Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 7 February 2019 at 10.00 am
County Hall

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	one vacancy

Notes: ***Date of next meeting:*** *4 April 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

January 2019

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 - 16)

To approve the minutes of the meeting held on 29 November 2018 (**JHO3**) and to receive information arising from them.

For ease of reference when considering the Matters Arising from the 29 November 2018 meeting, a list of actions is attached at **JHO3.**

4. Speaking to or Petitioning the Committee

5. Forward Plan

10:15

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

6. Clinical Commissioning Group (CCG) - Update

10:20

This item provides a report (**JHO6**) on the key issues for the CCG and will outline current and upcoming areas of work, including the presentation of the Primary Care decision tree. It will also include a verbal update from the Oxford University Hospitals NHS Foundation Trust (OUH) in response to the recent Care Quality Commission (CQC) inspection of operating theatres.

7. Review of Local Health Needs - Wantage Planning for Population Health Needs Report

10:50

The Committee will receive an update (**JHO7**) on progress in relation to the Review of Local Health Needs, including any possible revisions to condense the timescale for a decision, as requested at the last meeting.

8. Health & Wellbeing Board - Membership and Strategy

11:20

System leaders will provide a response to questions raised at the last meeting in relation to the Health & Wellbeing Board's membership and its Integrated System Delivery Board (ISDB). The draft HWB Strategy is also attached for feedback (**JHO8**)

9. Care Quality Commission (CQC) System Review

11:50

System leaders will attend to give an update on progress on the CQC Action Plan, as determined by the second local area review (**JHO9**).

10. Report from Task and Finish Group on MSK Services

12:30

The final report from the Committee's Task & Finish Group on Musculo – Skeletal (MSK) services will be presented (**JHO10)**.

This will be jointly presented by the CCG and this Committee.

11. Healthwatch Oxfordshire (HWO)

13:10

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) will be present to report on the views gathered by HWO and its latest activities (**JHO11**) (to follow).

12. Chairman's Report

13:20

The Chairman's report is attached at **JHO12**. It includes updates on health and social care liaison and the Terms of Reference for the Wantage Community Hospital Task & Finish Group.

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, 29 November 2018 commencing at 10.00 am and finishing at 2.10 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen (Deputy Chairman) Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Hilary Hibbert-Biles Councillor Laura Price District Councillor Nigel Champken-Woods District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Jane Hanna OBE (In place of Councillor Alison Rooke)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle

Officers:

Whole of meeting	J. Dean and S. Shepherd (Resources) and Rob Winkfield (Adult Social Care)

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

52/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Jane Hanna attended for Cllr Alison Rooke and apologies were received from Councillor Sean Gaul and Anne Wilkinson.

53/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillor Hilary Hibbert-Biles declared a personal interest in Agenda Item 6 'Health Visiting and School Nursing Services' on account of her former membership of the Oxfordshire Health & Wellbeing Board in a capacity as Cabinet Member for Public Health at the time when the contract for School Health nurses in the county's primary schools was commissioned.

Councillor Monica Lovatt declared a personal interest in Agenda Item 9 – 'New Governance of the Oxfordshire Health & Wellbeing Board' on account of her membership of the Health Improvement Board which is a sub-group of the Board.

Dr Alan Cohen declared an interest in Agenda Item 9 also on account of him being a trustee of Oxfordshire Mind.

54/18 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 20 September 2018 were approved and signed subject to the following amendments:

- In relation to page 18 – the interim Director of Public Health, Val Messenger, came up to the table and undertook to circulate to members of the Committee a more correct meaning to the words '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';
- In relation to page 13, line 3, to correct '650 new homes' with 6,500 new homes'; and
- In relation to the top of page 19, sentence 1 – to delete 'cardio -diabetes' and correct to 'people with severe mental illness'.

There were no matters arising.

55/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The following requests to address the meeting had been agreed:

- Didcot Town Councillor Cathy Augustine (Agenda Item 9);
- Councillor Jenny Hannaby (Agenda item 9);
- Maggie Swain, on behalf of Save Wantage Hospital Campaign (Agenda Item 11); and
- Councillor Jenny Hannaby, Local Member (Agenda Item11).

