hourly rate paid to care staff in Oxfordshire was already the highest rate in the country. This was also reflected in the banding rates for residential homes;

- Kate Terroni was asked about those current staff who had not undergone the new certificate training course. She responded that there was always an expectation that staff would have undergone some kind of training when they come into employment, and, in reality a new employer would often want a person to redo any training already undertaken. She added that this was an opportunity to work with Health Education England on a new plan, which it was hoped would be in existence in 6 – 9 months. It was hoped also that existing care workers would be able to apply for the certificate;

- When challenged by a member of the Committee that it appeared that a large amount of work was being undertaken which would have no direct influence on patient outcomes, Kate Terroni stated that the CQC Action Plan was premised on single path commissioning which would require one single conversation and ultimately lead to more coherent planning for a person, rather than the person themselves having to navigate a pathway.

- When asked if there was a process of measurement in existence which would highlight whether this method was having a beneficial impact on patients, Kate Terroni gave an example of a very different way of working which was to the benefit of the patient first and foremost. 'Stranded' hospital patients were being worked with by an integrated team of practitioners prior to discharge in order to support their leaving in a timely way with the maximum support. Lou Patten added that this also meant that outcomes for patients could be measured in more of a timely way;

- A member sought reassurance that the Joint HWB Strategy had not been fully finalised and refreshed to align with patient experience, asking if there would be services which the Committee could focus on when scrutinising, which would align with those that the CQC were also looking at. He also pointed out that all the system leaders, or their representatives, were not currently around the table for this item. Kate Terroni responded that all the system leaders were now members of the HWB and would be present at meetings, adding also her assurance that close working was in existence. She pointed out that this item was more about the theory, but the next item, the Winter Plan, would illustrate how system leaders were working in practice. Dr McWilliam gave his assurance that the new, overarching, high - level Strategy would be discussed at the next meeting of the HWB. Moreover, the HWB would address the work of the Integrated Service Delivery Board whose remit covered the work under the pooled budget umbrella. He added that there would be no shortage of dashboards to measure in this system of working. Work was already moving at great speed, for example, the Health Improvement Board and the Children's Trust were looking at its current and future priorities and how it could align with the HWB. At the end of this process there would be a need to stitch everything together in order to obtain end to end priorities in a format which made sense for all, including the public and that also took account of that the CQC wanted to see. The public would have a hand in shaping this process via the Reference Group. He commented finally that this would not be a straightforward task as there were issues to address requiring further work such as how to improve the DTOC stats, housing etc; and

- A member pointed out her view that bullet point 4 under 3.1 of the report presented which stated that 'many of the actions in the CQC Action Plan are strategic in nature and it would be very difficult to link them to specific impacts on people' needed to be refreshed to take account of the premise that any strategy anywhere should have direct measurable impact on patients at the end of the day. She asked also if people would be assessed at home without a knowledge of what was needed? Kate Terroni responded that home first was best practice, together with possible short stays in hospitals, therapy or interventions.

It was **AGREED** to:

(a) thank all for attending; and
(b) request the representatives to return in the new year to present the CQC feedback;
(c) also to request the representatives, when they return, to give some indication of how outcomes have improved given all the hard work undertaken; ensuring that targets identified are nationally set where appropriate, and, alongside this, to identify what the trajectory is for the local Oxfordshire system.

45/18 2018-19 OXFORDSHIRE SYSTEM WINTER PLAN

(Agenda No. 7)

The Committee welcomed the following representatives to the meeting:

- Louise Patten and Diane Hedges, Chief Executive and Chief Operating Officer, Oxfordshire Clinical Commissioning Group (CCG)
- Tehmeena Ajmal, Winter Director for Oxfordshire, (joint appointment for Oxfordshire health and social care system)
- Pete McGrane – Acting Clinical Director, Operations Services, Oxford Health NHS Foundation Trust (OH)
- Ross Comett – Head of Operations, South Central Ambulance Service (SCAS)
- Kate Terroni, Director for Adult Social Services, Oxfordshire County Council (OCC)
- Rachel Piri, Lead for Older People Commissioning Mkts, OCC

Diane Hedges gave a presentation on the 2018-19 Oxfordshire System Winter Plan, together with a summary on what worked and what didn't work in relation to last year's Plan. She took the opportunity to introduce the newly appointed Urgent Care Director, Tehmeena Ajmal, who worked to the Chief Executives of OUH, OH, OCCG, SCAS, GP Federation and the Director of Adult Services, OCC, co-ordinator of a Team from all these organisations on a demand/capacity dashboard. This would hold information updated on a day to day basis and sometimes on an hour to hour basis, looking at, for example, how many people were waiting to be admitted, or how many were waiting for an ambulance, so that actions could be taken quickly and patients were supported appropriately through the Winter period, enabling them to recover quickly. Following a review of last year's Plan it had been found that:

- too much time had been spent on the delayed transfers of care and insufficient attention given to caring for people in their own home;

- emergency care and Out of Hours did not necessarily co-ordinate or plan ahead on what may be needed on a day to day basis;
- there was duplication in some areas where three teams were working together – more time with people was required rather than excessive geographical travel.

Tehmeena Ajmal had discussed with Healthwatch Oxfordshire and provider and third sector organisations on how to keep people safe and well and how to work together to ensure there were plans in place for people to receive help when needed, for example for volunteers to go to the shop for the basics, such as milk and bread.

In relation to risks, she added that it was important to ensure that influenza inoculations for front line staff were begun earlier. Also, during inclement weather it was important that each organisation had an instant plan which would ensure that they had sufficient capacity to look after people in their own homes. She was also looking to ensure that nursing staff and therapists could respond quickly when they were needed and with no gaps, by creating overall system plans. There was also a series of projects to best help people to stay at home. Each organisation was asked to identify what could be done with the funding in order to respond to the Winter Plan. This confident style approach enabled the Team to use resources most effectively. She emphasised that hospital beds were available when required.

Diane Hedges informed the Committee that £700k had been set aside by the Better Care Fund Joint Management Group for winter pressures, funded by OCC and the OCCG. There was also an additional level of improved capacity, for example, the preparatory work which was being undertaken with pharmacists and the Out of Hours service prior to the onset of winter.

Kate Terroni was asked to explain further how this new system would work, given the DTOC statistics and despite the excess demand for beds which had been forecasted. She explained that there would no longer be a monthly update, there would be a weekly email summary of exactly what the position was alongside weekly capacity demand. It would in future be a collective decision made by all the Chief Executives to ensure delivery. Sara Randall added that this new process gave a good sense of the current position and what was required for the following week.

A member asked if there was sufficient capacity for those people in domiciliary care who were not on the Health pathway, but who required a bed. Kate Terroni responded that early on in the process she had sat down with the providers and looked at what the allocations looked like at local level and if there was additional capacity to help specifically with winter pressures. She added that she had also been working with providers on a wider basis and had confidence with the joint planning which was taking place. She was also working with third party providers. In addition, a review of short stay beds had taken place to help avoid admission to hospital and looking at the range of options available to people.

A member made a plea for a clearer and easier to understand explanation of the additional projects and how they tied up with the whole.

When asked if there were sufficient staff/ambulances strategically placed throughout Oxfordshire to cater also for people living in the rural areas, Ross Comett responded that they were strategically placed in Adderbury, Kidlington, Oxford and Didcot. They were also placed at standby points and at the main hubs across the county in Wallingford, Abingdon and Bicester. They were controlled centrally in Bicester and were able to be despatched at a constant flow. There would be an array of back fill for any gaps in provision in the form of first responders, with defibrillators, and with the Fire Service. Moreover, there were sufficient ambulances and crews and the service was forecasting for additional staff and reviewing rostas in anticipation of the growing demand. Pete McGrane added that part of the learning process had been that the systems that did well were those that were actively working with the 111 service so as to deploy ambulances in places where they were really required. If this was to be put in place and it could be assured that sufficient ambulances were able to attend, this would not then place undue stress on the service.

A member asked if the ambulances would be suitably equipped to manoeuvre around the narrow roads in the rural countryside, particularly in winter weather conditions. Ross Comett responded that the normal ambulances were very heavy which gave better traction on the roads. There was also a fleet of four by four vans manned by officers who were clinically trained. In times of heavy snowfall or heavy rain where roads were no passable, Fire Service responders, mountain rescue services and air ambulance were also deployed to get help to people.

A member asked how would the necessary supply chain work for patients being cared for at home during adverse weather. Tehmeena Ajmad responded that her team was working with the hospital on the use of nurse practitioners who would bring the appropriate equipment out to the home environment. In addition, Oxford Health was giving a lot of thought to ensuring a quick response. Sara Randall also explained that the Trust had worked with NHS England after 5.3% of bed occupants had been victims of the flu virus last year (which was more than the average of 4.1%). To this end the Trust was ensuring wide advertisement of flu vaccines for patients and staff to cover the winter pressure period.

Tehmeena Ajmad was asked if she had a ‘Plan B’ if the gap should widen in relation to the sufficiency of beds in January. She explained that the Team had been working through various scenarios to ensure a speedy response in the provision of additional capacity where required; and one of the things she was focusing on was how to create more capacity for patients to go home as soon as possible. This was in the form of additional nurses and therapists, as a patient’s health decreased if they remained in bed for too long. She was also looking at creating capacity for more beds, if required, during the winter pressure period.

Pete McGrane was asked if it would be more beneficial if a patient, who was unable to be treated at home, was moved from an acute bed to a community hospital, rather than staying in the system. He responded that in the past this was deemed the best solution, however, it prolonged hospitalisation which was detrimental to patient outcomes. This was the clinical experience every day, particularly for a frail patient, with complex health problems. Furthermore, the process of disruption could also prolong their stay in hospital with one week in bed equating to 10 years loss of muscle function. It could also affect people socially. Thus, from a clinical point of view

it was important not to take patients into a community hospital setting, but to put them into the right place.

In response to some Committee members remaining unconvinced of the reasoning behind the assurances given that increased demand for services could be managed effectively, Pete McGrane stated that it was important for the Team to understand which parts the Committee was unhappy with. To this end he offered to return to a future meeting to talk through what could be put in place in relation to Plans C and D.

In response to a question about what facilities were available for older people to obtain their flu jab, Diane Hedges stated that the take-up had been good last year, but this was still deemed not sufficient as more were claiming the jab this year. The OCCG was looking very proactively with the NHS at some possible options, one of which was for pharmacists to undertake the injections and another for eligible patients to receive a text message where possible. She added that the OCCG was also monitoring those GP practices who did not perform as well last year to ensure all patients received their jabs. She explained that there were also issues with supplies of vaccines not getting to some practices.

With regard to a question about whether there was sufficient GP availability across the practices, Diane Hedges responded that the OCCG was still working on directly slotting in GP hubs into the 111 service, and also on enhancing the availability for GP appointments. At the same time the OCCG was also working on resourcing more primary care so as not to de-nude the in-house scheme.

Diane Hedges confirmed that there would be a larger number of community hospital beds available on a short-term basis in recognition of the fact that during the period of winter pressures they would be needed. She explained that the OCCG did not contract on beds, but on the number of episodes. In past years a whole range of beds had been available, some of which lay empty. There was a need for greater and better usage of beds available, therefore greater bed capacity.

In response to a further question about whether the OCCG/Trusts were looking at community beds on a county, not local capacity, Sara Randall explained that each morning there would be a meeting which would take place to decide where was the best place for each person to go. This would be led by OUH, OH and Social Care based on the needs of the patient and the needs of the whole family.

The representatives were thanked for the report and for their attendance.

46/18 CCG: KEY AND CURRENT ISSUES

(Agenda No. 8)

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

Cllr Brenda Churchill, speaking as a Cogges GP Surgery patient, a member of Cogges Patient Participation Group (PPG) and Mayor of Witney, stated that the closure of the surgery came as a shock and had caused the Town great concern. Whilst they were aware that the circumstances of this closure differed from the Deer

Park Surgery closure, the fact remained that there were only two doctors' surgeries remaining in Witney. These struggled to take on an extra 4,500 patients, with the additional problem of shortness of space. With the extra 7,749 additional patients, she asked how they would cope. Moreover, extra doctors would be required at a time when surgeries were struggling to recruit and in circumstances where a large number of houses were being built. She also pointed out that many of the patients at Cogges lived outside of Witney in South Leigh and in several more of the villages to the east of Witney; asking how would patients travel into Witney to see a doctor when there was no bus service serving those areas.

Cllr Churchill also pointed out that, in her view, if some of the IRP ,recommendations regarding Deer Park patients had been taken on board by the CCG then this situation would not have happened. The recommendation to not preclude opening the Surgery again had not been looked at seriously, and, in her view should have been. As a consequence, she urged the Committee not to allow another surgery to close until such time as fully workable business plans could be seen, to ensure that other practices had the capability of taking the 7,749 patients, plus the new patients. She concluded that, in her view, the CCG's Locality Plan was not workable and Witney town now needed the OCCG et al to begin to look at what needed to be done to give the people of Witney the patient care they deserved.

Cllr Rosa Bolger, speaking to save Cogges Surgery, stated that Cogges Surgery was essential to Witney and its surrounding villages. She pointed out that this repetition of the Deer Park Surgery closure was no different to the picture emerging nationwide which, to date, had seen the closure or merger of 200 GP practices. She informed the Committee that a community workshop had been convened to ensure that all voices were heard. The community wanted the GPs to remain at Cogges. Cllr Bolger told the Committee that a positive meeting had taken place with the OCCG, who appeared to understand the importance of keeping the surgeries open in the Town. She asked that the Committee continue to scrutinise this matter and to commit to working with the OCCG to retain the surgery, as a steer towards a better solution. In addition to apply pressure to ensure that the highest bidder was intending to retain services at Cogges, to ensure it thrived, rather than be closed. She also appealed to the Committee not to allow any further closures of practices in the town, pointing out that vulnerable patients needed to be seen in their own community.

Louise Patten assured the residents of Witney that the CCG had worked with the practice before it had made the decision to give notice on its contract. She reminded the Committee that GP practices were independent businesses that contracted with the NHS. She told the Committee that the OCCG continued to learn from the Deer Park experience and was ensuring that it was covering its statutory responsibility to ensure that Cogges patients received ongoing GP services. Furthermore, the OCCG was able to demonstrate that it had talked together with the community and was working with the constituent systems to ensure that all were working together for the residents. She pointed out that the OCCG could have made the decision to disperse the list, or for a local merger, but, by going out to limited invitation to tender throughout, it had demonstrated its ultimate wish for services to continue on the Cogges site. Louise Patten explained that, by contract law when going out to limited application, local GP providers were to be asked if they wished to continue. If this proved not to be so, then the next step was to ask for wider interest. She assured the

Committee that the CCG would strive to work with other PPG's with the same open and transparent approach. She thanked the PPG for their work in communicating information out to patients, adding that there would be continuous updates provided as the process continued.

Questions from the Committee and responses received were as follows:

- When asked if there would be a need to negotiate with the leaseholders, Louise Patten responded that the CCG could not mandate that services were provided from that specific building because it was privately owned. Talks had taken place with the leaseholders of the premises. The CCG had stipulated the weighting was high on the list when making a decision relating to a local provider.
- In response to a view expressed by a member of the Committee, who was also a local member for Witney, that an important part of the local engagement process with the community was one of understanding the specifics of the model and how it fitted in with the legalities of the tendering process (which was a factor of tension with regard to Deer Park), Louise Patten agreed that it would be reasonable to publish a high level evaluation and then the OCCG could afterwards summarise some of the specifics relating to those from other providers. This Councillor also expressed her view that the experience with Cogges had differed greatly from that of Deer Park, with the OCCG going to greater efforts to conduct early dialogue with the community;
- Another local member for Witney thanked the speakers for their clear and concise statements and also re-affirmed his colleague's view in relation to the improved attitude of the CCG towards the Witney population. He asked if the West Oxfordshire District Council's local plan had picked out any provision for new medical centres in and around Witney, to accommodate the 15k new homes being built, a third, if not more of which were in Witney and its surrounds. He asked the OCCG to be aware of this and to speak to local planners. Another member pointed out that county and district council's timeframes were far larger than the OCCG's and this ten year gap needed to be addressed. Louise Patten agreed that future NHS planning had not previously been done well, however, there was a growing understanding that planning could not take place unless there was also sufficient infrastructure. The OCCG had conducted two meetings with West Oxfordshire planners and was also working with other councils across Oxfordshire - and was beginning to increase its involvement. It had been agreed that there was a need for proper infrastructure governance and there needed to be an improved response in the longer term;
- A member pointed out that one of the concerns with regard to the Deer Park closure was the unstable effect on other practices when GP's either decided to retire early or were approaching their retirement in the longer term, asking what the OCCG was thinking about doing about workforce issues. Dr Collison agreed that there were very real pressures on the workforce both in the local area and nationally. On this basis GP practitioners had been promised 5k extra GPs, which had not yet materialised. In the meantime, it was necessary to make the best use of resources, including that of the workforce. The OCCG was trying to work

out which parts of the workforce could take on the less complex cases such as administration, nursing and therapist staff. In addition, how the OCCG could show support for busy practices, who were, she pointed out, independent businesses, if practices began to creak at the seams. A member suggested that a possible difference could be made by looking at childhood vaccine data;

- Dr Collison responded to a question about what was taking place locally in the short term to acquire more doctors, stating that workforce strategies were being developed across a few centres. In addition, a significant amount of work was being done to encourage trainees to stay in the county. She added that the high cost of living was a very real issue and there was a need to make jobs attractive to entice them to stay. She added that the GPs job was very stressful and people were retiring early with 'burn out'. The situation at Cogges was a real - life example of where this was happening;
- With regard to flu vaccinations, Dr Collison stated that this was going well and work was underway to decide how to work with other eligible adults and children in schools in order to provide then earlier than last year.

With regard to Oxfordshire vasectomy services, Louise Patten was asked how the OCCG could justify removing the NHS service when need for it could be demonstrated, pointing out that it went against health inequality principles and 'breaking the cycle' as demonstrated in the Director of Public Health's Annual report. She responded that the current service had been provisionally flagged up as a real issue concerning staffing. When the contracts were originally set this was based on historic activity and set against the amount of money which was available. Each year providers were having to switch their priorities. Furthermore, it was not unusual for GPs to let people know of the routes that were available to them. Many CCGs had ceased funding these services. In some cases, an Independent Review Panel would make exceptions to the rule. Generally speaking, however, the OCCG would have to look at whether to fund this service. Elsewhere, people had gone to private practitioners.

The Committee AGREED to;

(a) keep the above issues under review;
(b) note the report as a whole; and
(c) Thank the QCCG for the report and for their attendance.

47/18 PLANNING FOR FUTURE POPULATION HEALTH & CARE NEEDS

(Agenda No. 9)

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

Julie Mabberly, speaking on behalf of the Wantage Hospital Campaign Group stated that when she previously addressed the Committee prior to the temporary closure of the hospital in 2016, it had been understood that this closure was subject to statutory

consultation. This had not taken place adding that an engagement exercise was not the same as one of consultation. She pointed out:

- that 650 new homes had been planned for the Wantage area, now the figure stood at 1,000;
- there was a significant percentage of people aged 65 and over and the local NHS was not making the most of the family and friends asset and resources;
- the difference in care in community hospitals to that of acute hospitals was that patients were encouraged to leave their beds;
- it was not understood where the required 142 beds would be situated.

Cllr Hannaby, local member for Wantage, spoke of the 'invisibility' of Wantage Hospital stating her view that the 'new plan' presented to Committee would not be implemented quickly. She called for a comprehensive online consultation plan to which the public could give their comments. It was her view that, had legionella not broken out, the situation would not be as it was currently. She stated her belief that the OCCG had taken this as an opportunity to close the hospital, commenting that Wantage Hospital was a vibrant hospital which had served the community well. The Hospital also gave employment to a large number of people in the area. She urged the Committee to help the people of Wantage in their campaign to keep it open until such time as the health provision was decided for the area. She asked for equal treatment with other towns in Oxfordshire, expressing her fear that this kind of proposed engagement for the county would begin to split communities and one town against the other. Furthermore, it was her belief that the Hospital needed to be open to assist with the winter pressures. She concluded by stating that if the consultation was not open and transparent, it would be unsuccessful.

Joan Stewart, speaking on behalf of 'Keep our NHS P,ublic' campaign commented that at first glance, the framework suggested a gentle move towards approval. However, it was her view that beyond the window dressing, the intention was still the same which was to mask underfunding and the provision of few hospital beds. She added that in the past there would have been a consultation, but this review was not in the same vein. She asked if the proposed options would be deliverable. She pointed out that an audit of the community hospitals had already been carried out in 2016, and, in her view, the primary care locality plans were already in motion and underway. She asked where was the interconnection of the community hospitals, warning that a domino effect could ensue alongside greater fragmentation, with a potential for localities to be pitched against locality. She asked where in the paper was the evidence of greater integration of health and social care, despite the much publicised systemic delivery. She warned that in her view this paper was premature and there was a need to reconsideration.

Louise Patten and Dr Collison (OCCG) and Pete McGrane (OH) attended for this item. Louise Patten stated that phase 2 had been suspended and it had been decided not to consult until the needs of the local population was known. After that, a dialogue would be conducted with the public. Until then plans for a formal consultation could not be developed. Moreover, there had been much talk about how committed each organisation was to working as a system and about the need for discussion with the planners. The NHS, the community and the County Council were going to work together looking at the wellbeing of the people of Oxford. It was also

about working together with the voluntary sector to deliver this. She pointed out that the Health & Wellbeing Board owned this paper and this process. What was being presented here was a draft to glean the comments of the Committee on whether the system leaders had got the process right and whether it was sufficiently clear.

She continued that the frustrations voiced by the public had been heard, ie. the lack of transparency, lack of trust and their wish to be involved. There was a need to conduct intelligent conversations with the public, setting out to everybody what the needs were, and then armed with that information, state what the process would be. This would be conducted with a shared understanding of working together to develop that solution. She added that certain services would have to be provided at scale as the costs would be too high to provide for a small number of people coming through the door. Certain services would need to be provided in towns and there would be a joining up of towns and localities. This was about having an honest conversation. With regard to the consultation process, the OCCG would take on board the wishes of the public, for instance, not to hold forums or public meetings when mothers and children could not attend. It had been understood that online, ongoing engagement was the favoured approach.

She added that the review would look at the health and care needs of the local population and what would be needed in the future, whilst taking into account housing growth. Moreover, the review of services and assets would need to describe services in local towns, for example, looking at GP practices and how to co-locate services there. Dr Collison added that the OCCG would try to ask the question about whether it made sense clinically and was it evidence based? The OCCG had some evidence of growth and size of the population in an area, and, for example, the growing numbers of older people in an area, but more knowledge was needed. With the huge advances in technology the OCCG needed to ask itself whether it should operate within the current system or did it need to do more. She explained that there were three principles of emerging good practice. These were:

- integration of health and social care;
- delivery of more care closer to home; and
- not keeping patients in bed for too long.

She informed the Committee that Dr Ian Sturgess, Director of Improved Healthcare, had been invited to Oxford to advise on how to design models, encourage integration etc. It had been found that there was much potential going forward and good examples both around the country and locally, for example, the integrated delivery teams close to EMUs (Abingdon) and RACUs (Horton) could assess and treat patients. Another example given was around diabetes care/prevention which could be conducted by specialist nurses within communities rather than in hospitals. This was evidence of an up-to-date method of working out people’s needs and a good way of delivering care. The OCCG was looking forward to working with the public on the development of pilot services, which could lead to full consultation on any service change.

Questions from members of the Committee were as follows:

Louise Patten was asked whether capacity would make it necessary to run the consultation at one locality at a time, or concurrently. If it was the former, she was asked if it might prove to be 'an eternity of engagement'? She responded that she did not know at this stage but to conduct it properly would take a lot of time. Dr Collison also spoke of a wish to set up a framework which would be applicable to anywhere in the county which would begin with what was needed, and then looking at what could be done at local level on a smaller scale and then what would be required at a county level.

Cllr Monica Lovatt, the Vale of White Horse District Council representative on the Committee, expressed her pleasure at the plan to engage locally with the people of Wantage and asked what was going to happen and how long it would take. She also commented that she was aware of the OCCG's engagement on planning matters. She asked if they would consider starting with Wantage as it was a very rural area and was growing fast. Louise Patten responded that the OCCG had tried to set out a timescale for the Wantage gateway. She added that all of this process was not new, it was how Health planned, but it would be a much more integrated approach with other services and communities. A lot of data was already being gathered in local plans. By December, the OCCG would try to identify gaps in services in this area and if some services could be provided locally in Wantage. She added that by March the OCCG would be looking at service solutions and there would be clarity on the needs of the locality, the dialogue with the planners having been completed. She added that there were two aspects to the work, one of which was those services which could be looked at as a focused piece of work, not necessarily linked to overnight beds. The decision had been taken with Thame Community Hospital not to go to overnight community beds and to look at the different services being provided in the hospital. She gave the example of the rehabilitation services being provided at Townlands Hospital, Henley, where patients did not stay overnight and transport was available. She reiterated that service gaps did not mean overnight stays. Cllr Lovatt responded that the residents of Wantage and its surrounds were looking for modern, up to date facilities and quality care.