56/18 FORWARD PLAN

(Agenda No. 5)

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

It was **AGREED** to:

(a) reinstate GP Federations onto the Plan, in particular in relation to smaller practices and their survival; and
(b) make the 'Social Prescribing' item broader to encompass housing leisure services in order for the Committee to look at it 'in the round' – and to ensure that this is a major item on a future Agenda.

57/18 HEALTH VISITING AND SCHOOL NURSING SERVICES

(Agenda No. 6)

The Committee welcomed the following representatives from the Health Visitor and School Nursing services in Public Health, OCC:

Val Messenger – Deputy Director of Public Health
Donna Husband – Lead Commissioner,
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

Each presented their part in a series of slides as attached to the Agenda at JHO6.

Questions asked by members of the Committee, and responses received, were as follows:

- How is performance measured? - There are key performance indicators included in the contracts, performance of which is managed by Health and the Performance Scrutiny Committee, OCC. There is a Public Health Outcomes Framework which is broken down into various categories. Sometimes the issues are hard to link to a specific activity and therefore not in contract management;

- How are inequalities tackled? - Equal access to all is offered, the service adapts to the needs of individuals, for example, health visitors offer the service where it is most suitable and convenient for the user and it offers a delivery of the service in the home itself, particularly in rural areas. It also uses interpreters where needed;

- Where are the nine centres for Health Visitors located? - the county is divided into 9 localities and within each there are 7 teams. For example,

West Oxfordshire has teams in central Witney, Carterton and Chipping Norton. Additional services are also provided in Charlbury;

- How do Health Visitors connect with people? – They establish good therapeutic relationships with people early, in order for relationships to be built. For example, if there are concerns regarding a person's mental health during their ante-natal period, the health visitor may do the liaison work and carry out joint visiting with other professional to assist that person in their transition to another service;

- How does the service support children with a fluidity of gender? - The service is experiencing a growing need in this sphere and it has trained nurses to both help the children and also to assist teachers with how to respond to it;

- What about the people that are not being seen – 73% of mothers attend antenatal classes, but what about the other 27%? – The service is offered to all people working with midwives. Some mothers feel that they do not require the service and there is an element of choice in that. There is a system in place for health visitors to work with midwives to identify those mothers they are most concerned about and they do endeavour to track them down. There is also contact with primary care colleagues. Thus, included within the 73% of antenatal contacts are some for whom there is some concern;

- Up to 63% of women breastfeed their babies until they are 6 weeks old. Compared to other countries this is low – how can numbers be raised, given that many mothers are returning to work earlier? - If one compares Oxfordshire with the national figure (47%), Oxfordshire is exceeding this. Those mothers who are still feeding at 6 weeks tend to continue until 6 months (6 - 8 weeks statistics includes combination and exclusive feeding). Work is ongoing with employers to encourage them to provide the right facilities to enable mothers to continue doing so. The Oxfordshire Midwifery Team is also supporting baby-friendly initiatives. **The Committee requested a break-down of the statistics in order to ascertain how many mothers were exclusively breastfeeding rather than combination feeding;**

- A member asked if there was a set of national standards and any external accreditation where assessors could talk to the mothers? - there is very little evidence of health promotion as it is not possible to do randomised control trials. The tendency is to work with the users themselves to ensure that any messages go out. The service does its best to evaluate this to ensure that groups are targeted. It is also ensured that clients are directed to accredited websites for information;

- A committee member pointed out that there was no mention of drugs and alcohol education included within the work the school health nurses carried out in schools? – It is better to glean this kind of knowledge when working

on a one to one basis with the child. OCC's Drugs and Alcohol Team work closely with schools and delivered training to school nurses;

- What is the difference between school health nurse support workers and school health nurse assistants? Is there a difference in where they are being used? – SHN assistants is a new support role, at NHS/Agenda for change a band 3 support worker is responsible for height and weight measuring, for example – and they do not do any follow up on the results. They will also lead on the health education side. School Health nurses are a band 5, and qualified School Health Nurses are qualified nurses with enhanced training;