Louise Patten was asked if the consultation would begin by February or March 2019, as, by then the OCCG would be clearer on the design of services. She reported that the OCCG would first decide on services and buildings and it was envisaged that consultation could be more fluid. If, however, there was a significant service change, such as a reduction in service, then consultation would be more formal. A member asked if consultation had already taken place in relation to some services and whether engagement would be putting more water between the original reductions in service and the revised models; adding that it was important that this was clarified for meaningful public scrutiny purposes. Otherwise it would make it increasingly difficult for the Committee to scrutinise. She added that a significant engagement exercise would be required and, in her view, it needed to be looked at as a whole. Louise Patten responded that it would be undertaken locality by locality, so enriching an understanding of what people wanted for their area. However, many services would require a look at all localities together before deciding the best way forward. This would be linked to usage of services. Wantage Hospital, for example, would require a formal consultation process because it would have to be wider than the needs of

Wantage itself, as the beds were part of a larger network. She gave the example of Townlands Hospital in Henley as an example of an area where hospital based services were looked at together with local services and then tuned with those facilities which were loved by the public.

Louise Patten was asked when the point of full consultation would take place, to which she responded April/May 2019, as there was a need to look at the wider localities across Oxfordshire to do so. It would be linked to a sustainable future, but not linked to beds.

With regard to Wantage Hospital, members asked how long would it be before formal consultation, as a significant time had gone by since its closure. Louise Patten responded that all services were linked to community hospitals. If sufficient local engagement was not to take place then a legal process would ensue and all would be back at the beginning. She assured the Committee that the OCCG could develop a vibrant future for the buildings which could help to cement this local asset into the community. On the future of Wantage Community Hospital, the conversation had not yet taken place about what could be provided in Wantage.

Members joined in expressing concern for the residents of Wantage at the lengthy term of temporary closure of the Hospital beds. At the time the temporary closure had been predicated on formal consultation within 6 months. The Committee now understood that funds to treat the legionella had been set asiide. Pete McGrane reported that the money had been set aside based on the assumption that there was a need for long term planning for the site. He added that it would also give an opportunity to look at services for a much broader spectrum of the population, such as services for mental health, diabetes, respiratory diseases etc.

Following further discussion, it was AGREED (unanimously) to:

(a) thank all for their attendance and inform the OCCG that this Committee had taken on board the comments made about the outline framework of planning for the future population needs of the county and generally recognised the good work that was in progress, together with the need for wider consultation on some services;

(b) urge Oxford Health to release and spend the capital sums invested in relation to Wantage Hospital in this financial year, in order to make good the fabric of the building where necessary; and

(c) RECOMMEND the OCCG to accelerate this action so that by the next meeting of this Committee on 29 November 2018, it would be in a position to move forward with concrete proposals for Wantage Hospital which would include either the resumption of some services or a public consultation on the future of the Hospital.

48/18 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 10)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO), reported the views gathered from members of the public and the latest activities of HWO (JHO10.)

She reported that she was pleased to see Health and Social Care working together in a closer way and its impact on DTOC statistics.

Cllr Lovatt reported that the Committee's Task & Finish Group had met the previous week and had valued the information received from Healthwatch Oxfordshire on the patient experience of the Healthshare and MSK service. The Group would be publishing its recommendations in due course. Cllr Pressel made reference to the evaluation of the survey on breastfeeding support, to which she had had an involvement, together with the literature for the public to be found in GP and dentists surgeries. This had revealed that NHS England would be looking to produce information sharing leaflets.

When asked about the outcomes of the workshop on dentistry, Rosalind Pearce reported that NHS England had not been able to send anybody to the meeting; and there had also been limited availability of other NHS representatives who had been scheduled to attend. The meeting had focused mostly on carers and dental services in care homes. She added that HWO had worked with the local dental network on how recent toolkits could be re-designed. It was hoped that, in six months' time, there would be a beneficial outcome for patients.

The Committee AGREED to thank Rosalind Pearce for the report and for her attendance.

49/18 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2017/18

(Agenda No. 11)

The Director of Public Health, Dr Jonathan McWilliam, presented his independent Annual Report for 2017/18 (JHO11). The Committee was asked to receive the report and to consider any key issues which it would like to see taken forward in the year ahead.

Dr McWilliam highlighted the following for 2017/18:

- There had been good signs of organisations such as health, housing and planning working together to highlight solutions to be worked for together. For example, the work undertaken with residents in Barton and Bicester;
- Many indicators had seen an improvement, such as those for smoking (though there was a need to maintain an oversight in particular on smoking amongst manual workers);
- Positive work was ongoing with mental wellbeing, for example, good work was taking place by school health nurses and work with the military and veterans;

- Infectious diseases were doing well, but there was a need to be on our guard for any new infections.

Cllr Pressel highlighted a number of issues and Dr McWilliam responded as follows:

- Healthy new towns – how are we spreading the learning? Dr McWilliam responded that Public Health was taking part in discussions in relation to this;
- The need to integrate health issues into local planning? – Dr McWilliam stated that organisations were doing much better in relation to this as compared to ten years ago, though this still needed to be monitored;
- The lack of support for breastfeeding mothers in the communities, some baby cafes were struggling – Dr McWilliam commented that the amount of support for this was unknown;
- Health inequalities needed to feature prominently in all strategies – how was it monitored? Dr McWilliam stated that more targets could always be produced, but all strategies had inequalities written into them and this was being worked on at the moment by the Health Inequalities Commission;
- How can this Committee lobby the Government for a minimum price for alcohol and a watershed in advertising fast food to be set at 9pm? Dr McWilliam stated that in his view the Government was doing well in tightening the screening of obesity using non-legislative means and there was an increasing gradual awareness amongst the population;
- How to survey and target the pockets of areas in Oxfordshire where oral health was poor – does it go far enough? – Dr McWilliam agreed that the national survey of oral health in children did not reach wide enough;
- STI's, are very high in Oxford - how do the statistics compare with comparable cities? – Dr McWilliam responded that Oxford was comparable with similar cities and urban areas;
- Dementia statistics had risen over the last 10 years. It was understood the Oxford City figures were lower, are they increasing at a different rate? - Dr McWilliam responded that it was too complicated to draw conclusions as it involved different lifestyles;
- When would staff be recruited to the Healthy Living Team? – Dr McWilliam stated he was not aware of any problems;
- Tests for tongue-tie in breastfed babies? – Dr McWilliam responded that this would be included on the list for exploration. He undertook to circulated information on this issue; and
- The need for the take-up of health checks to be improved? – Dr McWilliam stated that Oxfordshire did well comparatively. There was, however, no facility to send reminders. Public Health worked with various groups to advocate take up.

Dr Clarke asked how were the MRSA figures arrived at. Dr McWilliams responded that they were reported nationally from hospitals. Any record on community acquired strains was far more pathogenic. He agreed to circulate a more detailed response to this.

Dr Cohen suggested the inclusion of a further group in relation to cardio-diabetes, and also stated his view that much could be improved if inequalities were targeted in a much more targeted way.

Dr Ruddle expressed his appreciation that mental health issues had been included in light of the large rise in teenager mental health problems. He asked how this was taken forward in terms of priority judgements in Oxfordshire? Dr McWilliam responded that it was the 'cinderella' of services and had been included in his report for the past 4/5 years. It had also been well raised by councillors and the public and this had helped enormously. He added that there was good clarity in the communities and good advocacy groups.

At the end of the discussion it was **AGREED** that the following recommendations go forward for Cabinet: to

(a) ask Cabinet to consider lobbying the Government for a minimum price on alcohol and a watershed of 9pm for the advertising of fast food on TV; and
(b) **RECOMMEND** Cabinet to ensure that there is an evaluation of the Healthy Towns project when it comes to an end and also to ensure decisions are made on how to spread the learning arising from the project.

The Committee thanked Dr McWilliam for all his good work over the years as Director of Public Health for Oxfordshire and in his role as adviser to the Committee and wished him well in his retirement.

50/18 OHFT STROKE REHABILITATION SERVICES PILOT REPORT

(Agenda No. 12)

The Committee welcomed Dominic Hardisty, Oxford Health, and Sara Bolton, OUH to the meeting.

Dominic Hardisty gave a summary of the report JHO12 stating that:

- All the evidence had been very positive and looking at patient flow outcomes had been found to be the correct way forward;
- There were problems with staffing, particularly with nurses. OH were trying to resolve this, using agency nurses for the present; and
- It was their view that this change of service constituted a substantive change.

Dominic Hardisty was asked how many patients there were from outside the southern part of the county. He responded that he did not have this data to hand but would circulate this. He added that what was required was the best possible care and if this required travel for some patients for approximately 20-25 days then it had been found that they willingly undertook this.

He was also asked how it fitted in with the wider locality plan for West Oxfordshire and were the general purpose beds open at the same time? He responded that the

Stroke pathway did not stray into premises of local services and it was a countywide provision.

The Committee AGREED (unanimously):

(a) to thank Dominic Hardisty and Sara Bolton for the report and for their attendance; and
(b) that the indications from the pilot had been good and that this service be accepted as a substantive change and it should continue in its present form.

51/18 CHAIRMAN'S REPORT

(Agenda No. 13)

The Committee had before them the Chairman's report (JHO13).

Cllr Monica Lovatt gave a report on the MSK Task & Finish Group which had now met three times. The first meeting was to hear the views of patients, GPs, HWO and the Local Medical Council. The second to hear clinician's views and the third to hear the view of the previous provider.

Attendees were asked to share their views of the new service, how they had experienced any differences from the former service, what worked well and was there any room for improvement. She added that the Group now needed to digest what they had heard and to draw together the evidence. It would then be publicised as part of the Chairman's report to the February meeting. She thanked her colleagues on the Task & Finish Group and Sam Shepherd, Policy Officer, stating her view that the Group had set the framework and guidelines for future Task & Finish Groups.

The Chairman thanked Cllr Lovatt for the report agreeing that this was a very good and encouraging example for future Groups to follow.

The Committee AGREED to receive the Chairman's report.

..... in the Chair

Date of signing .....

HOSC Actions from 20th September 2018

Item no	Item	Action	Lead	Progress update
40/18	Forward Plan	Amend Forward Plan to include: a) School nurses needs to be in secondary and primary schools. b) A summary on the ASC Green Paper and the system response when available. a) Include committee members suggestions b) CQC re-inspection visit; findings and response	Sam Shepherd (OCC)	Forward Plan amended for consideration on the 29th November 2018
41/18	CQC: Evaluation Framework	Ensure that targets are identified as nationally-set where appropriate and explain alongside nationally-set targets, what the trajectory is for the Oxfordshire system.	Kate Terroni (CCG)	Information circulated to the committee on 20th Nov 2018
42/18	Winter Plan 2018/19	a) Share a weekly look back and weekly look forward with the committee during the winter period. b) Report back to the committee on contingency plans to create capacity and manage demand pressures when they occur.	Tehmeena Ajmal (CCG)	a) Situational reports will be initiated in December b) Contingency plans to follow
43/18	CCG Update	a) Share with the committee, the specification and high-level evaluation framework for a GMS contract which is being used for commissioning Cogges Surgery. b) Post-tender, share an annoymised summary of some of the innovation identified through the process.	Louise Patten (CCG)	*From the CCG:* There is no specification as GMS is standard but the evaluation framework used for the process has been published on our website (as requested by HOSC) along with all other documents. Members can find this here: https://consult.oxfordshireccg.nhs.uk/consult.ti/cogges/view?objectId=36

HOSC Actions from 20th September 2018

Item no	Item	Action	Lead	Progress update
				2131#362131 We have not yet completed the process so not yet able pull out any innovation.
44/18	Review of local health needs	Report back on the committee's following recommendations: a) The Oxfordshire Clinical Commissioning Group (CCG) Board to consider the committee's comments about the effective coordination of local needs with broader county health issues in their proposed framework for assessing local health needs; b) Oxford Health Foundation Trust to take a recommendation to their next Board meeting to release the reserved capital funds, in this financial year, to undertake remedial works on Wantage Community Hospital. This is to ensure the condition of the building does not exclude it from options for the future of health services in the local area; and c) The CCG to accelerate the timeframe for the process they propose in assessing health needs and be ready to come forward with	Louise Patten (CCG and Stuart Bell (OH)	On the agenda for the meeting of 29th November

HOSC Actions from 20th September 2018

Item no	Item	Action	Lead	Progress update
		concrete proposals at the 29th of November HOSC meeting. This includes to be ready, or close to being ready, for any necessary consultation on services in Wantage Community Hospital. For example, this may include the resumption of some services or change to services for consultation.		
45/18	DPH Report	a) Information to be circulated with regard to the exploration of tongue tie issues as they relate to breastfeeding. b) Information to be sought and circulated on the extent of community acquired (rather than hospital acquired) pathogenic MRSA.	Val Messenger (OCC)	a) Information circulated to the committee via email (17th Oct 2018) b) Information circulated to the committee via email (22nd Oct 2018)
45/18	DPH Report	Send the following recommendations to the Cabinet and Council: a) Consider lobbying the government for a minimum price on alcohol and a watershed of 9pm for the advertising of fast food on television b) Ensure that there is an evaluation of the healthy towns project when it comes to an end and to ensure decisions are made on how to spread the learning.	Jonathan McWilliam (OCC)	Recommendations reported to Cabinet on 16th October 2018:

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HOSC Forward Plan – November 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:

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

Meeting Date	Item Title	Details and Purpose	Organisation
Feb 2019	Report from Task and Finish Group on MSK Services	Final report from the HOSC Task and Finish Group on MSK Services. To be jointly presented by HOSC and the CCG.	HOSC/CCG
Feb 2018	Transition of LD services	• HOSC to receive a report on the benefits of the changes to LD services for patients	CCG

Updated: 20 Nov 2018

Meeting Date	Item Title	Details and Purpose	Organisation
Feb 2019	Health inequalities	• Review of progress in the Health and Wellbeing Board's progress with the Health Inequalities Commission recommendations. • (request made on 16/11/17 that progress be reported to HOSC every six months to ensure health inequalities remains a priority).	HWBB
April 2019	Dentistry	• Provision and capacity of NHS dentists in Oxfordshire • Dental health of adults and children in the Oxfordshire population, including where inequalities exist • Programmes of work to promote dental health	NHSE/OCC (Public Health, Adults and Children's)/CCG
April 2019	Quality Reports	• Quality Reports from: Oxford University Hospitals, Oxford Health and SCAS on the progress against their high level priorities. • Formal response from HOSC required on the final draft accounts	OH/OUH/SCAS/Federations
June 2019	HWBB Annual Report	An annual report to HOSC on the activity of the HWBB, covering: • Activity of the Board over the financial year 2018/19 in pursuit of the Health and Wellbeing Strategy • How it performed against its aims and objectives during that period, including an overview of performance for all the sub-partnerships of the Board (e.g. HIB/Children's Trust & Integrated Systems Delivery Board). • Report to include assessment of how revised governance arrangements are working • Plans for 2019/20.	
June 2019	Winter Plan 2018/19	• Evaluation of the Winter Plan 2018/19	

Updated: 20 Nov 2018

Meeting Date	Item Title	Details and Purpose	Organisation
Future Items			
To be confirmed	CQC Action Plan progress	• Progress on the CQC Action Plan, as determined through the second local area review	
	Adult Social Care Green Paper	• The potential implications of the ASC Green paper on the local health and social care system	System-wide
	GP appointments	• Scrutiny of GP appointments. • What are the numbers of GP appointments available in Oxfordshire and where? • What are the trends with GP appointments, nationally and locally? How long, how many, at what times and in what locations in the county. • What are the costs of GP appointments?	CCG/ GP federations
	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns. • Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure
	GP appointments	• Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored	CCG
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on	

Updated: 20 Nov 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		health inequalities	
	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell)	
	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? • 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

Donna Husband – Lead Commissioner, OCC

Emma Leaver – Service Director

Pauline Nicklin– Head of Service

Nicky Taylor – Operational Manager, Health Visiting
Angela Smith - Operational Manager, Health Visiting
Helen Lambourne – Family Nurse Partnership Supervisor
Margaret Fallon- Operational Manager,
School Health Nursing

Best Start In Life – Public Health Nursing

- Oxfordshire County Council commissions
  - 0-5 service delivered by Health Visitors and Family Nurse Partnership
  - 5-19 service delivered by School Health and College Health Nurses

National Picture

Oxfordshire 0-5 Service 2017-18

142,047 contacts with families

73% pregnant mothers seen antenatally

7,173 births

99% new birth visits completed

97% babies seen at 6-8 weeks

182 families in the Family Nurse Partnership Programme

94% children seen at 1 year old

94% children seen at 2 years old

96% mothers received a maternal mood assessment

Oxfordshire 5-19 Service 2017-18

24,440 contacts with school aged children

1471 onward referrals

38,381 interventions in schools

25% liaison
20% mental health &wellbeing
18% safeguarding
18% sexual health

100% schools and colleges have a health improvement plan in place

1,528 contacts with young people

3,537 interventions in colleges

76% sexual health
14% mental health & wellbeing

Public Health England

All O♥R Health

Healthy Child Programme: The 4-5-6 approach for health visiting and school nursing

0–5 years
HEALTH VISITING

0–19

5–19 years
SCHOOL NURSING

Safeguarding

ACCESS EXPERIENCE OUTCOMES

HCP
HEALTHY CHILD PROGRAMME

Safeguarding

VISIBLE ACCESSIBLE CONFIDENTIAL

6 HIGH IMPACT AREAS

- Parenthood and early weeks
- Maternal mental health
- Breastfeeding
- Healthy weight
- Minor illness and accidents
- Healthy 2 year olds and getting ready for school

5 HEALTH REVIEWS

- Antenatal health promoting visit
- New baby review
- 6-8 week assessment
- 1 year review
- 2-2½ year review

Healthy Child Programme: Pregnancy and the first five years of life

4 LEVELS OF SERVICE

- Community
- Universal Services
- Universal Plus
- Universal Partnership Plus

5 HEALTH REVIEWS

- 4-5 year old health needs assessment
- 10-11 year old health needs assessment
- 12-13 year old health needs assessment
- School leavers – post 16
- Transition to adult services

Healthy Child Programme: 5 to 19 years old

6 HIGH IMPACT AREAS

- Resilience and wellbeing
- Keeping safe
- Healthy lifestyles
- Maximising learning and achievement
- Supporting complex and additional health and wellbeing needs
- Transition

The workforce – Health Visiting

- Nursery Nurses
- Community Nurses
- HVs- Nurses with additional training at University - SCPHN
- Family Nurse Partnership Nurses

4 level service model for HV

- **Community**：work to support and develop local services and ensure clients know how to access them
- **Universal**：lead the delivery of the Healthy Child programme to families with children aged 0-5 years. We deliver a rolling health promotion programme and offer advice to support families to develop healthy relationships and attachments with their baby and child
- **Universal Plus**：provide additional support to families as episodes of care when a health need is identified e.g. support with post natal depression, infant feeding
- **Universal Partnership Plus :** working in partnership with family and other agencies to provide ongoing support to families with complex issues e.g. SEND, substance misuse, safeguarding concerns, LAC, teenage mothers. This level include the family Nurse Partnership

Family Nurse Partnership

- Offered to first time vulnerable teenage mothers.
- Licensed evidenced programme. Benefits children and families who have poorest outcomes. 9th year in Oxfordshire.
- "Oxfordshire remains one of the highest performing sites in the country" (FNP National Unit, 2018)
- April 2017-March 2018 worked with 608 Clients, Children, Fathers/Partners as Universal Partnership Plus.
- Intensive programme of up to 64 contacts over 2.5years.

Department of Health

Health visitors work with families & communities to improve access, experience, outcomes and reduce health inequalities

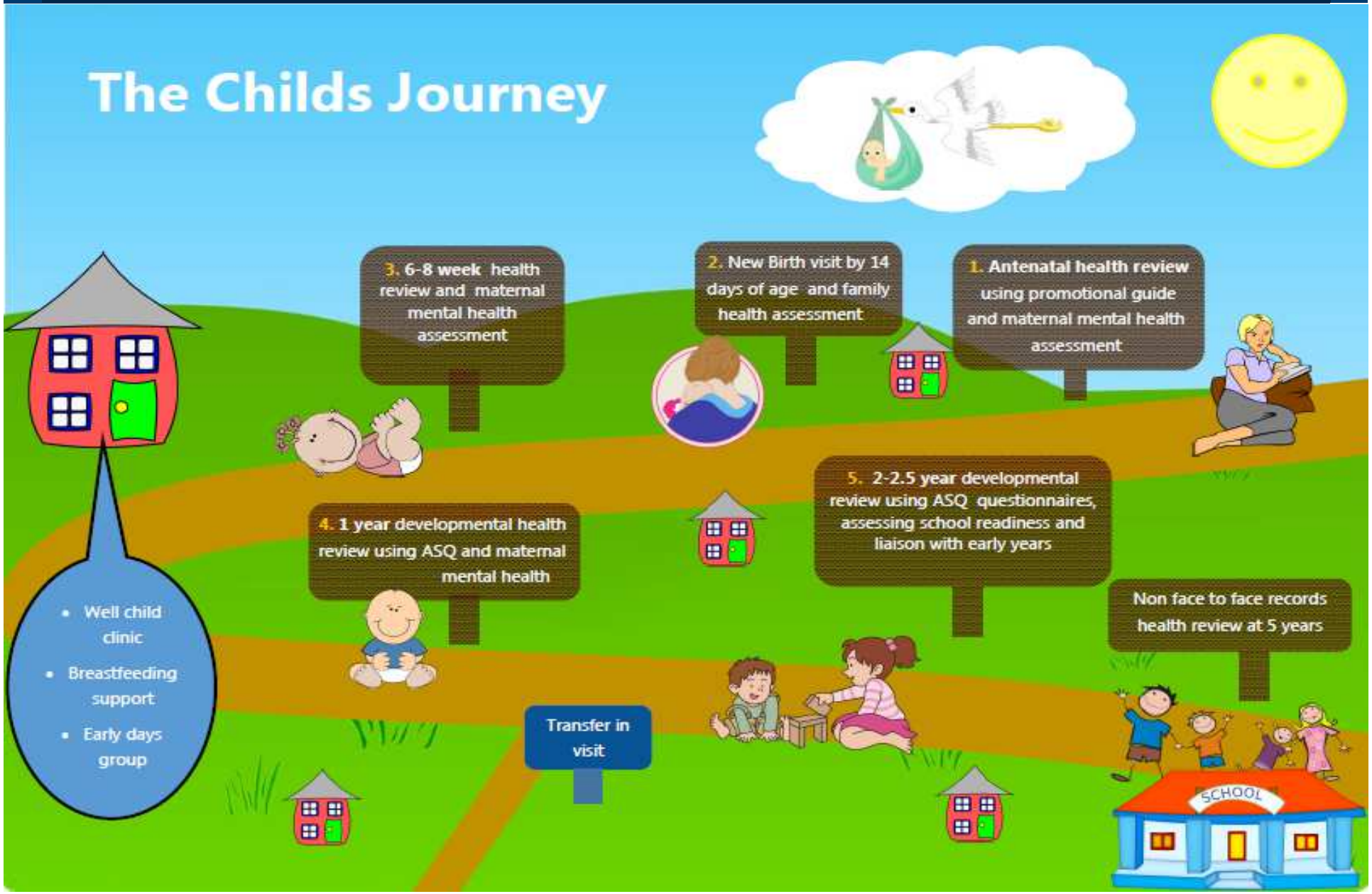
4 levels of service:
- Your community
- Universal
- Universal plus
- Universal partnership plus

5 universal health reviews*:
- Antenatal
- New baby
- 6 – 8 weeks
- 1 year
- 2 – 2 ½ years

*mandated for 18 months

6 high impact areas:
- Transition to parenthood
- Maternal mental health
- Breastfeeding
- Healthy weight
- Managing minor illness & accident prevention
- Healthy 2 year olds & school readiness

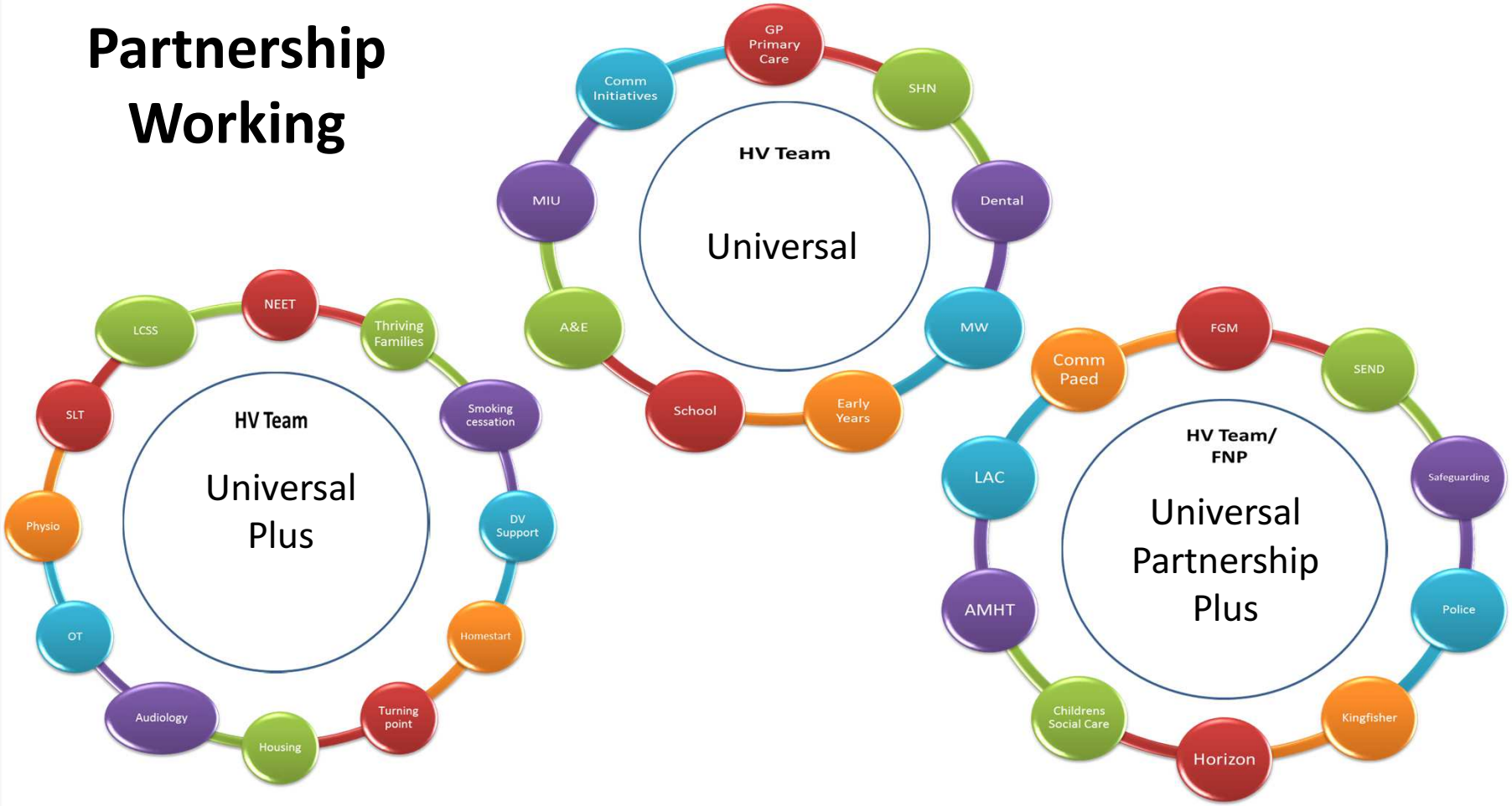
#healthvisiting


The Childs Journey
1. Antenatal health review using promotional guide and maternal mental health assessment
2. New Birth visit by 14 days of age and family health assessment
3. 6-8 week health review and maternal mental health assessment
4. 1 year developmental health review using ASQ and maternal mental health
5. 2-2.5 year developmental review using ASQ questionnaires, assessing school readiness and liaison with early years
Non face to face records health review at 5 years
Transfer in visit
Well child clinic
Breastfeeding support
Early days group
SCHOOL

high impact areas:

Transition to parenthood
Maternal mental health
Breastfeeding
Healthy weight
Managing minor illness & accident prevention
Healthy 2 year olds & school readiness

Partnership Working



0-5 delivery following changes to Children's Centres

❖ **Maternal Mental Health –**

- Perinatal Mental Health Specialist HV
- Knowing me Knowing you Groups

❖ **Estates –**

- Working with Community Initiatives
- More home visiting

❖ **Establish new professional relationships -**

- Children and Family centres
- LCSS
- Consistency of health promotion messages
- Support for school readiness

Public Health England

All O♥R Health

Healthy Child Programme: The 4-5-6 approach for health visiting and school nursing

0–5 years HEALTH VISITING

Safeguarding

ACCESS EXPERIENCE OUTCOMES

0–19

HCP
HEALTHY CHILD PROGRAMME

5–19 years SCHOOL NURSING

Safeguarding

VISIBLE ACCESSIBLE CONFIDENTIAL

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Healthy Child Programme: 5 to 19 years old

6 HIGH IMPACT AREAS

- Resilience and wellbeing
- Keeping safe
- Healthy lifestyles
- Maximising learning and achievement
- Supporting complex and additional health and wellbeing needs
- Transition

The Childs Journey

•Primary School SHN Team
•SHN Based in every Secondary Schools
•College Nurses

NCMP and follow-up

Health Needs Assessment

Transition to Primary school/ school readiness.

1:1 appointments and individual work

Confidential Drop-ins, referrals and 1:1

Transition to College and adult services
College / adult services

Health Promotion and education sessions

Transition to Secondary school

The workforce - School Health Nursing

- SHN Support Workers
- Community Nurses
- SHNs- Nurses with additional training at University - SCPHN
- College Nurses
- SHN Assistants – New role being developed

5-11 Years Offer

- Oral health promotion
- Hand hygiene
- Transition – pre-school liaising with HVs and offer of Health reviews
- Annual Health needs assessment – CP, CIN, EHA & Young Carers
- NCMP reception & year 6
- Promoting NSPCC 'Pants' rule and FGM
- Enuresis Groups
- Safety sessions - Water, road, bike, sun, internet safety & accident prevention
- Growing -up session
- School readiness groups
- Medical needs care-plan & EHCP
- A&E and hospital attendance follow-up
- LAC Health reviews
- Drop-ins for year 5 & 6 students in targeted schools
- Assessment of emotional health needs and referral to CAMHS
- NCMP whole school event
- Referrals- SALT, audiology

SAFEGUARDING

11-19 Years Offer

Immunisations year 8 and 9

Smoking cessation

One to ones

Exam stress sessions

Transition to secondary school

Transition HA to college or leaving school

Education sessions – smoking, healthy lifestyles, risk taking sexual health

Transition to adult services

Drop-ins

Daily access

Sexual health and contraception offer and outreach

Leaving school preparation sessions

SAFEGUARDING

School and Community

- Promote 'Our Healthy Year' resources to schools
- Collaborative Partnerships
- Social media
- LCSS
- Mental Health In-reach
- New Parent meeting
- Staff training for Anaphylaxis, asthma and epilepsy
- SHIPs and CHIPs
- Head Teacher and Senior Leadership meetings
- PSHE in Special Schools
- CASO
- Support to families
- PH initiatives, promotion and events – supported by PHPR
- SHN newsletters Termly parental newsletters, promoting healthy lifestyles

SAFEGUARDING

What they say:

SHN:
I have used the advice the school health nurse gave me and it has helped a little bit'

FNP:
"I just wanted to text u saying thank you for everything you have done, you and all the nurses are amazing and the whole service is brilliant. I don't know where I would be without you."

HV:
The health visitors have always been really helpful to me. Especially battling Postnatal Depression. (My HV), has been amazing. Couldn't be happier with the work they do

HV:
"Overall a professional and caring service" IWGC for HV

FNP: "I've learnt a lot from having B (Nurse) support me! She's being amazing and I don't think I would of been able to do it without her. She has made me realise that the most important resource for my baby is ME and I think this service is very beneficial". Client age 18

SHN:
Words cannot express just how grateful we are for your involvement and support in our very difficult family situation.
In our opinion you fulfilled your professional capacity perfectly in all areas and then also went above and beyond. We couldn't have asked you to do any more.

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healthwatch Oxfordshire

Your voice on health and social care

1 Healthwatch England Healthwatch Network Awards 2018

Healthwatch Oxfordshire has won an award at the Healthwatch England national conference.

Celebrated every year, the Healthwatch Network Awards highlight the ways in which local Healthwatch organisations across the country have helped make people's views of health and social care services heard.

Healthwatch Oxfordshire was nominated for an award in the category 'Championing diversity and inclusion, Understanding the needs of a community that is seldom heard'. It won the 'Highly Commended'.

The nomination was for the video 'Patient Voices…Our Story', which Healthwatch Oxfordshire and local filmmaker Nicola Josse made with the Patient Participation Group of Luther Street Surgery, Oxford, and Oxford Health. This GP practice service the city's homeless population and the film highlighted how the patients themselves were getting involved to shape how services are run. Oli, Chair of the Luther Street PPG along with Rosalind Pearce, Executive Director of Healthwatch Oxfordshire presented the video at a workshop. The video was very well received and discussed widely at the workshop.

The film was made with a grant from NHS England's Celebrating Participation in Healthcare scheme.

Jane Mordue, Chair of Healthwatch England, said at the Awards Ceremony: "Last year, more than 341,000 people shared their views about where things could be improved in health and social care with the Healthwatch network.

"The Healthwatch Network Awards are a fantastic opportunity to celebrate this work, highlighting the difference local Healthwatch have made by using this wealth of intelligence to help decision makers target their efforts to make things better.

"This year we received some outstanding entries from the network with over 150 submissions. We were impressed by the quality and incredible range of work on show and they all highlight the real impact we can have when people's experiences are placed at the heart of the services they receive."

To watch the video view online at https://youtu.be/3ZLJ_G-3QMw or visit our web site www.healthwatchoxfordshire.co.uk

2 Update on activity

2.1 Dentistry - update

Healthwatch Oxfordshire invited key stakeholders to a workshop on 17th September to discuss our findings and begin to identify how they can be addressed. The main

outcome was agreement by the attendees to work together to develop an assessment tool for use by care homes to identify and put in place dental needs of individual residents.

It is worth noting that NHS England commissioners for dental services did not attend the workshop but have expressed interest in working in the future with Healthwatch Oxfordshire and other stakeholders.

2.2 Wantage

The report on our focused activity in Wantage in May this year has now been published together with the responses from Oxfordshire County Council and jointly from Oxfordshire Clinical Commissioning Group and Oxford Health NHS Foundation Trust https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/ The report highlighted What we heard in five themes and made four recommendations. The themes were:

1. There is concern about insufficient provision at the Wantage Health Centre on Mably Way;
2. There is concern about the new houses being built without the additional resources;
3. Public transport has been reduced and no longer meets some residents' needs;
4. Residents would like to see the Community Hospital be reopened;
5. GPs don't always refer to CAMHS quickly enough and the waiting lists are long when they do.

Recommendations

1. Improved communication between Oxfordshire Clinical Commissioning Group and the people of Wantage about the expansion of the health centre - what is the reality of the situation?
    a. Healthwatch Oxfordshire has asked Oxfordshire Clinical Commissioning Group for the latest on the proposed developments and the response given on 3rd September 2018 was:
2. Open dialogue between Oxford Health NHS Foundation Trust and the community about the closure of the Community Hospital.
3. Increased mental health awareness training for GPs.
4. When planning local health, social care services, and additional housing, authorities should consider the travel and transport needs of the local community including access to public transport and supporting local community transport schemes.

2.3 Oxfordshire Joint Health Overview and Scrutiny Committee MSK/Healthshare Task and Finish Group

Healthwatch Oxfordshire reported to the Task & Finish Group, presenting a report that collated patient stories and information gather from patients from our

Feedback Centre and telephone calls. The stories we heard were so disturbing that we decided to publish our report without further delay.

In total we have heard from more than 50 patients, all often describing a dire patient experience, summarised as follows:

- confusing and poor communication between Healthshare and the patient;
- often long and complicated patient experience through from GP referrals, Healthshare, to GP referral, to Healthshare, to hospital, back to Healthshare, referrals…and so it goes on;
- people not being able to contact Healthshare by telephone despite frequent, and often over a long period of time, making calls; emails not being answered;
- patients not knowing where to go to make a complaint;
- long waiting times for appointments.

The report outlined our key concerns and recommendations as follows:

1. Constant problems with accessing Healthshare telephone number
    a. Increase capacity at Healthshare to answer calls within agreed time
    b. Do not let people hang on waiting for reply then cut them off!
    c. Offer a call back system
2. Patients not receiving written confirmation of appointment time and location
    a. Automated letter sent within 24 hours of when appointment made with contact number and email for cancellation / further information
    b. Use mobile telephone text for confirmation and reminder.
3. Patients are being asked to travel substantial distances to appointments
    a. Review of locations of service considering where people live who are being referred.
    b. First choice appointment offered at closest location – ask the patient as they will know travel / public transport needs.
4. Information about Healthshare not given to patients on referral – confusion arises about whether this is an NHS service or not and how to contact them prior to receiving 'welcome' letter
    a. General Healthshare leaflet given to all patients referred by GP to include contact number, email, commitment to contact within set time.
5. The Healthshare complaints procedure, including how to complain, should be accessible on the web site and in paper form. Patients who file a complaint should then be responded to stating whether Healthshare are treating this as a formal complaint.
    a. Healthshare must be required to report to OCCG on complaints received.
    b. Healthshare should place the Healthwatch Oxfordshire widget on its website, thus giving patients a route to an independent voice.
6. 'How are we doing?' is **not** part of a complaints procedure.

a. Healthshare should be required to report to OCCG analysis of 'How are we doing?' not just on the patient survey.

7. Patient satisfaction survey does not ask any questions about the referral process or administration.
    a. Healthshare Patient satisfaction survey must include questions about the referral process, and communication between Healthshare and patient.

Prior to publication, the report was sent to Oxfordshire Clinical Commissioning Committee and Healthshare Ltd for comment and response. All the recommendations were accepted or already being acted upon. Three recommendations are to be implemented by 19th October. These are:

- Formal complaints procedure and information to be clearly available on the Healthshare website
- Healthshare to include in its monitoring information what they have heard from their 'Tell us how we are doing' form
- The inclusion of questions about the referral process to be included in the Patient Satisfaction survey questionnaire.

Our report and the responses from Oxfordshire Clinical Commissioning Group and Healthshare Ltd can be found here https://healthwatchoxfordshire.co.uk/our-reports/

The promised improvements in the telephone service, and communications between the service and patients will be monitored closely by Healthwatch Oxfordshire.

2.4 Community Support Services and voluntary sector day centres review

One of Healthwatch Oxfordshire's main projects to date this year is a review of people's experiences of going through the service changes to community support services – day centre support – across the county. In October 2017 major changes were made to access and operational aspects of day centre provision, including eligibility, transport and a single service for elderly and people with learning disability.

Healthwatch Oxfordshire staff are visiting the eight county council Community Support Service centres and six voluntary sector day centres talking to service users and staff to understand their experiences through this change. We have surveyed 800 people who used day centres prior to the changes in 2017. This project has taken more than nine months to plan – working with the county council and Age UK Oxon – and is now in full flow.

A final report will be published in time to present to Joint Oxfordshire Health Overview & Scrutiny Committee (HOSC) in February 2019.

2.5 Abingdon pop-up shop

For the first time ever, Healthwatch Oxfordshire opened a pop-up shop in a local town. Over four days at the end of August we located two members of staff and a volunteer in Abingdon town centre, promoting Healthwatch Oxfordshire and encouraging members of the public to come and tell us their experiences of health and social care services. We contacted more than 100 people and learned some good lessons from this approach that will be applied when the team is next out and about in the community.

2.6 Project fund

The first of our reports on research carried out with support from our Project Fund and supported by Healthwatch Oxfordshire staff was published. Titled 'Men's Health' this covers access to men's health check-ups and health services by the Black, Asian and Minority Ethnic community in east Oxford. Healthwatch Oxfordshire have been successful in gaining an award from NHS England Communities Fund to co-produce a video with the group about the research approach taken. Further information can be found here.

2.7 Enter & View[1]

Enter & View report on Cherwood House Care Home is published on our website and available here.

2.8 Hospital Signage

After a lengthy campaign by Healthwatch, improved signage has been installed at the JR, providing designated parking spaces for hospital transport vehicles, and better public information about the services available from the Patient Advice and Liaison Service (PALS).

3 External meetings attended in September and October 2018

The following list includes meeting attended by the Executive Director, Chair, Board members representing Healthwatch Oxfordshire, and members of the Healthwatch Oxfordshire staff team. The list does not include groups and organisations contacted as part of our listening / outreach activity.

- West Oxfordshire District Council
- Locality Forum Chairs & Oxfordshire Clinical Commissioning Group (in attendance)
- North Oxfordshire Locality Forum event in Chipping Norton

[1] Enter & View - The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

- Patient Participation Partnership West Oxfordshire (locality Forum) event in Witney
- Health Overview & Scrutiny Committee – 20th September
- Health Overview & Scrutiny Committee – Task and Finish Group – MSK/Healthshare
- Health & Wellbeing Board – workshop
- Oxfordshire Adults Safeguarding Board 26th September full Board meeting & joint meeting with Oxfordshire Children's Safe Guarding Board; Engagement Group
- Oxfordshire Clinical Commissioning Group – Primary Care Commissioning Committee (non-voting member)
- Cherwell Partnership Network (member)
- Teleconference with Care Quality Commission managers
- Health Inequalities Commission – Implementation Group
- Thames Valley Integrated Urgent Care - Clinical Assurance Group – representing Thames Valley Healthwatchs
- Dentistry Reports follow-up meeting with stakeholders
- Oxford University Hospitals NHS Foundation Trust AGM
- Healthwatch England Annual Conference
- Newbury Street GP Practice
- Bicester Healthwatch Oxfordshire Town event follow-up meeting
- Cherwell Seniors Forum
- Oxfordshire Stronger Communities Alliance (OSCA)

4 Media

During September and October 2018 Healthwatch Oxfordshire has received 10 requests for comments from the media; we have had 12 individual items of media coverage including radio, television and local newspapers. Stories that have received media coverage include:

- Healthshare report
- Wantage report
- Luther Street award
- Quoted in story about more healthcare assistants to free up nurse
- Dentistry in Care Homes and dentistry report
- Healthwatch Oxfordshire Board meeting in public in Thame
- Potential closure of Cogges GP surgery in Witney
- 10am-10pm hospital visiting hours.

Overview and Scrutiny Committee.
29 November 2018

Chairman's Report

1. Health liaison

1.0 The Chairman and committee received briefings regarding the following issues, which are each summarised below.

1.1 GP contract decision pathway workshop

1.2 On Friday the 21st September, three HOSC members attended a stakeholder workshop at the Kings Centre to discuss a decision pathway in the instance a GP hands back its contract. This workshop included representatives of NHS England, the Local Medical Committee, Healthwatch, Patient Participation Groups and patients themselves. The meeting was held as a result of contract notices given in Oxfordshire practices, with different paths taken and different outcomes.

1.3 During the meeting, the factors which need to be considered were explored and the following issues raised:

- Consideration of the size of the practice
- Rural or urban setting of the practice
- Early indications of a struggling practice
- The employment model the practice is working with and their existing partnerships
- The estate the practice occupies
- Viable options for the future (inc capacity considerations)

1.4 The results of the workshop are being fed into a draft 'decision tree', which the same group of stakeholders will consider again on the 21st of November 2018. The decision tree will consider the lessons of what has (and has not) worked in Oxfordshire in the past.

HOSC recommendations on review of local health needs and Wantage Community Hospital

1.5 A meeting was held on the 2nd of October with five HOSC members, the Director of Governance from the CCG and the Chief Executives of the CCG and Oxford Health FT (OH) to discuss recommendations that were made by HOSC at its meeting on the 20th of September 2018. The meeting was requested by the CCG and OH to clarify HOSC expectations regarding the recommendations the committee made during its meeting. The recommendations were:

1. *The Oxfordshire Clinical Commissioning Group (CCG) Board to consider the committee's comments about the effective coordination of local needs with broader county health issues in their proposed framework for assessing local health needs;*
2. *Oxford Health Foundation Trust to take a recommendation to their next Board meeting to release the reserved capital funds, in this financial year, to undertake remedial works on Wantage Community Hospital. This is to ensure the condition of*

the building does not exclude it from options for the future of health services in the local area; and

3. *The CCG to accelerate the timeframe for the process they propose in assessing health needs and be ready to come forward with concrete proposals at the 29th of November HOSC meeting. This includes to be ready, or close to being ready, for any necessary consultation on services in Wantage Community Hospital. For example, this may include the resumption of some services or change to services for consultation.*

1.6 The following summarises the discussion:

- The Chairman stated that the HOSC recommendations were made formally, in public, given the committee's consideration of all the issues presented to them on the 20th of September 2018. Representatives of the committee present at the meeting of the 2nd of October, were not empowered to change or negotiate these recommendations but could offer clarity on what was expected in response.
- With specific reference to recommendation (3), and accelerating the timescales involved for consultation, the CCG outlined how there are specific requirements on the NHS with regards to consultation. The law requires NHS bodies to engage with members of the public before making decisions on changes to health services and then to formally consult where changes are substantial. Where formal consultation is required, NHS England need to provide assurance on proposals which are written in a Pre-Consultation Business Case (PCBC) which contains all the necessary evidence for assurance. The NHS England assurance process takes two months to complete and a consultation period would run for 12 weeks, in line with statutory guidance.
- There was a discussion regarding the definition of consultation and engagement so as not to confuse expectations with legal definitions in the NHS. The interpretation of what is consultation and what is engagement has specific legal definitions for the NHS. Consultation for the committee is about open communication with the public and giving the public opportunities to have their say in the shape and provision of services. The NHS understands this to be more like an early step of the process, going out to formal legal consultation only when proposing service change.
- Engagement is a development phase of exploration with patients and residents. Proposals emerge from this, along with identifying alternative models. Consultation is a formal set of options which are clinically safe, sustainable with staff, affordable and deliverable. In engagement, people might say they want access to primary care, they might be concerned about dementia or they might be concerned with access to community hospital beds. Engagement bears this out.
- HOSC, at its meeting on the 20th of September, understood that the new approach is one of engagement that comes up with options, some which can be progressed without consultation and some which may need consultation. HOSC was also clear that the Wantage Hospital closure was supposed to be temporary but two years (three by the time consultation is likely), is not temporary. By end of November, the committee expects to see an acceleration of the proposed framework up to deliver proposals which can be taken forward, either to recommence services, deliver identified services from Wantage and/or to move forward appropriately to consultation. The Committee want specific information which will describe how decisions will be taken to move forward on any consultation. This may include the CCG speaking to local residents, looking at models working in other places and be

understanding which aspects may be able to change anyway and which are likely to need consultation.

- Changes to models of service delivery in other community hospitals which have been made in the past are not popular when first proposed and people think they are losing hospital beds. The models of care now in Henley Townlands and Thame Community Hospitals are now popular with patients and residents, but this was not the case before and during the changes.
- The original reason for not progressing remedial plumbing works at Wantage Hospital was because the issues with the system which had been created by incremental changes, creating spaces in the plumbing system for legionella to develop. Carrying out remedial works and spending £450k when changes to the configuration are very likely would not be a good use of public money. Oxford Health FT Board will reconfirm the money will be available to replumb the hospital, as determined necessary, so that the need for replumbing does not stand in the way of the options.
- There is a need to have as wide ranging an engagement process as possible, so that the process is not just about beds; its about primary care as well, local health issues and other models. The process has to be sufficiently broad in consideration of local health need, yet it is key that proposals are specific; with specific dates for events and decisions by the HOSC November meeting.
- The HOSC paper deadline is seven weeks away and by that time, the recommendations make it clear that the CCG needs to be ready to come to HOSC having taken action, be specific and have an understanding of proposals for engagement and then consultation. The stages of the framework proposed at the HOSC meeting on the 20th of September need to be progressed at pace. There needs to be a vision and a strategy developed for Wantage which the CCG need to schedule engagement on and make a decision for moving forward to formal and legal consultation. The end point needs to be sooner than the existing process indicates (e.g. February-March instead of May 2019).
- The CCG can begin the conversation with Wantage residents before the HOSC meeting in November; this is engagement work which will flow into the formulation of proposals which may or may not require consultation but they cannot move into a formal consultation until the engagement work has been completed and options have been developed. This is a requirement of NHS England assurance, who are the body that give the approval to move to consultation.
- The CCG and OH need to have a conversation with NHS England to explain the locally specific issues which need resolving so that the broader health issues picture can be looked at. NHSE need to understand the local context and that HOSC and health are working together, in-line with the recommendation from the Secretary of State and in-line with the local HOSC/health protocol which NHSE themselves were involved in developing.