- What is the strength of partnership with Children's Social Care? – There is a very good relationship with social care colleagues, at all levels. Health Visitors and School Health Nurses have a separate but very clear role and work very closely with Children's social workers, both at leadership team level and with social workers on the ground. Looked After Children (LAC) are top priority - and school nurses know who the vulnerable children were. Social workers are also linked with schools;

- If a child suffered from, for example, epilepsy, how were transitions dealt with? - whose role was it to lead with the Education Health Plan? - Multi-professional teams worked around the family and the child is tracked and monitored, so that the child can achieve its aspirations. All LAC Children have compulsory, six monthly assessments completed on them. The school health nurses hand over to secondary school nurses on transition. Strong links are forged with specialist nurses (with epilepsy/allergy clinics, for example) and with OUH, in order to ensure a close working relationship between all nurses. SEND holds all to account and provides a link and knowledge base;

- The Committee asked if there was anything the Committee could assist with in respect of supporting the continuation of funding for the training of school health nurses? – Health Education England allows the organisations to train. Notification has been received that 15 School Health Nurses and Health Visitors can be put forward for training but it is not sure if it would be possible to do the same next year. The service was moving to an apprenticeship model for Health Visitors from 2020. Good staff were being developed in Oxfordshire and innovative work was in train to keep staff developed. The Committee will be approached for assistance in maintaining the movement forward with the apprenticeship model for 2020 if needed;

- How does cross – border work take place over the borders? – This is an ongoing challenge. If a client is seen in Henley, they are seen by Berkshire midwives. Regular meetings take place between midwives in different counties every 6-8 weeks to ensure that each is aware of who they are working with, regardless of borders. There are also links with GP colleagues over the borders. Birth notifications come via the Child Health Information Service to ensure knowledge of babies from birth;

- Mental health and children is a priority area nationally with concerns that children waiting for the Child & Adolescent Mental Health Service (CAMHS) is nowhere near target. What are the issues causing it? Is there anything you would put into your services to assist the process, if you had the finances with which to do it? – Mental wellbeing is a real issue and the system is currently looking at a Public Health England Prevention Concordat in a bid to make mental health a priority. A bid has been submitted to provide additional capacity to support school health nurses in their ability to intervene and give them access to CAMHS. Early anxiety and distress amongst younger children, leading to behavioural issues; and emotional distress amongst teenagers, is a big issue. There is currently work taking place looking at the impact of social media on children and young people. If money was not a problem then there would be a wish to put it into work around resilience amongst primary school children. The Kingfisher Team (CSE) was currently working with primary school teachers to educate them. Parents had a significant role to play in providing their children with protection and resilience to problems encountered with social media and more study in relation to this role could be undertaken.

Councillor Hilary Hibbert-Biles concluded the discussion by pointing out her view that the Family Nurse Practitioners service should be expanded because it did a very good job. In addition, since the School Health Nurses and Health Visitors service had come into the local authority, some good work had taken place and continued to take place.

The Chairman thanked all for their attendance and for an excellent presentation.

It was **AGREED**: to

(a) request the information documented above in relation to target/performance measures for breastfeeding;
(b) refer the issue of where the division lies between scrutiny of health services in HOSC and in OCC's Performance scrutiny to ensure that effective scrutiny is taking place on both sides; and
(c) request service officers to let the Committee know if there was anything the Committee could do to help in furthering any requirements needed in the service, as documented above.

58/18 HEALTHWATCH OXFORDSHIRE

(Agenda No. 7)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) was present to present her report (JHO7) on the views gathered from members of the pubic and the latest activities of HWO.

She reported on the work HWO did around Healthshare and the information given to HOSC's sub-group. Most of the recommendations given to the CCG had been accepted and put into practice by the CCG and she expressed her thanks to the CCG. She also pointed out that the report did not cover responses received from the

CCG and Wantage Town Council with reference to Wantage Hospital, most of which was on HWO's website. She added that HWO had not found out anything that was not already known, and hearsay had been reinforced by discussion with many people on the subject.