Next steps:

- The CCG and OH to meet with NHSE to explain the local circumstances and what they are expecting them to do with regards to assurance as the terms with which they deal with these issues need to be different.
- CCG and OH to feed in to the HOSC Planning Group after the NHSE conversation.
- CCG and OH to report back to HOSC on the 29th of November against the recommendations outlined by the committee.

Chairman's meeting with the CQC

1.7 The Chairman was interviewed on the 6th of November as part of the Care Quality Commission (CQC) re-visit to understand progress being made by the Oxfordshire health and social care system since its inspection in November 2017.

2. The Horton HOSC

2.0 The first meeting of the new Committee took place on Friday the 28th of September 2018 at 2pm in Banbury Town Hall. In considering the Oxfordshire Clinical Commissioning Group (CCG) and Oxford University Hospital (OUH) Trust's proposed approach to addressing the Secretary of State's recommendations in response to the referral of proposed changes to obstetric services at the Horton General Hospital, the following was agreed at the meeting:

1. A meeting of the Horton HOSC would be arranged in early/mid-November 2018 the CCG and Oxford University Hospitals FT (OUH) will share:

a) A more detailed scope for each of the proposed workstreams and a realistic timetable for completion.
b) A review of transfer times between the Horton and JR hospitals for mothers needing obstetric interventions and the contingency plans for when there are multiple demands on the dedicated ambulance or severe traffic delays, etc.
c) A clinical view on the acceptability of the quoted transfer times (30-120 minutes) from the Horton Hospital to the JR.
d) An overview of the data on mothers who have *chosen* to go to other hospitals because of the situation at the Horton and where those hospitals were.
e) Analysis of the current and future demand for services at the Horton, including an assessment population growth as a result of future housing and growth plans.
f) A comprehensive engagement plan that demonstrates a focus on the voices of local people and gives sufficient attention to mothers in Northamptonshire and Warwickshire.
g) Further refinement of the options (particularly option 4 in the papers provided to the Horton HOSC on the 28th of September to have 50 / 50 split of nontertiary births) to take account of the population share of births, as opposed to just the size – i.e. some sensitivity analysis.
h) An overview of the cost of patients going out-of-county vs. the income received from patients coming to the Horton.
i) The questions in the proposed survey before this is sent out.
j) Detail about the options appraisal process and any weighting of the appraisal criteria.
k) Further information about the approach to recruitment and retention of midwives and doctors at the Horton.

2. An 'opinion-evidence gathering meeting' will be held in December 2018 for the Horton HOSC to hear the views of key stakeholders, the public and interested parties in order to inform the Committee's future scrutiny of CCG and OUH plans.

The Committee agreed to initially invite the following witnesses (this is not an exhaustive list):

- The Local Medical Committee
- District Councils
- Healthwatch (across Oxfordshire, Warwickshire and Northamptonshire)
- Royal Colleges
- NHS England
- Thames Valley Clinical Senate
- Interested professionals (e.g. midwives, obstetric trainee doctors, middle-grade doctors, consultants)
- The Ambulance Service
- Mothers / families who are or have been affected by the loss of obstetric services at the Horton
- Campaign groups

2.1 The next meetings of the Horton HOSC are scheduled for:

- Monday 26th of November
- Wednesday 19th of December 2018.

3. Judicial Review

3.0 A Judicial Review was heard on the 6th and 7th of December 2017 in response to a legal challenge on Oxfordshire Clinical Commissioning Group's (CCG) consultation for Phase One of the Transformation Programme. The challenge was launched by Cherwell District Council, with support from South Northamptonshire Council, Stratford-on-Avon District Council, Banbury Town Council and interested party Keep the Horton General. Following the hearing at the High Court Judge, Mr Justice Mostyn announced his decision on the 21st of December to dismiss the judicial review on all six points relating the consultation process.

3.1 In response to the judgement, Keep The Horton General campaign lodged an appeal against this decision in January 2018. On 30th of October 2018, there was an announcement that Keep the Horton General Campaign were granted the right to appeal against Mr Justice Mostyn's decision in December 2017.

3.2 The CCG released the following statement from Louise Patten, Chief Executive in response to the decision to grant a right to appeal:

"We are disappointed with this new development as it has been nearly 11 months since Mr Justice Mostyn ruled in favour of the CCG in the judicial review of its Transformation Consultation process. The judge dismissed the claims brought by the claimants which included interested party Keep the Horton General campaign group. We are currently seeking clarification on the implications of this permission to appeal as well as the impact this legal process has on progressing the Secretary of State's recommendations and working with the newly formed joint Horton Health Overview and Scrutiny Committee."

"I personally feel that the Horton General Hospital has a vibrant future. Last year saw the refurbishment of the endoscopy unit; the award winning bowel scope screening test will be rolled out to the hospital in December and good progress is being made to develop a single access point for patients requiring urgent care at the front door of the Horton."

4. MSK Task and Finish Group

4.0 The HOSC MSK Task Group met several times during September, October and November. The following summarises the Group's meetings:

Date	Details
12th Sept	Meeting to gather views of MSK services from patients through Healthwatch and from GP's through the Local Medical Committee
17th Sept	Gather the views of clinicians working within the MSK pathway
19th Sept	Hear the perspective of a previous provider
9th Oct	Review information gathered and determine next steps; this included drafting some recommendations to discuss with Healthshare and the CCG
5th Nov	Meetings with Healthshare and the CCG to look at a full year's data, discuss performance and draft recommendations

4.1 The Group has made some interim recommendations, which the CCG and Healthshare are taking action on. In addition, the Task and Finish Group supported recommendations that Healthwatch made regarding the services made through their report to the Task Group. These recommendations can be found in Appendix A of this report and have been published on the Healthwatch website, along with positively received responses from Healthshare and the CCG, they can be found here: https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/

4.2 Following the Task Group's last meeting on the 5th of November, it is now in the process of gathering final pieces of information in finalising its recommendations. Its recommendations will be shared with the CCG and Healthshare for a response before reporting to HOSC in February 2019.

Appendix A: Recommendations from Healthwatch Oxfordshire Report on MSK services

1. Constant problems with accessing Healthshare telephone number:

a. Increase capacity at Healthshare to answer calls within agreed time
b. Do not let people hang on waiting for reply then cut them off!
c. Offer a call back system

2. Patients not receiving written confirmation of appointment time and location:

a. Automated letter sent within 24 hours of when appointment made with contact number and email for cancellation / further information
b. Use mobile telephone text for confirmation and reminder

3. Patients are being asked to travel substantial distances to appointments:

a. Review of locations of service considering where people live who are being referred
b. First choice appointment offered at closest location – ask the patient as they will know travel / public transport needs

4. Information about Healthshare not given to patients on referral – confusion arises about whether this is an NHS service or not and how to contact them prior to receiving 'welcome' letter a. General Healthshare leaflet given to all patients referred by GP to include contact number, email, commitment to contact within set time

5. The Healthshare complaints procedure, including how to complain, should be accessible on the web site and in paper form. Patients who file a complaint should then be responded to stating whether Healthshare are treating this as a formal complaint.

a. Healthshare must be required to report to OCCG on complaints received.
b. Healthshare should place the Healthwatch Oxfordshire widget on their web site, thus giving patients a route to an independent voice.

6. 'How are we doing?' is **not** part of a complaints procedure:
a. Healthshare should be required to report to OCCG analysis of 'How are we doing?' not just on the patient survey.

7. Patient satisfaction survey does not ask any questions about the referral process or administration:
a. Healthshare Patient satisfaction survey must include questions about the referral process, and communication between Healthshare and patient.

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Oxfordshire Joint Health Overview and Scrutiny Committee
November 2018

Progress Report Regarding the Oxfordshire Health and Wellbeing Board

1. Introduction

The Health Overview and Scrutiny Committee has requested a progress report from the Health and Wellbeing Board to cover the following questions:

1. How effective is the Health and Wellbeing Board (HAWB) at driving forward health, public health and social care integration?
2. Is there effective governance in place to deliver this?
3. How well is the HAWB preparing Oxfordshire's health and social care system for greater integration?

This paper includes:

- a report on the review of governance processes undertaken by the Health and Wellbeing Board.
- details of how the new arrangements are enabling integration across the health and social care system and a summary of how this will continue to develop.

The HAWB would also like to take this opportunity to engage with HOSC members about the refreshed Joint Health and Wellbeing Strategy so that their comments can be taken into account before the strategy is finalised.

2. New Governance Arrangements of the HAWB.

An extensive review of the governance arrangements for the HAWB was summarised in a paper to an extraordinary meeting in May 2018. The final arrangements were agreed at the HAWB on November 15th 2018.

The review process included a comprehensive series of evidence-gathering meetings when the Chairman, Cllr Ian Hudspeth, and the Vice Chairman, Dr Kiren Collison, met with a wide range of stakeholders in February and March 2018. These included current members of the HAWB, Chief Executives and Chairman of NHS Trusts and Federations, voluntary sector and contractual partners and representatives of the public. Other stakeholders, including District Councils and the Police and Crime Commissioner were invited to give their views in writing.

The findings from the review meetings and written submissions were collated in a discussion paper which was published for an extraordinary meeting of the HAWB in May 2018. The paper proposed changes to governance of the Board in the light of the comments and suggestions of the stakeholders. These ideas were debated and finalised. In statute, Health and Wellbeing Boards are sub-committees of upper tier Authorities and so the final arrangements were confirmed at a formal meeting of the County Council on May 15th 2018. The paper can be seen here:
http://mycouncil.oxfordshire.gov.uk/documents/s41674/HWB_MAY1018R01.pdf

The changes that have been confirmed have included revised membership of the HAWB which now includes:

- Leader of the County Council – Chairman;

- Clinical Chair of Oxfordshire Clinical Commissioning Group - Vice-Chair;
- 2 District/City Council representatives in their roles as the current Chairman and Vice Chairman of the Health Improvement Board;
- Cabinet Members of the County Council with responsibility for Adult Social Care, Children & Family Services and Public Health;
- Accountable Officer Oxfordshire Clinical Commissioning Group;
- C/E Oxford University Hospitals NHS Foundation Trust;
- C/E Oxford Health NHS Foundation Trust;
- C/E Oxfordshire County Council;
- A Healthwatch representative;
- The Lead District Council officer from the Health Improvement Board
- The Director for Children's Services;
- The Director for Adult Social Care;
- The Director of Public Health;
- An NHS England representative;
- Primary Care representation (under discussion).

2.1 Board Development

These changes effectively created a new Board, and so an Organisational Development approach has been taken to establishing the new HAWB and to create closer working practice as a team. This approach has so far included 3 workshops (on 19th July, 3rd October and 23rd October). The first and second workshops were externally facilitated by experienced LGA Associates who brought insights from other areas and challenge to members of the Board as they discussed priorities and principles for working together.

These workshops have enabled the HAWB members to

- Agree a shared vision for their work
- Devise and produce a new Joint Health and Wellbeing Strategy which will now be subject to engagement with the public and other stakeholders. This includes 4 priorities for the HAWB to deliver at strategic level and a life-course approach to health and service improvement across the whole system.
- Review the terms of reference for the HAWB and its 5 sub-groups to ensure they are aligned. These sub-groups are tasked with delivering a range of strategies and plans which align with the Joint HAWB Strategy
- Create the terms of reference for the new Integrated System Delivery Board to define its specific remit for integrating health and social care.
- Define reporting and monitoring arrangements so that all the sub-groups have a clear remit and responsibility for delivery.

As a result, the following outputs have been finalised:

- Clear and unified terms of reference for the HAWB and its 5 sub-groups which will enable delivery of priority work and reporting of outcomes.
- A shared vision - "*To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire"*
- 4 strategic priorities for the HAWB:
    - Agreeing a coordinated approach to prevention and healthy place-shaping.
    - Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan).
    - Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.
    - Agreeing plans to tackle critical workforce shortages.

- A life-course approach which includes priorities to be delivered for
    - A good start in life
    - Living Well
    - Ageing Well
    - Tackling wider issues that determine health
- An approach to Prevention has been agreed which will be implemented through all the work of the Board and across the system. It is summarised as "Prevent, Reduce, Delay" and is set out as follows:
    - Live longer lives (**prevent** illness), by helping people keep themselves healthy
    - Live well for longer (**reduce** need for treatment) by identifying any health issues early and supporting people to manage their long-term conditions
    - Keep us independent for longer (**delay** need for care) by providing the right support at the right time
- Tackling Health Inequalities is the second cross cutting theme of the JHWBS and is to be implemented by addressing 2 main issues:
    - Inequalities in opportunity and / or outcome – some people don't get a good start in life, live shorter lives or have longer periods of ill health
    - Inequalities of access – some people cannot get to services, don't know about them or can't use them
- Some outstanding details of the new arrangements will be finalised soon. They include
    - final clarification of primary care representation arrangements on the HAWB
    - Performance reporting from the sub-groups, which will be finalised and operational by the meeting in March 2019
    - Developing a streamlined approach for reporting progress to the Boards by the constituent organisations

The Terms of Reference for the HAWB and its sub-groups are attached as Annex 1.

The Draft Joint HWB Strategy for engagement with the public and with HOSC through this meeting is attached as Annex 2. A final draft version will be presented to the HAWB for adoption in March 2019.

3. Action taken by the Health and Wellbeing Board to drive forward health, public health and social care integration.

The action taken can be summarised as follows:

3.1 The review of the HAWB arrangements and the new membership described above is the bedrock on which further integration rests. We are now confident that we have the right people sitting at the table to drive forward change.

The point of the HAWB is to act as a collective for the benefit of local people. The Board does not in itself have extensive decision-making powers, and so relies on the decision-making powers of the Board members as conferred on them by their own organisations. That is why we have taken a careful team development approach to the new Board over the last six months. We believe that getting these basic steps right will deliver more improvements for the benefit of the people of Oxfordshire faster in the medium and long term.

The immediate fruit of this approach can be seen in the draft Joint Health and Wellbeing Strategy and in the setting of a clear vision and priorities for the Board. We look forward to hearing HOSC's views on these proposals.

3.2 The creation of the Integrated System Delivery Board (ISDB) as a sub-group of the HAWB has led directly to an acceleration in activity to integrate services.
Some of the direct results of the having an ISDB in place are already well known to HOSC. The concrete improvements made to integration of services include:

- Creation of a Winter Director supported by a joint Winter Team resulting in an improved Winter Plan and an embedded approach to reviewing all patients in a hospital bed for 7 days to ensure timely discharges when the person is medically fit. This approach is known nationally as reviewing "stranded patients." This is one of a suite of key initiatives that has seen delayed transfers of care at their lowest in recent years. HOSC has already been in receipt of regular reports on these developments.

- Creation of an integrated approach to population health management across the County. This is a systematic way of making sure services offer treatment for the early stages of disease as well as treatment by looking in detail at what causes problems and what could be done to prevent them.

- The ISDB has also taken forward the delivery of the CQC action plan and this is one of the HAWB's major priorities. CQC were particularly concerned about the leadership of the health and care system and about our unified approach to the flow of patients through our health and care services. They visited Oxfordshire to check on progress on November 6th and 7th. The Chair of HOSC was interviewed as part of this process. We await the formal feedback from the visit, but received favourable comments through informal feedback about improvements in integrated leadership of health and care services, while CQC noted that there is still considerable work to done.

- System leaders are continuing to come together to take a joint approach to workforce building on the joint recruitment campaign last winter. Significant exploration is underway around how workforce fits together across health and care and what works best locally whilst building on best practice from wider Sustainability and Transformation Partnership (STP). This has included the creation of the Oxfordshire System Workforce Action Group to embed an integrated approach to our key workforce themes such as workforce planning, recruitment and retention, leadership and organisational development, key worker housing and career pathways. CQC felt we had some excellent examples of best practice in our response to their previous recommendations on workforce.

3.3 Strategic-level discussions with the Growth Board about healthy place-shaping. This takes the approach to Healthy New Towns as a starting point and seeks to generalise the lessons learned across wider areas of the County. This then begins to integrate the 'growth agenda' and the 'health and wellbeing agenda' and helps to put 'health' into planning.

3.4 There has been considerable progress in embedding approaches to prevention across the system and the ambition to do more is set out in the JHWBS as noted above. The scope of the work to “Prevent, Reduce, Delay” has been well-received as all partners can easily see where their contribution fits into a system-wide ambition. The foundations for this work have been laid in the Health Improvement Board over several years, as County and District Councils have been working with NHS and other partners to establish strong preventive initiatives. These have included enabling and supporting healthy lifestyles, ensuring good uptake of screening services and pooling budgets to tackle housing issues and domestic abuse, for example. The approach is now being rolled out through clinical pathways and place-based initiatives, using Population Health Management methodology. This gives a clear, evidence based approach and enables a wide range of partners to contribute across the system. Learning from the Healthy New Towns is also crucial in the development of Healthy Place Shaping – addressing physical and social aspects of development across the county to **Prevent** ill-health, **Reduce** the need for treatment and **Delay** the need for care.

4. Summary

In summary, the HAWB has carried out a substantial body of work regarding its governance, membership and development as a Board.

A vision, priorities and strategy have been produced and sub-groups have been reviewed.

New initiatives around winter planning, system flow and prevention outlined in this paper show the early fruit of this approach.

Further improvements are to be expected over the coming year. It is too early to expect these to be reflected in performance figures across the Board, but the reduction in delayed transfers demonstrates the improvements made.
We await the views of CQC and will take these into account alongside HOSC’s comments as we move into the New Year.

Jonathan McWilliam, Jackie Wilderspin, Catherine Mountford, Kate Terroni

Annex 1a- Terms of Reference (Health and Wellbeing Board)

Health & Wellbeing Board
Terms of Reference

1. Health & Wellbeing Board

The Council has a duty to establish a Health & Wellbeing Board[1]. The Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

2. Role and Function

The Health & Wellbeing Board will have the following responsibilities:

(1) The Health & Wellbeing Board will create and own a single unifying vision for the improvement of the Health and Wellbeing of Oxfordshire residents.

(2) The Health & Wellbeing Board will create, own and monitor a comprehensive high-level health and wellbeing strategy[2] for the improvement of the Health and Wellbeing of Oxfordshire residents.

(3) The Health & Wellbeing Board will agree endorse a suite of strategies which will be created and also owned by its sub-committees and sub-groups. These will flow from the overarching Joint Health and Wellbeing Strategy.

(4) The Health & Wellbeing Board will monitor the implementation of its strategies and the member organisations will hold one another to account for delivery. The Board will receive regular reports from its sub-committees and sub-groups based on outcome measures set by each.

The Health and Wellbeing Board will
(5) Prepare a Joint Strategic Needs Assessment[3] to help determine the priorities and objectives for health and social care services across Oxfordshire and a Pharmaceutical Needs Assessment[4] to assess and set out how the provision of pharmaceutical services can meet the health needs of the population for a period of up to three years, linking closely to the Joint Strategic Needs Assessment.

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[1] The Board is a committee of the Council by virtue of the Health & Social Care Act 2012 and the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013

[2] In accordance with sections 116 and 116A of the Local Government and Public Involvement of Health Act 2007

[3] In accordance with sections 116 and 116A of the Local Government and Public Involvement of Health Act 2007

[4] National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

(6) Oversee the joint commissioning arrangements for health & social care across the county

(7) Maintain oversight of the commissioning intentions of both the Oxfordshire Clinical Commissioning Group and the Council;

(8) Generally exercise the functions of the Council and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 ("the 2007 Act");

(9) Exercise any other functions of the Council which may be delegated to the Board (other than the functions of the authority by virtue of section 244 of the National Health Service Act 2006);

(10) Encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in its area.

(11) Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(12) Establish and monitor Partnership Boards as required to help deliver required service change and improved outcomes.

Additionally the Board may:

(13) Encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health & Wellbeing Board.

(14) Encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(15) Give the Council its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

3. **Membership**

The rules on political proportionality do not apply to the Health & Wellbeing Board nor to any sub-committees set up by it. The membership[5] of the Health & Wellbeing Board will be:
(1) Leader of the County Council – Chairman;

(2) Clinical Chair of Oxfordshire Clinical Commissioning Group - Vice-Chair;

(3) 2 District/City Council representatives in their roles as the current Chairman and Vice Chairman of the Health Improvement Board ;

[5] *The membership is to be interpreted as the membership specified by Section 194 of the Health and Social Care Act 2012*.

(4) Cabinet Members of the County Council with responsibility for Adult Social Care, Children & Family Services and Public Health;

(5) Accountable Officer Oxfordshire Clinical Commissioning Group;

(6) C/E Oxford University Hospitals NHS Foundation Trust;

(7) C/E Oxford Health NHS Foundation Trust;

(8) C/E Oxfordshire County Council;

(9) A Healthwatch representative;

(10) The Lead District Council officer from the Health Improvement Board

(11) The Director for Children's Services;

(12) The Director for Adult Social Care;

(13) The Director of Public Health;

(14) An NHS England representative;

(15) Primary Care representation (under discussion).

(16) Such other persons, or representatives of such other persons, as the local authority thinks appropriate with the proviso that once the Board is established, the Board will be consulted before such appointments are made;

(17) Such additional persons as the Health & Wellbeing Board may determine.

4. Chairing of Meetings

Meetings of the Board will be chaired by the Leader of the County Council and the Vice-Chair will be the Clinical Chair of the Oxfordshire Clinical Commissioning Group as notified to the Monitoring Officer. In the absence of either of these persons, the Board will elect a chairman for the duration of the meeting unless or until the Chairman or Vice-Chairman arrive, in which case the Chairman or Vice-Chairman will preside as appropriate.

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5. Voting Rights

All members of the Board or of any sub-committee or sub-group (or of any joint sub- committee of two or more such boards) shall be treated as voting members of the Board or sub-committee or sub-group, unless the Council decides otherwise in any particular circumstance. In which case, before making such a direction, the Council must consult the Board.

Decisions will be taken by the majority of those present and voting and the
Chairman of the Board (or sub-committee or sub-group) will have a second or casting vote.

Notwithstanding the voting rights of members of the Board (or any sub- committee or sub-group), the meeting will reach its decisions by consensus where possible.

6. Validity of Proceedings

The Health & Wellbeing Board (and any sub-committees or sub groups) will operate according to this Constitution and also according to the Terms of Reference for the Board itself.

A meeting of the Health & Wellbeing Board shall not be quorate unless at least a quarter of the voting members are present for the duration of the meeting.

As a committee of the Council, the convening and conduct of meetings will be in accordance with the Council Procedure Rules approved by Council.

7. Cabinet and Scrutiny

The Cabinet may delegate functions to the Health & Wellbeing Boards and may receive recommendations from the Board.

The Health & Wellbeing Board is subject to scrutiny (but not to call-in except in respect of any functions delegated by the Cabinet) by the Council's Joint Health Overview & Scrutiny Committee and, as appropriate, the Council's Performance and Education Scrutiny Committees.

The Board may also ask a Scrutiny Committee or, with the relevant Portfolio Holder's permission, a Cabinet Advisory Group, to investigate issues relevant to both the Board and the committee or group.

The Board will make an annual report on its work to both the Council, to
Cabinet and to the Joint Health Overview & Scrutiny Committee.

8. Code of Conduct

All voting members of the Board (and its sub-committees or sub-groups) are subject to the County Council's Members' Code of Conduct. This includes the requirement to register Disclosable Pecuniary Interests and to declare them, as appropriate at meetings. Should a member have a Disclosable Pecuniary Interest in a matter before the Board (or sub-committee or sub-group), then the member (unless a dispensation has been received) should declare it and withdraw from the meeting, taking no part in the discussion or voting upon that item.

9. Substitution

Members of the Board may arrange for a named substitute to attend on their behalf. However, any substitutes should reflect the seniority and status of the member making the substitution.

Decisions should not be taken other than by the properly constituted Board; this means that at least a quarter of the original voting membership of the Board should be present when decisions are made.

10. Transparency and Openness

The Health & Wellbeing Board will meet in public at least four times a year. The Board may meet informally, and not in public, at other times e.g. for purposes of brainstorming, board learning & development and workshops.

The public's rights of access to the Board's public meetings will be subject to the Access to Information Procedure Rules (Part 8.1 of the Council's Constitution). These make provisions for the giving of public notice of meetings, access to agendas, reports and minutes, the supply of copies of such papers, the inspection and purchase of background papers and the circumstances in which the public may be excluded from meetings by virtue of the consideration of confidential or exempt information.

In addition, the Freedom of Information Act 2000 gives a general right of access to information held by public authorities and will extend to information generated by, or for, the Board and held by any public authority.

11. Sub-Committees Sub Groups and Informal Working Groups

The Health & Wellbeing Board will be mindful of its powers to appoint one or more sub -groups or sub-committees to discharge of any of its functions, with certain conditions. The Board may also appoint advisory groups, working groups or informal 'task and finish groups' to make recommendations to it on any of its functions.

Annex 1 sets out the provisions relating to the appointment of sub-committees, sub-groups and informal working groups and therefore to the appointment of a Reference Group.

Annex1

1. Appointment of Sub-Committees etc

The Health & Wellbeing Board may appoint sub-committees or sub-groups. The Board may appoint one or more sub-committees or sub-groups to discharge of any of its functions, with the following conditions:

(1) Where any functions may be discharged by the Board under 3(2) above, by virtue of section 196(2) of the Health & Social Care Act 2012, (i.e. functions that are exercisable by the authority), then unless the Council otherwise directs, the Board may arrange for the discharge of those functions by a sub-committee or sub-group of the Board, or an officer, or both.

(2) Where the Board discharges functions by virtue of any other enactment that section 196(2) of the 2012 Act, then unless the Council directs otherwise, the Board may arrange for the functions to be discharged by a sub-committee or sub-group of the Board.

In addition, the Board may appoint one or more sub-committees or sub-groups, reference groups or informal working groups to advise the Board with respect to any matter relating to the discharge of the Board's functions.

The membership of any sub-committees or sub-groups will be for the Board to determine. The sub-committees and sub-groups will operate according to this Constitution and also according to their Terms of Reference as established by the Board.

A meeting of the any sub-committee or sub-group shall not be quorate unless at least a quarter of its voting members are present for the duration of the meeting.

As a sub-committee of the Council, the convening and conduct of meetings will be in accordance with the Council Procedure Rules approved by Council.

Annex 1b- Terms of Reference (Children's Trust Board)

Children's Trust Board

Terms of Reference (2018 - 19)

FINAL

		Date
Prepared by	Nina Bhakri	October 2016
Reviewed by:	Children's Trust Board	23 November2016
Reviewed by:	Children's Trust Board	14 December 2017
Approved by:	Children's Trust Board	
Review Date:		March 2019

THE CHILDREN'S TRUST BOARD

TERMS OF REFERENCE

1. Introduction

1.1 The Children's Trust Board brings together the public, private and voluntary sectors to improve outcomes for all children and young people who live in the county.

1.2 This document sets out the strategic, decision making and operational structure of the Children's Trust Board and sets out the roles and responsibilities of partners.

1.3 This document will be reviewed and updated annually.

2. Objectives

2.1 The Children's Trust Board primary objectives are to ensure that effective multi agency working is in place at a strategic level across children's services and that the voice of children, young people and their families contributes to these arrangements and to decision making.

3. Purpose

3.1 The purpose of the Trust is to:

1. Oversee key areas of multi-agency strategic planning for children and young people.
2. Improve outcomes for children in relation to being successful, keeping safe, staying healthy, and being supported in relation to the agreed priority areas.
3. Drive the integration agenda where there is evidence that integrated working will improve outcomes for children and young people.
4. Champion the involvement of children, young people, parents and carers in partnership working with senior managers and politicians.
5. Ensure the Health and Wellbeing Board and other partnerships are sighted on the key challenges facing children and young people in Oxfordshire.

4. Role

4.1 The Role of the Children's Trust Board is to:

1. To identify and agree its shared priorities for children and young people
2. Agree actions for improvement
3. Agree systems and procedures for effective information sharing and collaboration
4. Implement an agreed approach to involving children and young people.

5. Values

5.1 The Children's Trust Board will be:

1. Strategic - members of the Trust are in a position to take a strategic overview and to influence decision making and delivery within their organisation.
2. Inclusive – the Trust will be a partnership of equals, actively involving all the key players in the public, private, voluntary and community sectors and children and young people.
3. Outcome focused – The Trust will establish common priorities together with agreed actions and milestones that lead to demonstrable improvements against measurable baselines.
4. A body that promotes equality – the Trust will serve the needs of all children and young people regardless of age, sex, disability, race, religion, belief or sexual orientation.

6. Responsibilities

6.1 The responsibilities of the Trust are to:

1. Produce an annual Business Plan setting out the Trust's strategic vision, mission, priorities and goals.
2. Oversee and refresh the Children and Young Peoples Plan which commissioners must have regard to when carrying out their functions.
3. Review performance via the Children's Trust dataset which is overseen by the Performance, Audit and Quality Assurance Sub Group of both the Trust and OSCB.
4. Encourage and promote integrated working between children's services, health and social care and other local services including voluntary and public sector services and commissioners.

7. Structure

7.1 Membership:

7.1.1 Members of the Trust are required to be of sufficient seniority to be able to:

- Speak for their organisation;
- Commit their organisation on policy and practice matters;
- Hold their organisation to account.

7.1.2 The Trust membership is drawn from each of the agencies or organisations set out below:

1. Oxfordshire County Council: Education and Learning, Children's Social Care, Adult Social Care, Public Health, Joint Commissioning, Cabinet member for Children and Families, Cabinet member for Education and Public Health

2. Oxfordshire Clinical Commissioning Group

3. The City and District Council Members
4. Thames Valley Police
5. Oxfordshire Safeguarding Children Board
6. Oxford Health NHS Foundation Trust
7. Safer Oxfordshire Partnership
8. Oxford University Hospitals NHS Trust
9. Representation from schools and colleges
10. Representation from the local Voluntary and Community Sector
11. Parents/carers appointed by Healthwatch Oxfordshire as Healthwatch ambassadors
12. Voice of Oxfordshire Youth (VoXY)

7.1.2 Membership will be reviewed and agreed annually

7.1.3 The meetings will require attendance by 7 of the 12 organisations listed above to be considered quorate.

7.2 The Chairman:
The Trust will be chaired by the Cabinet Member for Children and Family Services, Oxfordshire County Council.

7.3 Vice Chairman:
The Vice Chairman will be a representative from Oxfordshire Clinical Commissioning Group.

8. Accountability

8.1 How the Trust is held to account:
The Trust will present regular reports to the Oxfordshire Health and Wellbeing Board, Oxfordshire Safeguarding Children Board and the Voice of Oxfordshire Youth.

8.2 How the trust holds others to account:
The Trust is not a formal decision making body in the commitment of resources. The Trust does, however, hold partners to account by the way in which it operates to build influence with partners.

9 How the Trust will Operate

9.1 The Trust will focus its resources on the following three areas where it has identified it can make a difference:

1. Early Help and Early Intervention
2. Educational Attainment for vulnerable children and young people
3. Managing transitions into adulthood

9.2 Forward Plan

The Trust will produce an annual Forward Plan to ensure clearer oversight of key risks and issues across the system. The Forward Plan will support the overall strategic direction of service delivery and escalation of issues as appropriate.

9.3 Time limited task and finish groups:

9.3.1 The Trust may, from time to time, establish working groups to pursue particular projects. These groups will be set up on a "task and finish" basis and will be dissolved once the project has been completed.

9.3.2 These groups are responsible to the Trust for delivering against agreed objectives. They will be expected to report their achievements against priorities to the Trust on a regular basis.

9.4 Meetings:

9.4.1 The Trust will meet four times a year and publish an annual plan for its meetings.

9.4.2 The agenda for three of the meetings will include a focus on at least one of the priorities listed above and also include time to consider emerging and core business.

9.4.3 Core business includes:

1. Performance monitoring and management
2. Updates from the Trust's Task and Finish Groups
3. New and emerging national, regional and local developments which impact on the business of the Trust.

9.4.4 Agendas will be presented using the "standing agenda" template in **Appendix 1.**

9.4.5 Annual Business Planning Meeting:

The Trust will review and update its business plan and terms of reference at its annual business planning meeting.

10 Communication, Consultation and Engagement

10.1 The Trust is responsible for engaging and involving children, young people, their families, carers and other local stakeholders to help shape plans and decisions about children's services.

10.2 To achieve this, the Trust will work with the Voice of Oxfordshire Youth to ensure that the voice of children, young people and families influence and inform the business of the Trust.

10.3 Responsibility for communications for the Trust will be delegated to the Policy Team of Oxfordshire County Council.

11. Code of Conduct

11.1 A code of conduct is designed to promote public confidence in the actions of the Children's Trust Board.

11.2 Members of the Trust must comply with this code whenever they:

1. Conduct Trust business
2. Act as representative of the Children's Trust Board

(This code is available in **Appendix 2).**

12. Decision making arrangements

12.1 Where an item is placed for decision, that decision will be taken by agreement of the Trust members, by vote if necessary.

12.2 The Chairman of the Trust may initiate and coordinate out of session decision making, via written (electronic or hardcopy) communication with all Trust members.

13. Performance Management

13.1 The Trust has an agreed performance management framework that details how performance against the Children and Young People's Plan will be managed and monitored throughout the year. This is reviewed and updated annually.

14. Confidentiality and Information Sharing

14.1 Information used by the Children's Trust Board and provided to external bodies will be accurate, timely and fit for purpose.

14.2 Members of the Trust are encouraged to share information as required for the purpose of planning, developing and monitoring partnership projects and services by ensuring all data is in line with the Data Protection Act 1998.

14.3 All members of the Trust are responsible for communicating any relevant information to their organisation, unless that information is deemed confidential to a particular meeting.

Annex 1c- Terms of Reference (Health Improvement Partnership Board)

Oxfordshire Health and Wellbeing Board

Health Improvement Partnership Board

Terms of Reference

Purpose

The Oxfordshire Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Health Improvement Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities

To achieve its purpose, the Health Improvement Partnership Board has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources.
- To drive the development and delivery of services across Oxfordshire that meet agreed priorities and objectives, as determined from the Joint Strategic Needs Assessment (JSNA).
- In particular to:
    - *Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement,*
    - *Work together to recommend priority areas to improve health in order to make a real and measurable difference to outcomes,*
    - *Recommend actions and responsibilities to make that improvement a reality,*
    - *Hold each other to account for making the agreed change and for reporting progress.*
- To meet the performance measures agreed by the Oxfordshire Health and Wellbeing Board.

Membership

The core membership of the Health Improvement Partnership Board is:

- Five district/city councillors – one of whom will be Chairman and another Vice-Chairman
- County Council Cabinet Member for Public Health
- Two Clinical Commissioning Group representatives (one clinical representative and one commissioner representative)
- Director of Public Health for Oxfordshire

- Public Health Specialist
- District Council officer representative
- Healthwatch Ambassador

In attendance

- District Councils' officer for Partnership Development

Representatives from Thames Valley Policy and Oxfordshire County Council Children's Services will also be invited to relevant Board meetings to participate in discussions around Domestic Abuse.

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Health Improvement Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board.

The Health Improvement Partnership Board will also be subject to existing scrutiny arrangements with the Oxfordshire Joint Health Overview and Scrutiny Committee providing the lead role.

Members of the Board will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least once a year in public. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

Officers from the County Council will service meetings of the Partnership Board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures. The Partnership Board will review the terms of reference on an annual basis.

These terms of reference were accepted by the Oxfordshire Health and Wellbeing Board at their meeting in March 2018

Annex 1d- Terms of Reference (Adults JMG & Better Care Fund JMG)

Terms of Reference for Adults JMG & Better Care Fund JMG

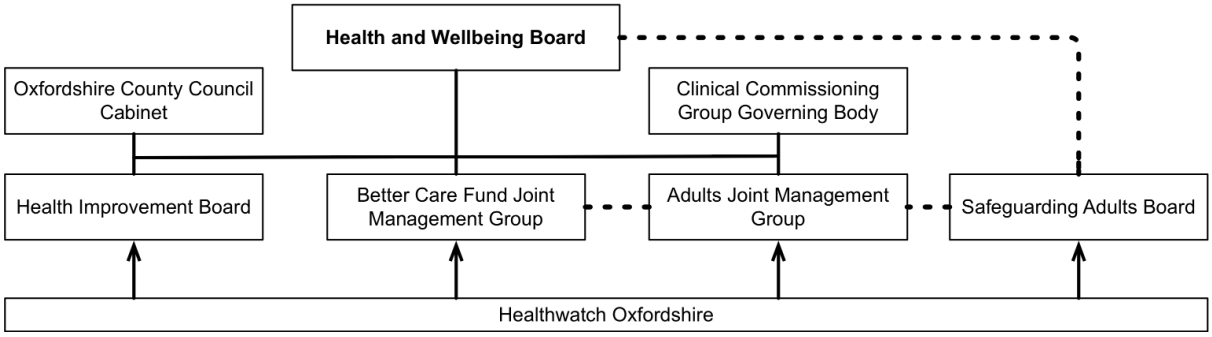
Section 1 – Provisions common to all JMGs

1. Role of JMG

The role of the JMG is to monitor strategy, governance, finance, performance and risk regarding the management of funding resource.

Strategy and Governance

a) Deliver the commissioning strategies through the Commissioning Intentions agreed annually by the Partners
b) Managing and overseeing progress against key outcomes for adults within the Oxfordshire Health and Wellbeing Strategy, including reporting to each meeting of the Health and Wellbeing Board.
c) Work with Healthwatch Oxfordshire to ensure the involvement of service users and carers in the development and delivery of commissioning strategies and intentions.
d) Review the operation of this Agreement and consider its renewal subject to the terms of any existing contractual commitments
e) Review and consult on commissioning strategies and intentions, and revise this agreement as appropriate
f) Annually and formally agree the annual contribution made by each Partner.
g) Annually and formally agree Commissioning Intentions for the Pooled Fund.



Finance

h) Be responsible for the allocation of budget to cost centres. Budget holders are responsible for delivering the agreed strategy within their allocated budget.
i) Be responsible for ensuring that spending is contained within the resources available and maximising the use of the resources.
a) Receive monthly finance reports from the Pool Manager as set out in this Schedule.

b) Agree such variations to this Agreement from time to time as it sees fit.
c) Review and agree annually revisions to this agreement as required.
d) Agree a scheme of financial management with the Pool Manager.
e) Set such protocols and guidance as it may consider necessary to enable the Pool Manager to approve expenditure from the Pooled Funds.

Performance

f) Receive monthly performance reports from the Pool Manager
g) Consider progress on key objectives as outlined in this agreement and consult further where necessary.
h) Approve the monthly, quarterly and annual reports on outcomes as appropriate from the Pool Manager to be submitted by the JMG to the Partners for information.
i) report on progress to stakeholders through the relevant programme or partnership board

Risk

j) Monitor the appropriate reports quarterly to assess any risk that expenditure might exceed the contributions to the Pooled Fund and that where there is such a risk ensure actions are put in place to address the overspend.
k) Review risks quarterly in relation to delivery of objectives, performance of commissioned services, and reputation of the Partners in relation to the Pooled Budget
s) Review any other risks quarterly relating to the performance of this agreement
t) Review annually the overspend and underspend provisions of Clause 8 and Schedule 3 of the Agreement.

2. Role of Pool Manager

The Pool Manager shall retain oversight of the pool as a whole and retain responsibility for the:

2.1 Submission of monthly finance and performance reports to the JMG;
2.2 Submission of monthly, quarterly and annual reports on finance and performance to JMG for approval and submission to the Partners;
2.3 Preparation of an annual budget and commissioning intentions for approval by JMG;
2.4 Management of the Pooled Fund on a day-to-day basis; and
2.5 Reporting to the JMG immediately any forecast overspend / underspend on Pooled Funds and submit an action plan to bring the budget back into balance or seek guidance from JMG on actions to achieve balance.

3. JMG Support

The JMG will be supported by officers from the Council and the OCCG. From time to time and they may be involved in assisting the JMG in implementation of the aims, objectives and intended

outcomes set out at Clause 3 and as specified in Schedule 1 and performance targets as agreed by the JMG.

The Pooled Budget Officers Group will report to the JMG and offer a level of integration to both the Council and OCCG regarding the level of activity, management of financial risk and the delivery of the strategic objectives. They will be responsible for reporting to the Joint Management Group on activity, spending and performance that standardises the approach across the pooled budgets.

4. Meetings

4.1 The JMG will meet bi-monthly with at least one meeting annually held in public and used to review the overall pool position

4.2 The Joint Management Groups will be supported by a Pooled Budget Officers Group that will meet on the alternating months.

4.3 JMG members will receive an agenda and accompanying reports and papers at least 5 working days before each meeting.

4.4 However, it is recognised that on occasions and dependent on dates of meetings it may not always be possible to produce financial reports this far in advance, in which case they will be circulated as far in advance of the meeting as possible.

5. Decision Making

5.1 Decision making in relation to the pooled budgets will rest with the Joint Management Groups unless delegated appropriately.

5.2 Decisions of the JMG shall be made by those JMG voting members present and shall require the unanimous consent of all voting members. Where there is disagreement between the Partners the Lead Commissioner shall have discretion to take such action or inaction as it decides in accordance with its obligations under this Agreement. All decisions shall be recorded in writing. Minutes of the meetings to include all decisions made shall be kept and copied to the JMG members by the Pool Manager within 14 days of every meeting.

5.3 The views of those in attendance will be taken into account for all of the work of the JMG including decision making. These views will be recorded in the minutes of the meeting. This will include agreement or disagreement to the decisions made by voting members.

6. **Deputies and Quorums**

6.1 All members of the JMG will have named deputies who may attend meetings on behalf of the JMG members. Such deputies will have authorisation from the respective Partners to take any actions that the member is authorised to take. Such deputies should be appropriately briefed

and with sufficient authority to fulfil the same role and be able to make similarly informed decisions on behalf of the organisation they represent as the member for whom they are deputising. In exceptional circumstances an alternative deputy will be allowed subject to this being confirmed in writing from the member to the Pool Manager prior to the meeting and being agreed by the other Partner. Such alternative deputies will have authorisation from the respective Partners to take any actions that the member is authorised to take.

6.2 Meetings will only be considered quorate if there are 2 members/deputies attending from each of the Partners.

7. Confidentiality

From time to time the JMG will be discussing both financially and commercially sensitive information and personal client and carer information. It is important that all members of the JMG and all other attendees are clear that they must treat the information as confidential and that they must discuss and use such information outside the JMG only where it is appropriate to do so in order for them to fulfil their obligations.

8. Openness and Transparency

8.1 The JMG will meet once yearly in public.

8.2 The public's rights of access to the JMG's public meetings will be subject to the Access to Information Procedure Rules (Part 8.1 of the Council's Constitution). These make provisions for the giving of public notice of meetings, access to agendas, reports and minutes, the supply of copies of such papers, the inspection and purchase of background papers and the circumstances in which the public may be excluded from meetings by virtue of the consideration of confidential or exempt information.

8.3 In addition, the Freedom of Information Act 2000 gives a general right of access to information held by public authorities and will extend to information generated by, or for, the Board and held by any public authority.

Section 2 – Pool-specific provisions for each JMG

A BETTER CARE FUND including services for older people and for adults with physical disabilities

A1 JMG Membership

A1.1 Oxfordshire County Council will act as the lead organisation for the Better Care Fund.

A1.2 The membership of the JMG with voting rights will be as follows:

The Council:	The OCCG:
Director of Adult Social Care	COO & Deputy Chief Executive
Director of Finance	Director of Finance

A1.3 Each named representative assigned to the roles specified above may be changed by the Partner which is being represented by written notification to the other Partner.

A1.4 In Attendance: (Non-Voting): Others may be invited where JMG consider this appropriate.

A2 Chair

The Better Care Fund Joint Management Group will be chaired by the Council Cabinet Member for Adult Social Care, or by his nominated deputy if absent, unless otherwise agreed by the Partners.

B. ADULTS WITH CARE AND SUPPORT NEEDS covering services for people with learning disabilities (of any age), autism, mental health needs and acquired brain injuries.

B1 JMG Membership

B 1.1 Oxfordshire County Council will act as the lead organisation for the Learning Disabilities and Acquired Brain Injury elements within the pool, and Oxfordshire Clinical Commissioning Group will act as the lead organisation for the Mental Health and autism elements.

B1.2 The membership of the JMG with voting rights will be as follows:

The Council:
Director of Adult Social Care
Director of Finance
The OCCG:
COO & Deputy Chief Executive
Director of Finance

B1.3 Each named representative assigned to the roles specified above may be changed by the Partner which is being represented by written notification to the other Partner.

A1.4 In Attendance: (Non-Voting): Others may be invited where JMG consider this appropriate.

B2 Chair

The Adults with Care and Support Needs Joint Management Group will be chaired by the Clinical Lead from Oxfordshire Clinical Commissioning Group, or by his nominated deputy if absent, unless otherwise agreed by the Partners.

Annex 1e- Terms of Reference (ISDB)

Oxfordshire
Integrated System Delivery Board

Terms of Reference

October 2018

Contents

Version History

Version	Prepared by	Reviewed by	Date	Action
0.1	Louise Patten	ISDB	15 May 2018	Work up further content with partners
0.2	Jo Cogswell	ISDB	16 October 2018	Request approval ahead of Health and Wellbeing Board
0.3	Jo Cogswell	ISDB	18 October 2018	Amended following ISDB feedback 16 October
0.4	Jo Cogswell	ISDB	24 October 2018	Amended following ISDB feedback on version 0.3 Presented for final ISDB sign off
1.0	Jo Cogswell	Health and Wellbeing Board	15 November 2018	To seek approval of final draft

Purpose

The key purpose of the Integrated System Delivery Board is to advance integration of health and social care in Oxfordshire as set out in the Health and Wellbeing Strategy. The vision of the Board is:

To work together in supporting and maintaining excellent health and wellbeing for all the residents of Oxfordshire

This vision will enable ISDB partners to advance the triple aim for Oxfordshire:

- **Better Health and Wellbeing** – improved population health and wellbeing
- **Better Care** – transformed care delivery, improved quality and experience
- **Better Value** – sustainable finances and optimal use of the Oxfordshire Pound

There is strong consensus that greater levels of integrated working across health and social care is critical to a sustainable future that best meets the health and care needs of the population. All organisations are committed to making this happen. The ISDB will enable us to focus on specific workstreams that will advance this integration in Oxfordshire at pace.

Key Objectives and Deliverables

The main functions of the ISDB will be to:

- Deliver the Health and Wellbeing Board's vision for integrated health and social care in Oxfordshire
- Develop a single system plan and timescales for an integrated health and care system
- Maintain focus on implementing the plan, taking into account any factors that may impact its successful delivery
- Keep up to date with contemporary thinking from health and care systems elsewhere including new commissioning and delivery systems to incentivise change and fresh thinking to tackle system challenges
- Ensure the Oxfordshire health and social care system maintains a consistent approach that remains aligned with wider and at-scale system working such as the BOB STP and other footprints (Ca Alliance, specialist commissioning)
- Work with the other Health and Wellbeing Board Sub-Groups and Sub-Committees to ensure that its vision is fully delivered

Principles

ISDB members have developed and agreed the following principles:

- **Ensure our vision and values are known and aligned at all levels of our system**
- **Maintain a collective responsibility for our health and care system**
- **Keep governance simple, with clear lines of accountability**
- **Recognise and nurture leadership at all levels**
- **Strive for system- wide continuous quality improvement**
- **Communicate regularly with our system colleagues and stakeholders**

System partners across health and care are committed to working together to best meet the health and care needs of our populations now and in the future. ISDB will champion this approach and is committed to working with key stakeholders and our local communities to ensure a transparent and evidenced based approach to future service provision decisions. Solutions will be developed as a system; not as individual organisations.

The work of the ISDB will plan for both now and the future delivery of services. As system partners we will follow a model that will see us address issues at the most appropriate and effective geographical or population level – together with neighbouring Counties, across Oxfordshire, sub County and neighbourhood.

The impact of the Oxfordshire Growth deal and what we know about our population changes will be a significant factor in our planning and delivery.

Membership

The ISDB will be chaired by a Chief Executive Officer from the health and social care system as determined by the membership of the group. At the time of writing this is the Chief Executive of the Clinical Commissioning Group.

Membership of the ISDB spans health and social care; commissioners and providers. Mental and physical health commissioners and providers are included. As a member of the Board each individual CEO or member is responsible for ensuring delivery within their organisation. All members will be held to account for system delivery, system behaviours and system working.

As work to deliver an integrated health and care system advances the membership of the group will be reviewed to ensure effective and appropriate representation and delivery. The following table (Table 1) sets out membership as at October 2018, membership of the Board will be reviewed as appropriate as the progress towards the delivery of integrated care advances.