Rosalind Pearce was asked if HWO had undertaken any further work on dentistry sine the last report documenting this. Rosalind Pearce reported that HWO had now taken the investigation wider to include countywide access to NHS dentistry, including that offered to care homes. She undertook to send a copy of the wider report to members of the Committee. She pointed out that a new NHS dentist was opening up in Bicester in recognition of the commissioners need to address the lack NHS dentists within the county.

Councillor Lovatt expressed her appreciation to HWO for organising the pop-up shop in Abingdon which had attracted approximately 100 people, with no advertisement beforehand. She also expressed her thanks for the work underway on the Musculo - Skeletal (MSK) service and in respect of Wantage Community Hospital by both HWO and this Committee. She agreed that it was a success and added her aim to employ the use of pop-up shops on a wider basis in the future.

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

59/18 CHAIRMAN'S REPORT

(Agenda No. 8)

The Committee **AGREED** to receive the Chairman's Report (**JHO8**) which included updates on Health and Social Care liaison and the MSK Task Group.

60/18 NEW GOVERNANCE OF THE HEALTH & WELLBEING BOARD

(Agenda No. 9)

Prior to consideration of this item and Item 11, the Committee was addressed by Councillor Cathy Augustine, Didcot Town Councillor and Oxfordshire delegate to the national Steering Group of the 'Keep our NHS Public' (KONP) campaign and County Councillor Jenny Hannaby.

Councillor Cathy Augustine stated that, in her view, despite the role of this Committee, unscrutinised change was happening now, at a pace, and without adequate public consultation. It was her concern that this made evaluation and scrutiny of the bigger picture for Oxfordshire almost impossible. Instead, the focus was on a loss of services in specific localities, which in her view was an attempt to confuse and distract, without recognition of the cumulative and domino-effect across the county. She added that HOSC was set up as an independence voice and should decide on its own, independent agenda on behalf of patients and residents. It should not fall into line with those bodies it was scrutinising, particularly in three key areas, governance, transparency and consultation.

She expressed her concerns that, in her view, the Health & Wellbeing Board papers contained 'opaque layers', which indicated a policy of secrecy behind closed doors,

which, in turn made it closed to scrutiny by this Committee. For example, there was alarm that the Integrated System Delivery Board (ISDB), which was the main driver behind the proposed Integrated Care System (ICS), was buried deep within the structure, and, virtually invisible from the scrutiny by elected representatives. Meetings which, in her view determined policy, were in closed session with no public minutes being produced, and there was no democratically elected representative serving on it.

She therefore asked the Committee to examine and challenge this 'flawed' governance proposal.

Cllr Jenny Hannaby shared the concerns expressed by the previous speaker in relation to the ISDB stating that there was a real danger of privatisation 'coming through the back door'. She added that the Joint Management Groups who managed the pooled budgets, only met in public once a year. Transparency and openness was a requirement.

She added her hope that the Health & Wellbeing Board would listen to these concerns. She stated, however, that not all was bad - she was pleased that the Board would be working with the Growth Board in respect of the Healthy Towns initiative as working with the district councils was the way forward.

Dr Kiren Collison, Chair of the OCCG and Vice Chair of the Oxfordshire Health & Wellbeing Board, Kate Terroni, Director of Adult Social Care and Catherine Mountford, Director of Governance, OCCG

Dr Collison stated that this was a good opportunity to explain where the revisions to the Health & Wellbeing Board (HWB) had reached. As was recognised by the CQC last year, and also by the Board itself, the Board was not as valuable as it could have been. A full process review was then undertaken, which began with the engagement and discussion with a wide variety of stakeholders, including the voluntary sector, councillors and the Board members themselves about the way the Board should be going. The outcomes of this was then taken to a special meeting of the Board in May and then to formal approval by the Trust Boards and County Council. It made sense to have more representation by Health on the Board, to represent the whole pathway, from prevention through to hospital care; and thus to give a good mix of views. She added that essentially it was now a new and different Board. There was an awareness that although some groups were not represented on the Board, there was a crucial need to hear their views. It had therefore been decided to create a Reference Group to include representation from the voluntary sector and the care sector, so that nobody was excluded.