Clinical leadership in terms of insight, influence and expertise is critical throughout the delivery structure. In this context 'clinical' is used in an all-encompassing way and refers to social care experts, Drs, Nurses, Allied Health Professionals and those involved in both the design and delivery of the services. The Clinical Leadership Group will be established and clinical leadership representation will be confirmed throughout the ISDB delivery structure.

Organisation	ISDB Member	Comment
Oxfordshire County Council (OCC)	Chief Executive Director of Adult Services	Commissioner and Provider
Oxfordshire Clinical Commissioning Group (OCCG)	Chief Executive (Chair)	Commissioner
Oxford University Hospitals Foundation Trust (OUH)	Chief Executive	Provider
Oxford Health Foundation Trust (OH)	Chief Executive	Provider
South Central Ambulance Service	Deputy Chief Executive	Provider
GP Federations	GP Federation Chief Executives[6] • OxFed • PML • SEOx • Abingdon Healthcare	Providers
Clinical Leadership Group	OCCG Clinical Chair[7]	Commissioners and Providers
Buckinghamshire, Oxfordshire and Berkshire West STP (BOB)	STP Executive Lead	Strategic Partner

Table 1 ISDB Membership October 2018

Governance

The ISDB is a subgroup of the Health and Wellbeing Board. The ISDB will report progress to the Health and Wellbeing Board and to individual organisations' respective Boards/Cabinet as appropriate.

[6] The GP Federation Chief Executives will each attend ISDB. Oxfordshire Care Alliance is expected to include OH and the 4 GP Federations in Oxfordshire. Representation will be reviewed when the OCA is formally established.
[7] The Clinical Leadership Group is a part of the governance and delivery structure providing a forum for 'clinicians' health and social care practitioner experts. The CCG Clinical Chair will lead work to develop the group and sit on the ISDB as representative.

The ISDB will operate in accordance with the governance arrangements delegated to it by its constituent partners within the scope of the health and care system plan.

The ISDB will be supported by a number of system wide delivery and enabling workstreams / delivery boards. A formal programme management structure will be developed to advance this.
All partners have committed to a consistent approach to the development, reporting and assurance in relation to the delivery of projects. This will enable a clear picture of progress and delivery, supporting a system view and assurance of delivery.

Existing delivery structures will be used, where possible to advance this system focussed work. As the new system approaches develop we will challenge 'old' structures to ensure that duplication or dilution of resources is avoided.

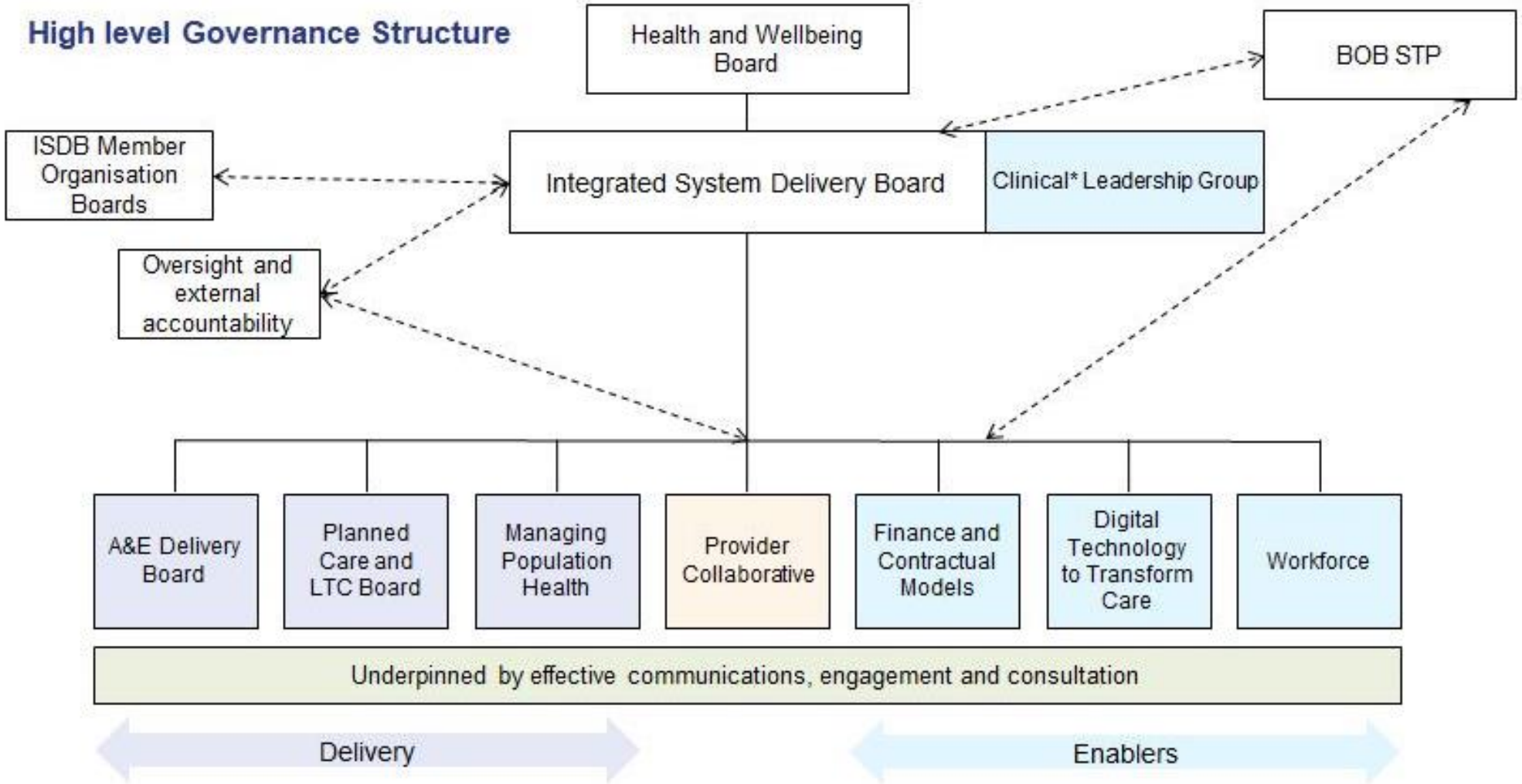
The scope and terms of reference of the workstream /delivery boards will be approved by ISDB. The workstream /delivery boards will be **accountable** for delivery; reporting through to the ISDB. The projects will be **responsible** for delivery and report through to the workstreams – at their delivery boards.

There are wider governance relationships with:

- the decision making bodies of each of the ISDB organisations
- external bodies with scrutiny, oversight, regulatory and / or external accountability functions including but not limited to the Health Overview and Scrutiny Committee, NHS England, NHS Improvement the CQC
- the STP and their delivery structure

It is not anticipated that the Integrated System Delivery Board will become the Integrated Care System or the Integrated Care Provider. Work to establish a provider collaborative or Integrated Care Provider will be the remit of the Provider Collaborative workstream. The terms of reference, membership and timescale for delivery for this aspect of the work will be overseen by the ISDB.

The ISDB is committed to effective communication, engagement and consultation throughout the delivery structure associated with the work towards integrated care. Resources will be specifically focussed to support and enable this; across all of the delivery and enabling workstreams / delivery boards.



Oxfordshire ISDB

*Clinical Leadership in this context is used in an all-encompassing way and refers to leadership provided by social care experts, Drs, Nurses, Allied Health Professionals

Meetings

ISDB will meet on a monthly basis. In light of the fact that the content of the meeting will include items that will be 'commercial in confidence' these meetings will be open only to ISDB members and invited attendees.

The meetings will be action oriented and the ISDB will focus efforts on advancing work to support delivery of the Health and Wellbeing Strategy and the delivery of integrated health and care for Oxfordshire.

The ISDB meetings will be supported by the CCG who will provide meeting secretariat services. Elements of the agenda may be supported by a wider group of attendees; typically drawn from the represented organisations on ISDB. This wider group of attendees will join the meeting for only the invited section.

The ISDB is a CEO membership Board. ISDB members are listed in Table 1; where a member is unable to attend no substitution or delegation is supported. Representation of the organisation in question can be made only during the invited attendees section of the meeting.

The ISDB will report progress to the Health and Wellbeing Board and to individual organisations' respective Boards/Cabinet as appropriate. ISDB paperwork will not routinely be made available within the public domain. This is due to the content of the papers and the discussions.

The ISDB will operate in accordance with the governance arrangements delegated to it by its constituent partners within the scope of the health and care system plan. Key progress and decisions within that delegation will be regularly reported in the public domain through the Health and Wellbeing Board.

Delivery Structure

Existing delivery structures will be used, where possible to advance this system focussed work. As the new system approaches develop we will need to challenge 'old' structures to ensure that duplication or dilution of resources is avoided or minimised.

To facilitate effective working the system will adopt a number of roles that will work within the governance and delivery structure. The details of these are included in appendices to these Terms of Reference.

Sponsors and SROs will work to ensure that there are effective mechanisms to unlock barriers to delivery, to address interdependencies and provide clear links into organisations.

ISDB Sponsor

- From the core ISDB membership
- **Accountable** for the workstream
- Provides ISDB representation and leadership to that workstream
- Leads and advocates for the workstream at ISDB
- Ensures the workstream delivers the required outputs and benefits
- May Chair the workstream delivery board
- Works with the workstream SRO to resolve risks and issues

Workstream SRO

- Likely to be from Exec level
- Works closely with the ISDB Sponsor and the Clinical lead to advance delivery of the workstream
- **Responsible** for the workstream - delivery of the outputs and benefits within it
- Provides leadership and oversight of the delivery projects
- May be involved with other workstreams
- Supported by Project Leads / Project SROs for the discrete project / delivery areas

Clinical Lead

- The term 'Clinical Lead' in this context is used in an all encompassing way and refers to leadership provided by social care experts, Drs, Nurses, Allied Health Professionals
- Brings insight, innovation and good practice examples
- Champions an integrated approach
- Works to provide a clinical voice and clinical leadership to a workstream
- Works closely with the ISDB Sponsor and the SRO to advance delivery of the workstream
- Provides a link to the Clinical Leadership Group

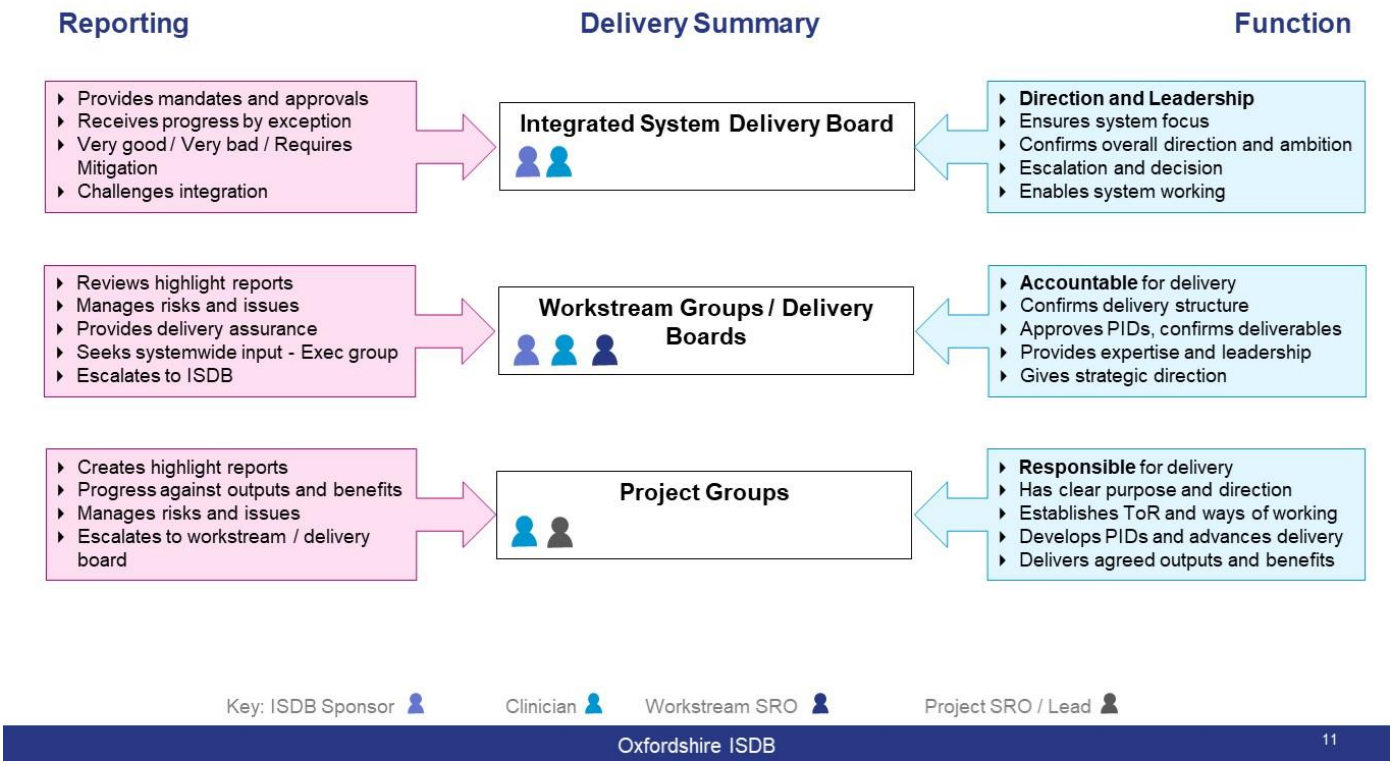
Consistent ways of working

- Workstreams will follow consistent approaches to the establishment of their delivery programmes
- All workstreams (and projects under them) will use the Verto support tool to drive common standards for Mandates. PIDs, Milestones, risks and issues, highlight reports etc
- Scope and terms of reference for each workstream to be approved by ISDB

Appendix Two – Summary of function

The ISDB will provide leadership in the programme structure to advance integration of health and social care in Oxfordshire as set out in the Health and Wellbeing Strategy.

The diagram below sets out the programme accountabilities and responsibilities that fit with the roles described in Appendix One.



In this context ‘clinician’ is used in an all-encompassing way and refers to social care experts, Drs, Nurses, Allied Health Professionals and those involved in both the design and delivery of the services.

Oxfordshire Joint Health and Wellbeing Strategy (2018-2023)

Draft for discussion at the Health and Wellbeing Board

15th November 2018

To the people of Oxfordshire,

This strategy is all about you, the people who live in, work in and visit Oxfordshire.

It tells the story of how the NHS, Local Government and Healthwatch work together to improve your health and wellbeing. We work together as the Oxfordshire Health and Wellbeing Board. The membership has just been reviewed, and so we see this as our chance to begin a fresh conversation with you.

The strategy paints a picture of the things we intend to do, but it needs input from you and so it is written as the start of that conversation with you.

It paints a picture, but we don't start with a blank canvas – health in Oxfordshire is good compared with the national picture. Residents live longer here than elsewhere and remain healthy into older age for longer than the national average. Local people take more exercise than in neighbouring counties and carry less excess weight. We consistently outperform other areas for measures such as breast feeding, teenage pregnancy and immunisation rates. These positive factors give us a solid foundation on which to build local services.

There is much already going on in our services and how they work together too. For example, we have some of the leading health sevice and academic organisations in the country on our doorstep, and many highly rated services. Levels of satisfaction from patients and users of our services consistently say that overall they are satisfied with the services they receive.

Yet we face challenging times. The population is growing and ageing. The number of people with chronic complex diseases is growing. Demand for all our services is increasing. House prices locally are high and this exacerbates staffing shortages. Money is very tight, and frankly we struggle to consistently support people well and deliver good outcomes.

We know we can do better than this and know we have to work together to find our way through these challenges. We are confident that we can. Our major asset is our willingness to work together and to work with you to find new solutions to old problems.

That's what this strategy is all about.

We have drafted a vision to guide us on our journey forward, it is our touchstone and our compass.

Our Shared Vision is: "To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire"

We have reviewed the current issues affecting us and have picked out the most urgent priorities for our renewed focus on delivery through partnership. We aim to: prevent ill health before it starts; give people a high quality experience as they use our services; work with you on re-shaping your local services and tackle our chronic workforce shortages.

The priorities can be summarised as:

- **Agreeing a coordinated approach to prevention and healthy place-shaping.**
- **Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan).**
- **Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.**
- **Agreeing plans to tackle critical workforce shortages.**

In addition to these priorities for the Board we will be developing our work together on a wide range of issues that affect different groups in the population. These are set out in the body of the strategy using an approach which covers all ages and stages of life– ensuring *A Good Start in Life*, enabling adults to continue *Living Well* and paving the way for *Ageing Well*. Many factors underpin our good health and we will work together to address these too under the heading *Tackling Wider Issues That Determine Health.*

And written through all these priorities is our absolute commitment to *tackling health inequalities* and *shifting the focus to prevention*.

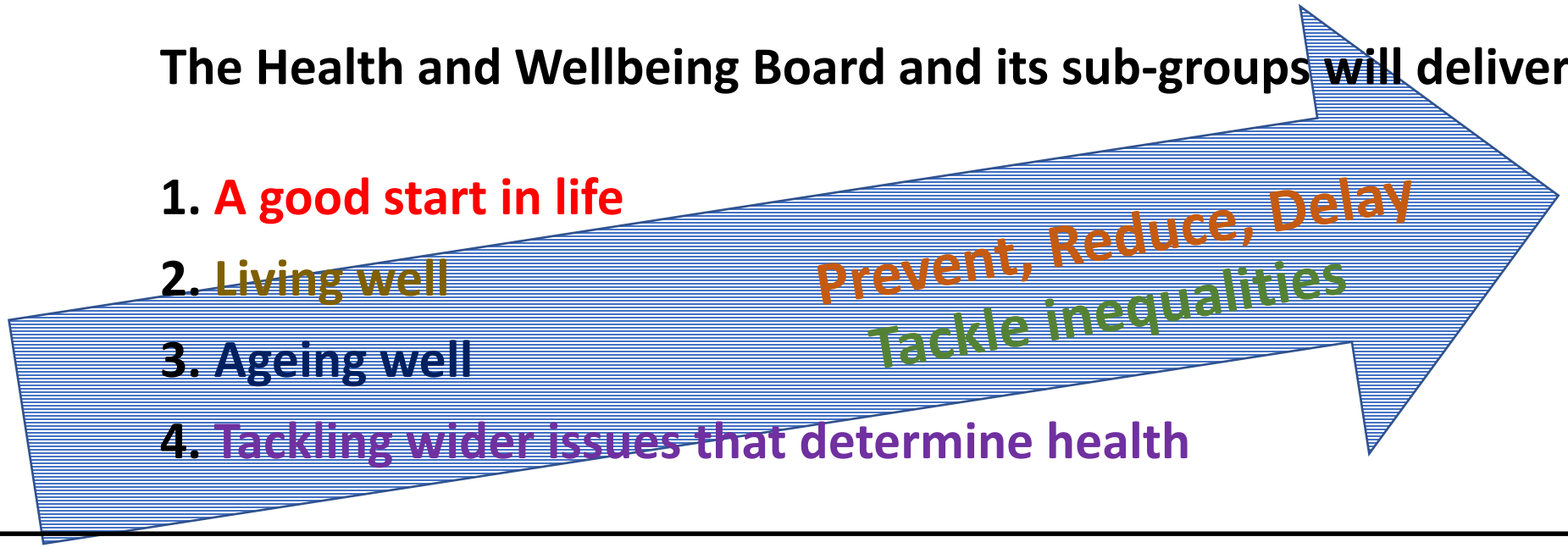
We hope our approach piques your interest, and look forward to sharing our ideas with you in the pages that follow…….

Overview of our priorities

The Health and Wellbeing Board's Priorities are:

- Agreeing a coordinated approach to prevention and healthy place-shaping.
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan).
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.
- Agreeing plans to tackle critical workforce shortages

The Health and Wellbeing Board and its sub-groups will deliver



The next few pages explain what we mean when we say we are focussing on
A good start in life, Living Well, Ageing Well and Tackling wider issues that determine health.

A Good Start in Life

Why is this important?

The best start in life starts with a baby's mother being healthy before and during pregnancy and childbirth. There is a lasting impact in future years from what happens in the early years of a child's life – influencing future physical and mental health, safety, educational achievement and a successful work life.

Schools, the influence of peers and social relationships are formative too. Brain development, attitudes to risk taking and controlling feelings and emotions that develop in adolescence and have consequences for health.

What do we need to do to make a difference?

- Enable children and young people to be well educated and grow up to lead successful, happy, healthy and safe lives.
- Schools and universal services working together with local, targeted and specialist services is key to improving outcomes.
- Shift the focus to prevention and early help through real partnerships and using resources effectively.
- Support the most vulnerable, including children with Special Educational Needs or Disabilities, to make sure everyone has an equal opportunity to become everything they want to be.
- Deliver responsive services that place children, young people and families at the heart of what we do.
- Work with all generations in families and communities.

The Joint Strategic Needs Assessment shows us that

- Children and young people aged 0 to 17 made up 21% of Oxfordshire's population as of mid-2016, a similar proportion to that in 2006. The greatest increases were in the age groups 0-4's and 5-9's.
- Childhood obesity in Oxfordshire is lower than the national average and is remaining stable, unlike the national rising trend.
- 14,000 children in Oxfordshire were affected by income deprivation.
- In the past year, there has (again) been an increase in the number of people referred for treatment to mental health services, particularly children and young people
- Oxfordshire has seen increases in the number of children referred to social care, children on protection plans and children who are looked after.
- Care leavers in Oxfordshire are less likely than average to be in employment, education or training.
- The proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard at Key Stage 2 was below the England average in 2017
- Oxfordshire has a relatively high rate of unauthorised absences from school

Living Well

Why is this important?

Oxfordshire is above the national average for many health outcomes, but many people still live with avoidable conditions such as heart disease, cancer and diabetes. Risk of contracting these illnesses can be reduced through adopting healthy lifestyles. Early detection of long term conditions leads to better outcomes.

People who are already diagnosed need to be supported to stay as well as possible and enjoy life.

There are some groups of people who are more at risk because of where they live, their age, ethnicity, gender, mental health or other factors. Appropriate targeting of services is needed for them. There needs to be care closer to home and smooth flow between services.

What do we need to do to make a difference?

- Shift the focus to prevention, enabling people to get the information and support they need to make healthy choices.
- Nurture healthy communities where people are able to participate, contribute and be healthy.
- Identify disease early and help people to manage their long-term conditions
- Deliver effective and high-quality services which are efficient and joined up.
- Make sure people are involved in the design and evaluation of services.
- Ensure that adults with care and support needs can access the services they need for holistic care, with parity of esteem for mental health.

The Joint Strategic Needs Assessment shows us that

- As of mid-2016, the estimated total population of Oxfordshire was 683,200. Oxfordshire County Council population forecasts, based on local plans for housing growth, predict an increase in the number of Oxfordshire residents of +187,500 people (+27%) between 2016 and 2031, taking the total population of the county from 687,900 to 874,400
- Life expectancy by ward for Oxford shows the gap in male life expectancy between the more affluent North ward and the relatively deprived ward of Northfield Brook has increased from 4 years in 2003-07 to 15 years in 2011-15. Female life expectancy in these wards has remained at similar levels with a gap of just over 10 years.
- **89,800** people in Oxfordshire reported by the Census 2011 survey as having activities limited by health or disability
- The latest survey of carers shows that around a third (34%) of Oxfordshire carer respondents have had to see their own GP in the past 12 months because of their caring role. This was a similar proportion in carers of all ages.
- For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396. Of these **1,959** (58%) were considered preventable
- The number and rate of GP-registered patients in Oxfordshire with depression or anxiety has increased significantly each year for the past 4 years.
- Rates of intentional self-harm in Oxfordshire are now statistically above the England average.
- In September 2017, there was a total of 644 advertised NHS vacancies (full time equivalents), 44% were for nurses/midwives and 22% were administrative and clerical.

Ageing Well

Why is this important?

The number of older people in the county is increasing and is projected to grow further, with the proportion of those aged over 85 increasing by 60-80% in the next 15 years. While people are living longer, many are spending more years at the end of life in poor health. The number of people with dementia is also growing.

The evidence shows that we should identify the people at risk, intervene earlier and develop multi-disciplinary working in new ways to support active ageing and prevent loneliness, ill health and disability among older people. There needs to be care closer to home and smooth flow between services.

What do we need to do to make a difference?

- Focus on prevention, reduce the need for treatment and delay the need for care by helping people to manage long term conditions
- Use innovative and appropriate aids, equipment and services
- Ensure services are effective, efficient and joined up and that the market for provider organisations is sustainable.
- Help people to maintain their independence and remain active in later life.
- Work in multi-speciality teams to ensure frail older people are cared for in the community
- Identify conditions early, including dementia, to enable people to manage their conditions and get the support they need from friends and family.
- Address seasonal and other pressures in the health and care system that can affect older people disproportionately

The Joint Strategic Needs Assessment shows us that

- As of mid-2016, the estimated total population of Oxfordshire was 683,2002.
    - Over the ten-year period, 2006 and 2016, there was an overall growth in the population of Oxfordshire of 52,100 people (+8.3%), similar to the increase across England (+8.4%).
    - The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.
    - By 2031, the number of people aged 85 and over is expected to have increased by 55% in Oxfordshire overall, with the highest growth predicted in South Oxfordshire (+64%) and Vale of White Horse (+66%).
- Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. Areas rated as “high risk” for isolation and loneliness in Oxfordshire are mainly in urban centres.
- Oxfordshire’s comparative rates of injuries due to falls in people aged 65+ and for people aged 80+ has recently improved, from statistically worse than average to similar to the South East average
- There has been an increase in the proportion of older social care clients supported at home, from 44% of older clients in 2012 to 59% in 2017.
- Oxfordshire County Council estimates that: of the total number of older people receiving care in Oxfordshire, 40% (4,200) are being supported by the County Council or NHS funding and 60% (6,300) are self-funding their care
- Assuming the use of health and social care services remains at current levels for the oldest age group (85+) would mean the forecast population growth in Oxfordshire leading to an increase in demand of:
    - +7,000 additional hospital inpatient spells for people aged 85+: from 12,600 in 2016-17 to 19,600 in 2031-32.
    - +1,000 additional clients supported by long term social care services aged 85+: from 1,900 in 2016-17 to 2,900 in 2031-32.

Tackling Wider Issues that Determine Health

Why is this important?

We know that the physical environment, the quality of housing and opportunities for active travel have a big influence on health and wellbeing.

There will be a massive increase in new housing in Oxfordshire, creating new communities. The challenge is to find a better way to plan for and shape communities so that they actually promote health and wellbeing, learning from the Healthy New Towns in Bicester and Barton.

We know that, overall, these factors play a huge role in shaping our overall health and hold the key to prevention.

The support of friends and neighbours in communities is also good for physical and mental health and gets more crucial as the population ages. We also want to protect people affected by difficult issues such as domestic abuse.

Health and care workers form a significant proportion of the local workforce. High house prices in Oxfordshire (Oxford is the least affordable place to live nationally) mean that we have chronic and enduring challenges recruiting and retaining in health and care staff, without which our services cannot function

What do we need to do to make a difference?

- Learn from the experience of the Healthy New Towns in Barton, Bicester and further afield and work together to apply these ideas to all our planning.
- To work with the leaders of the 'Growth agenda' in Oxfordshire in partnership on this agenda
- Protect vulnerable people from the risk of homelessness, threat of violence and the reality of cold homes
- Work together to reduce demand for reactive services and shift the focus to prevention. This will improve quality of life for residents and also contribute to the financial sustainability of public services.
- We need to work successfully together with the public in an effective dialogue about the need to re-shape services across the County, building trust and collaboration.

The Joint Strategic Needs Assessment shows us that

- District Councils' plans for new housing in existing (adopted) and draft local plans set out an ambition for new housing in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years
- House prices in Oxfordshire continue to increase at a higher rate than earnings
- Over the past 6 years there has been an increase in people presenting as homeless and of people accepted as homeless and in priority need in Oxfordshire, although the latest data for 2016-17 shows a decline. Loss of private rented accommodation is an increasing cause of homelessness.
- There has been an increase in the proportion of households defined as "fuel poor" in each district of Oxfordshire.
- Data from Thames Valley Police shows an increase in recorded victims of abuse and exploitation in Oxfordshire. The exception was the number of recorded victims of Child Sexual Exploitation which declined from 170 in Oxfordshire in 2016 to 106 in 2017

Prevent, Reduce, Delay

Prevent, Reduce, Delay. Prevention measures throughout the system will allow us to

- Live longer lives (**prevent** illness), by helping people keep themselves healthy and by creating a places for local people to live in
- Live well for longer (**reduce** need for treatment) by identifying any health issues early and supporting people to manage their long term conditions
- Keep us independent for longer (**delay** need for care) by providing the right support at the right time

What do we need to do to make a difference?

- To combat increasing chronic disease, we need to shift towards more preventative services. We need to join up NHS and County Council preventative services better with District Council preventative services, making it easy for people to choose healthy lifestyles.
- Funding preventative services is a challenge in the face of rising demand for treatment services but needs to be addressed
- Spread the learning from our Healthy New Towns through 'healthy place-shaping.

What the Joint Strategic Needs Assessment says

- An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese.
- Smoking prevalence in adults in routine and manual occupations was estimated at 24.5% in Oxfordshire, over double the rate of all adults and similar to the national average.
- The rate of hospital admissions for alcohol-related conditions gives a mixed picture in different age groups. By and large the rates are reducing, except for women aged under 40. In addition the alcohol-specific admissions for females under 18 in Oxfordshire has remained statistically above the national average in the latest data. The rate for males in Oxfordshire was similar to average.
- Oxford and Vale of White Horse were each better than the England average on the proportion of people who were inactive according to the Active Lives survey. Cherwell, South and West Oxfordshire districts were similar to the national average.
- The Joint Strategic Needs Assessment has no figures on numbers of people with high plasma glucose levels but does record In 2016-17 there were around 29,500 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes, up from 27,900 in 2015-16
- In 2016-17 there were around 89,900 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension, up from 85,800 in 2015-16. The prevalence increased from 12.29% of patients to 12.31%, remaining below the national and regional averages

Tackle Inequalities

Why is this important?

Addressing health inequalities is essential because we know there are 2 main issues:

Inequalities in opportunity and / or outcome – some people don't get a good start in life, live shorter lives or have longer periods of ill health

Inequalities of access – some people cannot get to services, don't know about them or can't use them

What do we need to do to make a difference?

- We need to use information well to identify communities and groups who experience poorer outcomes and ensure the right services and support are available to them, measuring the impact of our work.
- We need to work together to build on the success of recent years in coordinating our approach to wellbeing challenges which are the responsibility of multiple agencies. Examples of this are coordinated work for homeless people and people suffering domestic abuse with City and District Councils
- We need to continue to develop the ways we work with the voluntary sector, carers and self-help groups.
- We have to address the challenge of funding in all areas and ensure that decisions on changing services do not adversely affect people with poor outcomes

What the Joint Strategic Needs Assessment says

- Earnings remain relatively high for Oxfordshire residents. Despite relative affluence, income deprivation is an issue in urban and rural areas.
- 14,000 children in Oxfordshire were affected by income deprivation.
- Snapshot HMRC data (Aug14) shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families.
- 13,500 older people in Oxfordshire were affected by income deprivation, 68% of whom were living in urban areas and 32% in rural Oxfordshire.
- ONS analysis has demonstrated higher life expectancies and greater life expectancy gains for people in the higher socio-economic groups.
- Out of the 407 lower super output areas in Oxfordshire, the clear majority (80%) were ranked within the least deprived 50% in England on the income deprivation domain. The most deprived areas of Oxfordshire on income deprivation were 3 areas within Oxford (parts of Rose Hill & Iffley, Blackbird Leys and Northfield Brook wards).
- The Education and Skills domain of the Indices of Multiple Deprivation 2015 had 25 areas within Oxfordshire ranked in the top 10% most deprived nationally
- People diagnosed with severe and enduring mental disorders are at increased risk of deprivation due to the challenges of maintaining employment, housing and social connections.
- Common reasons for self-harm are: difficult personal circumstances; past trauma and social/economic deprivation together with some level of mental disorder. Self-harm can be associated with the misuse of drugs or alcohol.
-
- Out of the total of 407 Lower Super Output Areas135 (LSOAs) in Oxfordshire, 101 (31%) were 2 miles or more (3.2km) from the nearest GP surgery, covering a total population of 157,000 (25%) as of 2011.
-
- There were no areas of Oxford City classified as 2 miles or more from a GP surgery. Areas classified as 2 miles or more from a GP surgery in rural districts in Oxfordshire covered:
    - 3,700 households with no car (23% of total households in rural districts)
    - 30,300 people aged 0-15 (32% of the total in rural districts)
    - 28,800 people aged 65 and over (34% of the older population in rural districts).

What will we do to improve matters for local people?

1. A good start in life

Aim: 'Oxfordshire – a great place to grow up and have the opportunity to become everything you want to be'

Strategic Objectives

- **Be Successful –** This looks to ensure children have the best start in life; have access to high quality education, employment and motivational training; go to school feeling inspired to stay and learn; and have good self-esteem and faith in themselves.
- **Be Happy and Healthy** – Children can be confident that services are available to promote good health, and prevent ill health; learn the importance of healthy, secure relationships and having a support network; have access to services to improve overall well-being, and easy ways to get active.
- **Be Safe** – This looks to ensure children are protected from all types of abuse and neglect; have a place to feel safe and a sense of belonging; access education and support about how to stay safe; and have access to appropriate housing.
- **Be Supported** – Children are empowered to know who to speak to when they need support, and know that they'll be listened to and believed; can access information in a way that suits them; have inspiring role models; and can talk to staff who are experienced and caring.

Prevention of illness through promoting

- Healthy living
- Healthy weight
- Physical activity
- Mental wellbeing
- Childhood immunisations

Inequalities issues to be addressed by targeting particular groups with worse outcomes

- childhood obesity
- Identify hotspots for children missing out on education
- Inequalities in opportunity and life chances

Areas of Focus for the Children's Trust (2018-2020)

- Focus on children missing out on education
- Focus on social and emotional wellbeing and mental health
- Focus on young people affected by domestic abuse

Areas of Focus for the Health Improvement Board (2018-2020)

- Childhood immunisations
- Preventing childhood obesity
- Promoting physical activity including active travel
- Mental wellbeing for all
- Supporting Healthy place-shaping

Delivery Mechanisms include

1. ***Children's Plan*** - The implementation plan, within the CYPP, focuses on one theme within each of the four areas of focus each year. These are updated on an annual basis and are continually monitored by the Children's Trust Board throughout the year
2. ***The Health Improvement Board*** which oversees work on immunisation, obesity, physical activity and mental wellbeing for all ages

What will we do to improve matters for local people?

2. Living Well

Aim: Adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services.

Strategic Objectives

- **Prevent the development of long term conditions** by helping people to live healthy lives, live in healthy places and avoid the need to go to hospital
- **Identify ill health early,** through comprehensive screening programmes, good access to services and targeting those least likely to attend.
- **Ensure Parity of Esteem for mental health**
- **Deliver sustained and improved experience** for people who access services, by working together to deliver effective services and using the expertise of our customers and other key stakeholders to design, procure and evaluate services.
- **Ensure services are effective, efficient and joined up**, available when needed and that movement through the "system" is seamless
- **Nurture healthy communities** that enable people to participate, be active, give and receive support.

Prevent, Reduce, Delay

Keeping Yourself Healthy (Prevent)

- Promote healthy lifestyles including Reduce Physical Inactivity / Promote Physical Activity, Enable people to eat healthily, Reduce smoking prevalence, Promote Mental Wellbeing
- Ensure Immunisation coverage remains high

Reducing the impact of ill health (Reduce)

- Prevent chronic disease (e.g. diabetes) though tackling obesity
- Screening for early awareness of risk - cancer & heart disease
- Alcohol advice and treatment

Inequalities issues to be addressed

- Identify those at risk of premature and preventable disease and deaths and working to reduce that risk
- Improving the physical health of people with Learning disabilities or mental illness

Areas of Focus for the Health Improvement Board (2018-2020)

- Healthy Weight Whole Systems approach
- Reduce physical inactivity
- Mental Wellbeing and Prevention Concordat
- Public Health, Health Protection - immunisation and screening, air quality
- Housing and Homelessness
- Supporting Healthy place-shaping

Areas of Focus for the Joint Management Groups /Integrated Services Delivery Board

- Identify risk groups and design integrated services to meet their needs
- Provide care close to, or at, home, reduce urgent admissions to hospital
- Improve the satisfaction of service users
- Increase the number of people supported at home
- Improve the quality and sustainability of care providers in Oxfordshire
- Involve more local people and organisations in the development of services

Delivery Mechanisms	1. The Adults of Working Age Strategy – to be developed 2. The Health Improvement Board -work on social prescribing, mental wellbeing, public health protection and healthy lifestyles.

What will we do to improve matters for local people?

3. Ageing Well

Aim: to ensure that Oxfordshire is a place where individuals, whatever their age, are valued and empowered to live healthy, active and socially fulfilling lives, connected to the communities they live in.

Strategic Objectives

- **Increase independence, mobility and years of active life** for those aged 75+ through healthy lifestyles as well as using digital aids, equipment and adaptations and making tools for self-management available and easily accessible.
- **Ensure services are effective, efficient and joined up**, available when needed and that movement through the "system" is seamless
- **Support the care of frail older people** by developing multi-speciality provider teams in the community
- **Identify and diagnose dementia** at an early stage and support people, their families, carers and communities to help them manage their condition.
- **Support carers** in their caring role and in looking after their own health
- **Deliver preventative services** in the community to reduce or delay the need for health and care services

Prevent, Reduce, Delay

- **Prevent** ill health by addressing the growing problems of Loneliness and promoting mental wellbeing; Supporting carers; increasing coverage of immunisations and screening
- **Reduce** the impact of ill health through Falls prevention; tools for self-management
- **Delay** the need for services and care through services close to home;

Inequalities issues to be addressed

There are pockets of deprivation and significant numbers of ethnic minority groups within Oxfordshire. People in these groups often suffer the worst health and poorer health outcomes and need to be identified and targeted by appropriate services

Areas of Focus for the Joint Management Groups / Integrated Services Delivery Board

- The new Older People strategy will reflect the needs of a changing demographic and the increase in the numbers of people who are growing older across the county, particularly those aged over 85 years.
- It will also support those over 65 years that are currently fit and healthy whom we need to support to remain well, for as long as possible, whilst promoting early intervention and access to health and care services when they are needed.
- The new strategy will also address the needs of people suffering from dementia and people who are living into older age with a learning disability.

Delivery Mechanisms include	• Older People Strategy Carer's Strategy The Better Care Fund Plan There are also links to the Oxfordshire's Adult strategy, and a range of Health Improvement strategies. The Older People strategy also links to relevant pathways of care including Oxfordshire's Frailty, Mental Health (including Dementia), Learning Disability and End of Life pathways.

What will we do to improve matters for local people?

4. Improving Health by Tackling Wider Issues

Aim: to work together to ensure that living, working and environmental conditions enable good health for everyone

Strategic Objectives

- **Healthy Place Shaping –** which means ensuring the physical environment, housing and social networks can nurture and encourage health and wellbeing; learning from the Healthy New Towns in Bicester and Barton and applying this to other new and existing developments
- **Housing and Homelessness** – preventing homelessness and reducing rough sleeping
- **Protect vulnerable people** – from the impact of domestic abuse, cold homes and other factors
- **Contribute to financial sustainability** in the long term for public services by reducing demand

Prevent, Reduce, Delay

- **Prevent poor health outcomes through** good spatial planning for community interaction and active travel
- **Reduce** the impact of Domestic abuse, poor air quality, fuel poverty and other factors which have a negative impact on health

Inequalities issues to be addressed

- Focus on particular groups or locations where people have worse health
- Housing and homelessness
- Domestic abuse

Areas of Focus for the Health Improvement Board

- Healthy Place Shaping - Learn from the Healthy New Towns and influence policy
- Social Prescribing, including community and voluntary services
- Housing and homelessness prevention
- Health Protection
- Domestic Abuse services and training
- Affordable Warmth

Delivery Mechanisms include	1. Bicester and Barton Healthy New Towns 2. Housing Support Advisory Group 3. Domestic Abuse Strategy Group 4. Public Health, Health Protection Forum

Oxfordshire Health and Wellbeing Board

Shared Vision: *"To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire"*

Joint Health and Wellbeing Strategy & our 4 priorities:

1. ***Prevention and healthy place-shaping.***
2. ***Improving the resident's journey through the health and social care system.***
3. ***Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.***
4. ***Agreeing plans to tackle critical workforce shortages***

The Integrated System Delivery Board

Integrated System Delivery Plan
(to be created)

The Adults with Support and Care Needs Joint Management Group

Adults of Working Age Strategy
(to be created)

The Better Care Fund Joint Management Group

The Better Care Fund Plan

Carers Strategy

The Older People's Strategy
(under review)

The Children's Trust

The Children and Young People Plan 2018-2021

The Health Improvement Board

- ***Healthy Weight Action Plan***
- ***Public Health Protection***
- ***Affordable Warmth***
- ***Housing Related Support***
- ***Mental Wellbeing Framework***
- ***Domestic Abuse Strategy Group***

Monitoring arrangements (1)

The role and responsibilities of the Health and Wellbeing Board sub groups
Sub groups of the Health and Wellbeing Board are responsible for developing a suite of strategies and action plans to deliver this overarching Joint Health and Wellbeing Board Strategy. They will report their progress at every meeting of the Health and Wellbeing Board and will keep up to date performance dashboards to enable the Health and Wellbeing Board to monitor progress and hold partners to account. The boxes below give details of the performance indicators to be included in these dashboards.

The Health Improvement Board

The Health Improvement Board will monitor progress in 4 priority areas at all their meetings. They will report a range of indicators and progress towards outcome targets to the Health and Wellbeing Board including:

1. Keeping Yourself Healthy (Prevent)
    - Percentage of the population who are inactive (less than 30 mins / week moderate intensity activity)
    - Smoking quitters per 100,000 population
    - Smoking in pregnancy – smoking at time of delivery
    - Households in temporary accommodation
    - Immunisations rates including MMR, Flu
2. Reducing the impact of ill health
    - Uptake of NHS health checks
    - Children overweight or obese in Reception Class and Year 6
    - Uptake of cancer screening programmes
    - Diabetes prevention
3. Shaping Healthy Places and Communities
    - Participation in active travel
    - Making Every Contact Count
    - Outcomes from social prescribing

The Children's Trust Board

A performance dashboard is monitored routinely at the Children's Trust. A sub-set of these indicators will be reported to the Health and Wellbeing Board along with a narrative report on performance and any concerns. The measures are under review and could include the following areas in line with the Children and Young People's Plan

1. Be Successful
    - Attainment
    - Absence
    - Exclusions
2. Be Happy and Healthy
    - Access to CAMHS
    - Early Help
    - Hospital admissions
3. Be Safe
    - Domestic abuse
    - Looked after children
    - Child Protection Plans
    - Children as victims of crime

If other areas are identified from the wider Children's Trust dataset and need escalating, these will be included in the report to the Heath & Wellbeing Board

Monitoring arrangements (2)

The role and responsibilities of the Health and Wellbeing Board sub groups
Sub groups of the Health and Wellbeing Board are responsible for developing a suite of strategies and action plans to deliver this overarching Joint Health and Wellbeing Board Strategy. They will report their progress at every meeting of the Health and Wellbeing Board and will keep up to date performance dashboards to enable the Health and Wellbeing Board to monitor progress and hold partners to account. The boxes below give details of the performance indicators that are likely to be included in these dashboards.

The Joint Management Groups (JMGs) and Integrated Service Delivery Board (Integrated Services Delivery Board)

The Joint Management Groups (JMGs) and Integrated Service Delivery Board (ISDB)
The JMGs and ISDB will continue to report on a group of indicators with outcome targets to be achieved. Three areas of work are outlined below, with a few examples of indicators for each:

1. Working together to improve quality and value for money in the Health and Social Care System
- Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages
- Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95 %.
- Proportion of all providers described as outstanding or good by CQC remains above the national average

2. Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential
- Increase the number of people with mild to moderate mental illness accessing psychological therapies
- Increase the proportion of people referred to Emergency Departments Emergency Department Psychiatric Service seen within agreed timeframe
- Reduce the number of deaths by suicides
- Increase the number of people with severe mental illness in employment / settled accommodation
- Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by 2019

3. **Support older people to live independently with dignity whilst reducing the need for care and support**
- Reduce the average number of people delayed in hospital to 83 or fewer
- Ensure the 90th percentile of length of stay for emergency admissions (65+) remain better than elsewhere
- Increase the proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services
- Increase the estimated diagnosis rate for people with dementia

Engagement approach for the Joint Health and Wellbeing Strategy

Engaging the public and key stakeholders on the renewed strategy will ensure its profile remains high and will help to indicate where further communications will be necessary to ensure all those with an interest are familiar with the challenges and priorities.

Have your say!

It is proposed that a short survey is developed that will be made available on the Oxfordshire Clinical Commissioning Group's "Talking Health" website and the Oxfordshire County Council website.

People from across Oxfordshire will be encouraged to respond to the survey.

Stakeholder event

An event will be organised for key stakeholders who together will have a role to play in delivering the strategy.

This event will provide an opportunity for participants to refresh their understanding of the issues and priorities set out in the strategy and how they relate to their community and organisation.

And finally…… following these engagement activities

The final draft Joint Health and Wellbeing Strategy will be discussed, finalised and approved at the Health and Wellbeing Board meeting in March 2019.

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 29 November 2018

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:

- Respiratory Integrated Respiratory Team Partnership
- Care Quality Commission
- GP practice procurement decision tree

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

Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. Respiratory Integrated Respiratory Team Partnership

Clinical evidence demonstrates that people with chronic obstructive pulmonary disease (COPD) have improved outcomes and a better patient experience when their care is coordinated via a multi-disciplinary integrated care team, as recommended by NICE guidelines and the NHS RightCare COPD Pathway.

Oxfordshire Clinical Commissioning Group (OCCG) has been working with Boehringer Ingelheim Ltd (BI) to co-design a pilot enhanced integrated multi-disciplinary respiratory team (IRT) that will:

- Increase and improve accurate, timely diagnosis of respiratory disease;
- Identify a cohort of patients who are at risk of respiratory admissions;
- Optimise clinical management;
- Introduce early holistic and end of life care;
- Integrate the care of patients within primary & secondary care and community settings.

Whilst this is jointly funded by the CCG and Boehringer Ingelheim Ltd, the operational delivery of the pilot will be delivered by Oxfordshire's system health care providers: Oxford University Hospitals NHS Foundation Trust, Oxford Health Foundation Trust, GP Federations and the Oxfordshire County Council (OCC) commissioned stop smoking provider, Solutions 4 Health Ltd (S4HL).

The pilot will operate in the Oxford City and North Oxfordshire localities over a 15 month period, ending early February 2020. Whilst these areas have been selected due to their high levels of non-elective admissions due to this disease (inferring that more could be undertaken to support patients before having an acute exacerbation), plans will be in place to share best practice and learning from the pilot across the rest of our population in order to maximise benefits.

Oxfordshire healthcare professionals from primary, community and secondary care with expertise and interest in respiratory disease have been involved throughout development of the clinical case, through the IRT Project Group. Further patient engagement will be incorporated into the delivery of the project through the IRT Implementation Group, which will include at least one patient representative and establish reliable means to link into relevant patient groups and relevant third sector bodies.

2. Care Quality Commission

Inspectors of the Care Quality Commission (CQC) visited Oxfordshire in early November to follow up on last year's review of the Health and Social Care system. Their team consisted of 8 people, many of whom were part of the previous review team.

During the two day visit the team:

- Attended a presentation from system leaders showing what we have done since they were last here
- Interviewed 34 people from across the system including representatives from Healthwatch and the voluntary sector
- Held focus-groups with providers, front-line staff and commissioners

The CQC were primarily focused on the progress made against the action plan and the pace of change; I believe we were able to demonstrate good progress in the majority of areas.

This supportive review will be published within the next couple of months; they have expressed preference to present their findings at an extraordinary Health and Wellbeing Board meeting to be arranged in January.

3. GP Procurement Decisions

As part of our ongoing ambition to create greater transparency with our public, we have been working on the challenge of developing clarity on how we make decisions when an existing GP practice contract ends or when significant population growth is planned that might significantly affect sustainability. This has previously been discussed with HOSC and all agreed a local process should be explored.

A workshop was organised on 21 September to develop a process for Oxfordshire and Buckinghamshire to guide the CCGs' decision-making. The aim was to co-produce a 'decision tree' process map using various scenarios and possible options to guide the work. Participants included:

- Members from Oxfordshire HOSC and Buckinghamshire HASC
- Representative for Witney Town Council
- Patient representatives including from Deer Park patient group
- Patient member of Oxfordshire Primary Care Commissioning Committee
- Local Medical Committee
- NHS England
- Oxfordshire CCG and Buckinghamshire CCG
- Healthwatch

The various options available to the CCG were presented and scenarios were then discussed in small table groups with the intention of identifying the questions needing to be asked, the decisions to be made and the possible ordering that would create a clear process map.