Members of the Board had undergone some work to develop and had done so in three facilitated workshops to date to build relationships, how to work together effectively and get a feel for each other's backgrounds. It was felt that to meet in public was not the best way to go about this as it required a different environment in order to get to know each other and, by use of a storming process, to work out priorities, a vision and finally a full Health & Wellbeing Strategy, which was now open for further comment by the public. The Strategy had been the subject of a large

amount of work which followed the residents journey and included cross-cutting themes of prevention and tackling health inequalities throughout.

The four main priorities were:

- Agreeing a co-ordinated approach to prevention
- The residents journey through the health and care system
- To work with the public locality by locality
- Agreeing plans to tackle the workforce issues.

Kate Terroni stated that the key areas for the new Board was visibility and a 'joined up' leadership for Health and Social Care, setting the direction of travel for Health and Social Care services in Oxfordshire, to include the planning and identification of future health social care needs for the county. The ISDB was the 'engine room' to start delivering on the direction set by the HWB, adding that it was already doing some valuable work on the workforce. The sub-groups were performance related and would give visibility to the work which the HWB was doing.

Catherine Mountford stated that the Board had recognised that there was a need to take a wider view of transparency with patients and the public. The core of this work was the development of working together, responding to what was heard from the public and showing its commitment to that. This had been shown, for example, with the Older People's Strategy. It had heard that the public wanted services to be joined up and its structure was a reflection of this. She pointed out that the CCG had held its Board meeting on this day and at this venue, as it recognised the importance of working with other organisations on how to meet health and care needs.

Questions and responses received from members were as follows:

- In response to a question about the earlier suggestions that the private workshop meetings meant that the HWB was secretive, Dr Collison stated that the Board was multi-agency in its membership and it was felt that there was a need to get to know each other properly in order that they could work together effectively. She added that there was no mystery intended, in that they needed to go through a process of storming in order to move forward. Catherine Mountford pointed out that the HWB itself was still meeting in public and Board members required more time to get to know each other on top of the public meetings;

- A member asked if the panel saw any room for more democratic representation on the ISDB and the Joint Management Groups in light of some public concern that there was unscrutinised change taking place at quite a pace? – Kate Terroni responded that the JMG (Better Care Fund) was chaired by Cllr Lawrie Stratford and met in public once a year. The two pooled budgets were managed by the JMGs and oversaw a spend of £350m. They looked at how to achieve the most efficiency out of contracts and they were therefore bound by commercial regulations. There were regular quarterly reports to the HWB for public scrutiny. The ISDB was newly formed and settling in in terms of its membership. Conversations were only just taking place in relation to its clinical voice. There was an

awareness that there needed a little more thought to how to respond to the transparency/visibility of papers. **The Committee was asked for its views on this issue. The Chairman requested members of the Committee to circulate any views via himself on this issue him in good time and prior to the next meeting in February.** In terms of the concerns expressed regarding democratically elected membership of the HWB, Catherine Mountford commented that this had been signed off by the County Council. This would, however, be kept under review. She added that if there were any particular issues, this would be brought to the Committee and the Trust Board, as was the usual practice. The principle and approach of the new Board was to think together about how the NHS and Social Care was commissioned, provided and aligned and to work together to achieve the best results. For example, to work together on winter pressures to ensure that primary, acute and social care services were all working together for the patients and the public in an integrated way. Dr Collison added that the NHS 10 - year Plan was due out in December and it will provide great potential for looking at best practice across the country;

- In response to a question regarding a wish expressed by the voluntary sector to be involved in the integration of Health and Social Care on the HWB as provider, Dr Collison informed the Committee that following the discussions on the review there had been agreement that there was a vital need for a reference group in order that views from the voluntary sector and other stakeholder groups could be fed in. Kate Terroni added that there was a concern if all stakeholder groups were represented on the HWB it would become too unwieldy. This was a system for all voices to come to the table – it would be the subject of review if it was felt this was needed;