A second and final workshop has been organised for 21 November to complete the mapping, from which a defined process can be described that includes the linked scenarios that may affect such decisions. This work will then be shared with HOSC members and will be published by OCCG. It will also be shared with NHS England and neighbouring CCGs to support others when needing to make decisions relating to GP practices.

Louise Patten CEO
Oxfordshire CCG
November 2018

Planning for Future Population Health and Care Needs

Framework Summary

This framework aims to provide an evidence- based approach to planning for the design and delivery of services, engaging the public and key stakeholders at an early stage in order to fully understand the health and care needs of our populations. Once we have collectively understood these challenges, we can develop solutions together for the future delivery of services to meet those needs.

The framework and the stages within it can be practically applied at the most appropriate geographic or population level. There is a clear emphasis within this approach on locally developed solutions.

There will be a balance to addressing challenges locally with those that impact on a wider geography or population and need to be addressed at a broader level or for a greater population. Work to establish the most appropriate level at which to plan and deliver services will support this balance. Decisions will not be made in isolation.

Public involvement and engagement will be critical throughout, along with the involvement of clinicians and care professionals. The specific design of these engagement approaches will be bespoke to the population or geographical area covered in the scope of the use of the framework.

This framework was approved by Oxfordshire Health and Wellbeing Board on 15 November 2018

Principles of the approach – what we will and will not do

In line with the overarching principles of the Health and Wellbeing Board, we will uphold the triple aim for the people of Oxfordshire:

Better Health and wellbeing – improved population health and wellbeing
Better Care – transformed care delivery, improved quality and experience
Better Value – sustainable finances and optimal use of the Oxfordshire Pound

This is a **system approach** –partners will work together involving and engaging local communities to determine how best to meet future health and care needs. Solutions will be developed as a system not as individual organisations;

- **Population health management** principles will be followed – planning will include prevention and a focus on the wider social determinants of health;
- We will promote and enable **community and patient involvement** and engagement throughout - this will include co-design of approaches and co-production of key outputs;
- We will promote and enable **clinical* leadership;**
- Our work will be based on **parity of esteem** and address both physical and mental health;
- Future solutions and models of care will be **based on evidence** and will consider innovation and best practice from elsewhere;
- We will undertake appropriate reality checks – **are proposals realistically affordable, attainable,** can we be sure of a workforce to deliver the model(s), are the proposals right for Oxfordshire or a specific community within our County;
- We will sense check the level (geographic or population) at which solutions are being planned and developed – **we will not fragment or isolate decision making**;
- All planning approaches will be supported by robust **clinical and business cases** in the development of possible options;
- We will follow **best practice** and locally agreed change management approaches

The key stages of the framework have been summarised in the diagram overleaf. This should not be read as a set of prescriptive guidance or considered as the approach that will be applied to the whole of the County. It should be regarded as a support tool – the principles of which will inform how the planning and design for the future delivery of services will be approached.

*The term 'Clinical' in this context is used in an all encompassing way and refers to leadership provided by social care experts, Drs, Nurses, Allied Health Professionals

Population Health Needs Framework Summary

Stages can be run concurrently

November 2018
Health and Wellbeing Board Approved Version

	Planning and Co-design	Population Health and Care Needs	Review of Services and Assets	Innovation and Good Practice	Meeting Population Needs	Development of options
Key Activities	• **Co-design the detailed approach with particular emphasis on local involvement** • Informed by JSNA and community profiles confirm the scope of the focus of the work – neighbourhood / Town / locality etc • Establish a core project team • Establish a stakeholder group • Establish a clinical / professional group • Develop involvement strategy and communications plan • Hold a community event(s) to introduce and kick off the project	• Start population health management approach • Build on existing work to understand the current and future population needs • Identify key leads to be engaged in development of specific aspect of the needs assessment work • Segment the population to identify and consider need, use modelling to predict trends and changes • Identify any urgent or immediate concerns that require action • Plot out timescale for significant population changes linked to growth deal	• Identify key individuals and organisations to undertake review • Map what services are provided by whom, where and when • Map which population accesses the services • Identify physical assets and the services provided from those assets • Capture any sustainability issues – workforce, physical condition of buildings, non recurrent funding etc • Where possible highlight activity - what population segments access which services	• Identification of innovative approaches to the future delivery of services • Identify and understand the successes and impact that early adopter sites have achieved • Consideration of latest ideas and clinical good practice • Establish local views and ideas from those delivering services on how services could be provided differently in the future with innovation and integration • Work to identify initiatives and programmes that will address wellbeing and prevention	• **Co-design a range of small solution building events or a significant accelerated event** • Draw up suggestions and proposals directly informed by the preceding stages that will meet the identified population needs • Test whether or not all challenges or gaps can be addressed locally • Considering population health management what impact and benefit could wellbeing and prevention initiatives have for the future • Challenge – are emerging solutions / proposals affordable and deliverable	• **Further refine options informed by local engagement events** • Any additional detailed modelling and analysis to test proposals • Present options tested against deliverability, operational sustainability, affordability • Utilise a recognised Outline Business Case approach such as a 5 case model to summarise options for consideration • Identify any quick wins • **Confirm any potential significant service changes**
Page 122 Key Questions to be answered	• **How can co-design be enabled?** • **How will the approach be organised?** • **Who will lead the project from the system?** • **Who should be involved in this work locally?** • **How do people want to be involved?**	• What are the needs of the population across health and care? • What are the specific needs of segments of the population? • What future developments are planned that may change population requirements? • Is any immediate action required? • **What are local views of need?**	• What, where and when services are provided? • Where do patients that access the services travel from? • What are the physical assets in the system? • **What services do local people value and why?** • **What do we understand about local groups and schemes?**	• What emerging clinical and professional best practice is relevant to this population? • What future opportunities should we consider with respect to innovation and new models of care? • How could a less fragmented more integrated approach to health and care be of benefit?	• How could we work together as a system to best provide services to meet the needs of the population and at what scale? • What provider delivery models, commissioning approaches, clinical and service delivery models support that? • What can wellbeing and prevention support?	• What are the possible options for the future delivery of services that meet tests for deliverability • Do any options meet a test for significant service change? • What options are there for initiatives that will support and promote healthy living in the longer term?
Community Involvement	• **Co-design of approach** • **Initial public event with the community** • **Co-production local communications and engagement plan** • **Establishment of stakeholder group**	• **In line with co-designed approach e.g public events** • **Delivery in line with co-produced communications and engagement plan e.g. use of local Area Committees or similar to highlight findings**	• **In line with co-designed approach e.g public events** • **Delivery in line with co-produced communications and engagement plan e.g. use of local Area Committees or similar to highlight findings**	• **In line with co-designed approach e.g public events** • **Socialise emerging case for change locally** • **Innovation events**	• **2 day 'Open Space' solution building event** • **Delivery in line with co-produced communications and engagement plan**	• **Continued involvement with community** • **Development of options**
Deliverables	• **Co-production a project plan including timeline** • Confirmation of a core team • Establishment of local clinical and professional steering group • Establishment of local community stakeholder group • **Initial public event**	• Understanding of population summarised specific to area • Specific trends and trajectories for population segments • Summary of known population changes plotted over years • **Understanding of local views of need**	• Clear picture of what services are provide d where, when and by which organisation • An understanding of those services provided by the third sector • Picture of social capital • A summary of physical assets • Understanding of distance travelled to access services	• Options and opportunities for what innovative approaches across health and care can meet the needs of the population • Ideas for how to work in a more integrated way • Ideas for a longer term approach to the management of health and wellbeing	• Ideas and proposed solutions / options appropriate for the population and realistic scale • Options for new models of care • Suggestions for integrated delivery • **Community involvement in solution building** • Scale of service delivery	• A set of possible options for the future delivery of services across health and care, linked to key time or population change triggers • Proposals for longer term approaches that address wellbeing and prevention to improve overall healthy living

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of Meeting: 29 November 2018

Title of Paper: Planning for Future Population Health and Care Needs - Wantage

Paper for:	**Discussion**	✓	**Decision**	✓	**Information**	✓

Purpose and Executive Summary:

Oxford Health and Oxfordshire CCG acknowledge that the length of time since the temporary closure of the overnight beds at Wantage Community Hospital without a formal decision as to the future of those beds is longer than originally planned and longer than previous commitments made to JHOSC and the community.

In responding to the requests of the Health Overview and Scrutiny Committee Oxford Health Foundation Trust and Oxfordshire CCG have made every effort to recommend a course of action that will set out a clear plan for the future delivery of services for the people of Wantage in the most timely and transparent manner.

At the September 27 meeting OHFT Board confirmed its commitment to make funds available in due course for the remedial works to replace the existing plumbing at Wantage Community Hospital.

This paper invites the JHOSC and the people of Wantage to support the use of the population health framework to support how future health and care services are planned and delivered. This means that the work to specifically prepare a consultation on the single issue of the overnight beds will not be advanced separately. The community services needs of Wantage residents will be considered as a part of the overall population health and care needs approach.

Local residents may express frustration that this does not provide a quick answer to the issue of the temporary closure of the beds. This recommended approach will look at the wider health and care needs of Wantage, not simply the issue of the overnight community beds. The framework sets out community involvement and engagement as a critical factor throughout the framework approach.

We have identified resources to take forward the work in Wantage; working alongside the community as set out in the framework.

Recommendations:

Members of the JHOSC are invited to support the proposed scope of the Wantage Community engagement using the population health framework as this is the most timely option for concluding the future of the overnight hospital beds and describing

what other health and care services are planned and delivered for Wantage and the surrounding areas.

It is recommended that the JHOSC take a proactive role in the oversight of the work in Wantage and requests a report of the stakeholder group to the next JHOSC meeting.

Executive Leads:
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20 November 2018

1. Introduction

At the 20 September meeting of the Oxfordshire Joint Health Overview and Scrutiny Committee Members considered a paper that set out the draft framework developed to support a system wide approach to how commissioners and providers of health and care services in Oxfordshire propose to work together to meet the health and care needs of the population today and in the future. This framework has now been adopted by the Health and Wellbeing Board.

The paper also set out a proposed timescale in which the emerging approach could be used in Wantage to support the identification of population needs and advance the uncertainty surrounding the temporary closure of overnight beds at Wantage Community Hospital.

Members of the Committee and representatives of the Save the Wantage Hospital Campaign Group expressed concern and frustration at the length of time since the temporary closure. The JHOSC made some clear recommendations to both Oxford Health NHS Foundation Trust (OHFT) as the provider of Community Services and to Oxfordshire Clinical Commissioning Group (OCCG). These were confirmed in a letter from the JHOSC Chair.

> *The committee recognises the good work undertaken to date on the framework but has the following recommendations:*
> *1) The Oxfordshire Clinical Commissioning Group (CCG) Board to consider the committee's comments about the effective coordination of local needs with broader county health issues in their proposed framework for assessing local health needs;*
> *2) Oxford Health Foundation Trust to take a recommendation to their next Board meeting to release the reserved capital funds, in this financial year, to undertake remedial works on Wantage Community Hospital. This is to ensure the condition of the building does not exclude it from options for the future of health services in the local area; and*
> *3) The CCG to accelerate the timeframe for the process they propose in assessing health needs and be ready to come forward with concrete proposals at the 29th of November HOSC meeting. This includes to be ready, or close to being ready, for any necessary consultation on services in Wantage Community Hospital. For example, this may include the resumption of some services or change to services for consultation.*

Since the last JHOSC meeting Oxford Health and the CCG have focussed resources to advance the requests made by JHOSC.

2. Approach to meeting population needs

On 15 November Oxfordshire Health and Wellbeing Board approved a draft strategy for the Health and Wellbeing of Oxfordshire. That strategy sets out the following priority areas

- Agreeing a coordinated approach to prevention and healthy place-shaping
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan)
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality
- Agreeing plans to tackle critical workforce shortages

The draft strategy will now be subject of a public engagement process.

As a part of the same agenda the Health and Wellbeing Board approved the outline framework for advancing the population health needs work. This framework; adapted to include the feedback from the 20 September meeting of the JHOSC will now form the basis for the health and care system work; not only to fully understand the health and care needs of our populations but shape how we develop solutions for the future delivery of services to meet those needs. The approved framework summary is included at Appendix 2 for information.

The framework is a clear commitment from commissioners and providers across health and care in Oxfordshire to work together to identify the population health and care needs; now and in the future and to work in an open and transparent way, engaging local communities in the planning and shaping of services to meet those needs. The approach now formally adopted by the Health and Wellbeing Board includes:

- population health and demographics review
- consideration of the most effective and appropriate geographic or population level for the focus of work and delivery
- local service and assets mapping
- identification of good practice
- consideration of the impact of the Oxfordshire 'Growth Deal'
- the clinical case for change – what are the most up to date and emerging clinical models that we should be considering
- options development and review

There are great strengths to this approach being driven collaboratively in our system and it is a clear way forwards that will enable the joined up planning and delivery of future health and care services in Oxfordshire. This service led approach is a departure from the building focussed approach of the Phase Two Transformation Programme.

3. Remedial Works at Wantage Community Hospital

In direct response to the JHOSC recommendation OHFT Board discussed the matter of the temporary closure and the capital funding to undertake the required plumbing works at the Wantage Hospital site.

At the September 27 meeting OHFT Board confirmed its commitment to make funds available in due course for the remedial works to replace the existing plumbing at Wantage Community Hospital. OHFT Board did not support release of those capital funds at present time. OHFT Board noted that system partners are about to embark on a programme of work that will highlight the current and future needs of Wantage and surrounding areas, which will result in a clearer view of the future role of the hospital. As such it would mean that the money expended may well go into a scheme which very soon afterwards required substantial revision (at further cost).

The Trust Chair noted the importance of identifying the needs of Wantage and its surrounding areas and ensuring that funds were spent appropriately to meet these needs, not necessarily just focusing on beds within community hospitals.

Oxford Health remains committed to funding plumbing replacement at Wantage to serve whatever service requirements warranted at Wantage, including a return to the status quo ante, if that is what emerges from population health needs approach.

4. Accelerating the timeframe to assess health needs in Wantage including consideration of future of services at Wantage Community Hospital

Oxfordshire Clinical Commissioning Group and Oxford Health accept that much time has passed since the temporary closure of the overnight beds in July 2016. In good faith OHFT and the CCG previously stated that Phase Two of the Oxfordshire Transformation programme would answer the question as to the future of Community Hospitals in Oxfordshire.

Phase Two did not proceed as originally planned, this was because OCCG committed to developing a 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. This impacted on the timeframes for any potential formal process around the Wantage Hospital beds.

In response to the outline timetable for using the framework approach to determine health and care needs in Wantage; included in the papers for the 20 September meeting, the JHOSC specifically asked that the CCG work to accelerate the timeframe. The JHOSC further requested that that the CCG come to the 29 November meeting with concrete proposals as to the future of Services at the Wantage Hospital site.

System partners have worked together to advance as much work as possible to respond to the request to condense the timeframe. Since the last JHOSC meeting

consideration has been given to what information and evidence we have now, what we do not have and what we will need to be able to make the best decisions for the people of Wantage.

- The Public Health team has prepared a first working draft Place Profile for the South West locality. This is a key milestone in our work to understand population health and care needs
- We have prepared an outline engagement plan to support use of the framework in Wantage
- We have identified resources to take forward the work in Wantage; working alongside the community as set out in the framework
- We have arranged to meet with key representatives from Wantage including the Save Wantage Hospital Campaign Group to start to plan how we can use the framework and the engagement plan to advance our work in Wantage, this is likely to include the establishment of a stakeholder reference group that will be representative of the population of Wantage
- We have met with the South West Oxfordshire Locality Forum to discuss the approach and answer questions
- We have gathered the activity data in relation to Wantage registered patients and Wantage Community Hospital to inform our planning work
- We have reviewed the outline timetable for following the framework approach and sought opportunities to advance specific aspects whilst maintaining a high level of transparency and community involvement
- We have developed an outline timetable relating to an engagement and consultation approach relating to the temporary overnight bed closure at Wantage Hospital

5. Progress, initial findings and next steps

The formal mechanism by which health providers and commissioners must engage and consult on significant service change is quite clearly set out. Public involvement is a critical part of the approach, along with involvement of the JHOSC and an assurance process undertaken by NHS England.

We have given careful consideration about how we could approach reaching a definitive conclusion about the overnight bed provision at Wantage Hospital, mindful of the public and JHOSC's views for pace.

Oxford Health and Oxfordshire CCG have scoped out the length of time that it would take to address the issue of the temporary overnight bed closure in Wantage. There are clear guidelines that are nationally set for us to follow.

Appendix 1a maps out the timeline for formal consultation for the future of overnight beds at Wantage Hospital and includes

- Time to develop the business case
- Board approval of a business case to support a decision
- Formal assurance of the process and approach by NHS England
- Review and assurance of the approach by JHOSC
- Time to prepare clear and transparent consultation materials
- A period of NHS formal public consultation
- Review of the outcomes of the consultation, to include a review by JHOSC
- Preparation of recommendation for decision
- Board decision on the future of the overnight beds at Wantage Hospital

An approach that looks at the temporary overnight closure is likely to include activity around the following key points

- The overall provision of overnight community beds, including current and future projected occupancy
- The clinical case – responding to best practice and promoting the best outcomes for patients
- The potential likelihood or risk or harm to patients of Wantage should the beds close
- The economic case – how sustainable is the overnight bed provision

The Council elections scheduled for May 2019 will have an impact on the timeframe that formal public consultation could take place. As a result of this it is unlikely that there would be Board level decision on the issue of the overnight beds at Wantage Hospital until July or September 2019.

Local residents have reported concerns that decisions about services in Wantage have been taken in isolation and without the consideration of the needs of the Wantage population within the wider South West locality.

Appendix 1b includes the timeline for using the population health needs framework to advance the planning and design of services for Wantage and the surrounding areas. At face value the population health framework approach would take longer to determine future approaches to the delivery of services. However this approach would be broader, consider health and care needs, provide opportunities to respond quickly to identified gaps and to pilot services and ways of working that may lead to a vibrant mix of service provision in Wantage.

Best practice demonstrates that using the population health framework approach will result in a more comprehensive set of plans and proposals for the future of services in Wantage, including the future of the overnight beds.

Accepting that the local community and the JHOSC wish to see a resolution to the temporary closure of the overnight beds and that previous plans to do so have not been delivered Oxford Health and Oxfordshire CCG are recommending that the JHOSC and the local community support the use of the population health framework approach.

Commissioners and providers across health and care are confident that this approach will result in the right services for the people of Wantage and the surrounding areas.

The engagement approach set out in the framework will mean people from Wantage and surrounding areas will feel very much part of the process to review and design services for their local area.

Members of the community and local key stakeholders will be invited to work with the health and care commissioners and providers. This will involve designing and delivering tailored engagement so people feel they can participate in all or various stages of the process. This approach will support and enable local people and community groups to be active participants in the process.

7. Initial review of community admissions

An examination of admission data for all community hospitals in Oxfordshire shows a steady reduction in the number of overall admissions.

Admissions	2015/16	2016/17[1]	2017/18	2018/19[2]
Other Hospitals	1851	1642	1596	643
Wantage Hospital	124	52		
Total	**1975**	**1694**	**1596**	**643**

Table One Community Admissions (showing Wantage admissions)

In Oxfordshire patients are admitted to the most appropriate available community facility to meet their care needs, this is not always the closest community hospital. In January 2018 there were a total of 29,699 patients registered at the Church Street and Newbury Street practices in Wantage.

Of the 124 admissions to Wantage Hospital in the 2015/16 year 49 admissions were Wantage Practice registered patients. If we take into account multiple admissions for the same patient during the year these 49 admissions can be attributed to 44 Wantage registered patients. The remaining 75 Wantage Hospital admissions were 64 patients registered in practices outside of Wantage; the majority from the City and the South of the County.

For patients registered at Wantage Practices admissions to community hospitals are set out in the table below.

Wantage Registered Patient Admissions	2015/16	2016/17[1]	2017/18	2018/19[2]
Wantage Hospital	**49**	**15**	**-**	**-**
Other Hospital (total)	**95**	**113**	**120**	**41**
Abingdon Community Hospital	54	60	72	21
Bicester Community Hospital				1
Didcot Community Hospital	20	27	23	6
The Fulbrook Centre		2	4	2
Wallingford Community Hospital	11	14	11	9
Witney Community Hospital	4	10	10	2
(blank return – unknown)	6			
Total	**144**	**128**	**120**	**41**

Table Two Community Admissions for Wantage Practice Registered Patients

Before the 2016 temporary closure the majority of Wantage registered patients were admitted to community hospitals outside of Wantage. Abingdon, Didcot and Witney continue to provide the majority of the community inpatient services for Wantage registered patients.

[1] Wantage Community Hospital overnight bed provision was temporarily closed in July 2016

[2] Figures are for part year 2018

8. Discussion

Oxford Health and Oxfordshire CCG acknowledge that the length of time since the temporary closure of the overnight beds at Wantage Community Hospital without a formal decision as to the future of those beds is longer than originally planned and longer than previous commitments made to JHOSC and the community.

In responding to the requests of the Health Overview and Scrutiny Committee Oxford Health and Oxfordshire CCG have made every effort to recommend a course of action that will set out a clear plan for the future delivery of services for the people of Wantage in the most timely and transparent manner.

The result of this work is a recommendation from Oxford Health and Oxfordshire CCG that the JHOSC and the people of Wantage support the use of the population health framework to support how future health and care services are planned and delivered. This means that the work to specifically prepare a consultation on the single issue of the overnight beds will not be advanced separately. The community services needs of Wantage residents will be considered as a part of the overall population health and care needs approach.

Local residents may express frustration that this does not provide a quick answer to the issue of the temporary closure of the beds. This recommended approach will look at the wider health and care needs of Wantage, not simply the issue of the overnight community beds. The framework sets out community involvement and engagement is a critical factor throughout the framework approach.

The draft engagement plan is intended to provide an approach to the communications and engagement required to start a process of open dialogue with stakeholders on the future of health service provision. The approach aims to engage stakeholders, stimulate thinking and discussion, offer some involvement and engagement options and explore how we can create an engaged approach and process together.

9. Recommendations

Members of the JHOSC are invited to support the proposed scope of the Wantage Community engagement using the population health framework as this is the most timely option for concluding the future of the overnight hospital beds and describing what other health and care services are planned and delivered for Wantage and the surrounding areas.

It is recommended that the JHOSC take a proactive role in the oversight of the work in Wantage and requests a report of the stakeholder group to the next JHOSC meeting.

Appendix 1a

Outline timetable for formal consultation on the future of overnight beds at Wantage Hospital.

Activity	Timeframe	Outline Date	Comments
Preparation of pre-consultation business case	4 to 6 weeks	December / January	
Board approval of the content of the PCBC	4 weeks	End of January	
NHSE Assurance process	1-2 months	End of March	
Preparation of consultation materials	1 month	March / April	Can start work before assurance approval but needs to be informed by assurance outcomes
Formal Public Consultation	4-12 weeks	Start after 2 May	JHOSC will confirm the length of the consultation. Note that Council elections scheduled for May 2019 will impact on the start date
Consultation review and write up	6-8 weeks	July / August	To include review with JHOSC
Board Decision	4 weeks	July or September	

Appendix 1b

Outline timetable for population health and care needs in Wantage, including the future of the overnight beds.

	Outline Date	Comments
Planning and Co-design: Co-design the detailed approach with particular emphasis on local involvement	December	
Review of Services and Assets: Build on existing work to understand the current and future population needs	December / January / February	As per the framework these aspects of the approach can run concurrently
Population Health and care needs : Build on existing work to understand the current and future population needs	December / January / February	
Innovation and Good Practice: Identification of innovative approaches to the future delivery of services	January / February / March	
Meeting Population needs : Consider how services could best meet the needs of the population and at what scale	February / March / April	Opportunity to pilot service and ways of working
Develop Options: A set of possible options for the future delivery of services across health and care	February / March / April / May / June	To include review with JHOSC
Outcomes of the development of options could lead to formal NHS consultation process including any decision on the future of the overnight beds at Wantage lead		
Preparation of pre consultation business case	June / July	
Board approval of the content of the PCBC	July / August	
NHSE Assurance process	September	
Preparation of consultation materials	September / October	
Formal Public Consultation	October / November	
Consultation review and write up	November / December	
Board Decision	December / January	

Note for the purposes of the formal NHS consultation process following the use of the population health framework a more condensed approach has been set out. This is due to the large level of community involvement in the approach and engagement in the development of future options.