- In response to a question about the meaning of the term 'commissioner-provider collaborative', Kate Terroni explained that this was an area where people worked together at a local level to deliver services, for example, mental health services work involved working with the provider plus voluntary providers. The ISDB had a number of workstreams, for example, IT/ Estate/provider and commissioner collaborative. She added that more work was required in relation to this aspect, for example on how to bring together providers and how to share information with each other;

- In response to a question about how to resolve the tension of using this very radical methodology and listening to what the public considered to be important and gaining their trust and a meaningful inclusivity, Catherine Mountford commented that it was her understanding that the Committee's concerns in relation to the ISDB was not just about the meetings themselves, it was more about how the Board would work when listening to the public's concerns. Dr Collison added her understanding also that it was not just about being evidence driven, it was about how the public perceived services. It was the job of the Board to bring these aspects together and to show the results of this;

- A member expressed concern about the democratic accountability on the Board, and the fact that elected members had not been approached when the new Board was in its embryonic form for discussion and views. Councillors had their ear to the ground and received any worries the public had - Kate Terroni stated that the Board needed challenge from the Committee on delivery and outcomes – and if this proved to be of concern, then changes could be made to its membership on review.

At the conclusion of the question and answer session, the Panel was thanked for their attendance and it was AGREED:

(a) to request the officers to take back to the HWB the comments from HOSC on the make-up of the Board and its transparency and request a response on these;
(b) that members of the Committee send their questions and comments on the Strategy as soon as possible and to request the officers to send a collective set of questions and comments to the Board for clarification; and
(c) to add the CQC follow -up report to the special meeting of HWB on 29 January 2019 to the Agenda for this Committee on the 7 February 2019 meeting of this Committee.

61/18 CLINICAL COMMISSIONING GROUP - UPDATE

(Agenda No. 10)

The Committee had before them a report (JHO10) on the key issues for the OCCG, which outlined the current and upcoming areas of work.

Louise Patten agreed to send to the Committee the draft pilot report following the revision of the CCG's policy for working with the primary sector adoption. This involved a service review of the integrated respiratory partnership. She added that it would be helpful to see if the patient outcomes had been improved in relation to the management of long-term conditions. The Chairman requested that this be considered by this Committee before anything similar to this project is considered.

A member asked what the implications were when a private company was involved in the collection of data. She asked what was the governance around it, how it affected complaints and what would be the impact on health outcomes in the future. Louise Patten responded that much of this information was already included in CCG papers to the Board, provided by the providers, OUH, OH and the statutory voluntary organisations locally. Any issues around data was taken as part of the overarching description pack.

Dr Collison was asked about morale among staff in primary care. She stated that this was a national problem amongst the workforce. GPs were stretched, however certain conditions could now be allocated to nurses. In relation to waiting times for an appointment, not all data was collected in a coherent way. A large amount of work was being produced on the locality plan on this subject and it was thought that the reality wasn't going to be as concerning as originally thought, particularly now that

evening and week-end appointments were being offered to try to resolve the problem. It was important to distinguish between routine and urgent. The Chairman reminded all that there would be an Agenda item on this subject in the near future.

Dr Collison and Louise Patten were thanked for the report and for their attendance.

62/18 REVIEW OF LOCAL HEALTH NEEDS

(Agenda No. 11)

Prior to consideration of this item the Committee was addressed by Maggie Swain (Save Wantage Hospital Campaign Group), Councillor Cathy Augustine and Councillor Jenny Hannaby, Local Member.

Maggie Swain

Maggie Swain made the following points:

- She was a 'passionate advocate' of the Hospital as a result of her mother's past employment there and also in her own capacity as a volunteer up until the time of its temporary closure. Once her mother had become ill she had attended the hospital for regular respite;
- The campaign group agreed with the future plans by the OCCG to restore the overnight beds, which it was understood were linked directly with the pipework, but there were other facilities that could be restored without the need for the pipework to be done;
- In recent years it was the view of the campaign group that there had been a gradual decline in the services provides. These were the removal of X ray, the stoppage of clinics such as Ear, Nose and Throat and of Physiotherapy without consultation, and the temporary closure of the Minor Injuries Unit;
- Besides Grove, there were at least 18 villages/hamlets within a 5 mile radius, most of which had no services or transport; and there was a reliance on Wantage for them. For someone living in Letcombe Basset without transport;
- Since the Hospital's temporary closure in July 2016, money had been spent on the following, none of which had been of any help to the people of Wantage:
    - Securing the building due to the loss of 24 hour cover with the closure of the beds;
    - Moving Physiotherapy into the main area of the hospital, then closing it;
    - Provision of security guards to protect the building; and
    - The conversion of rooms to accommodate NHS staff that had been moved out of the Mably Way Health Centre;

In conclusion, Maggie Swain commented that the Campaign Group were aware that the OCCG had opened a dialogue with the residents of Wantage, but it appeared that nothing would be decided for a further year. This was 'totally unacceptable' as this meant the Hospital would have been temporarily closed for nearly 3 and a half years.

There was uncertainty whether there would be a slippage again or even cancellation. A way of gaining trust was to reinstate a service which had been lost.

Councillor Cathy Augustine spoke of her concerns that Phase 1 of the 'Big Health and Social Care' conversation spoke to only 900 people in total, across the whole of Oxfordshire, which amounted to less than 0.5% of the population. In addition, only 46 people responded to the South West Oxfordshire Locality Plan Survey and 4 in Didcot. As a result, Ed Vaizey, MP for Wantage and Didcot also raised a concern in Parliament about the lack of consultation.

She called for the Committee to exercise its powers of independent oversight and scrutiny to challenge NHS England on the imminent Integrated Care Service on the grounds that there may be potential for one large contractor which may be private, and a myriad of sub - contractors, which would be likely to lead to dis-integration.

Councillor Jenny Hannaby declared a personal interest as a volunteer for the League of Friends for Wantage Hospital. She made the following points to Committee:

- Over the years monies had been spent on the hospital, but not on the pipework which had had a detrimental effect on the Hospital;
- The statistics as set down on page 131 of the paper were 'disgraceful for the residents of Wantage' if compared to the admissions in other community hospitals. The beds had been temporarily closed, thus rendering the statistics to hold no meaning at all. The decision that Oxford Health was making was making, in her view, a 'non-viable' hospital;
- Some people would be unable to travel farther afield to other hospitals for treatment for the reasons outlined by Maggie Swain – Community Hospitals played an important part in offering support to these people;
- She reminded the Committee that Oxford Health and the OCCG had used the hospital from the time the legionella had been cleared up to July when it had been closed;
- Part 2 of the Oxfordshire Transformation consultation had not appeared, which had 'added fuel to the fire';
- Closure costed the taxpayer £180k per annum.

Cllr Hannaby stated that on her view the Wantage residents had been let down and urged the Committee not to support the paper, to take responsibility for mending the pipework and to make the monies available to recruit the staff one more.

This item has been included on the Agenda following the recommendations put forward at the last meeting on 20 September (Minute 47/18 refers) which included proposals for the resumption of services and any necessary consultation on services at Wantage Community Hospital. The Committee had before them two reports entitled 'Planning for Future Population Health and Care Needs' and 'Planning for Population Needs – Wantage'.

The Chairman welcomed Louise Patten, Dr Collison and Jo Cogswell (OCCG), together with Stuart Bell and Peter McGrane (OH) to the table.

Louise Patten stated that the CCG had taken all comments made by stakeholders and the public into account and had produced an improved framework.

Commissioners and providers had demonstrated a clear commitment to work together to meet the health and care needs of residents of Oxfordshire both now and in the future; and to plan and work alongside the public and with stakeholders in an open and transparent way. She drew the Committee's attention to some significant work which had taken place over the past ten weeks in the form of a place profile and draft outline timetable relating to engagement and consultation, if so required. She further stated her appreciation of the fact that residents were concerned about the future of Wantage Hospital, but the work was required to identify in a quicker timeframe, what the local needs were, together with services required.

Stuart Bell stated that the Committee's request to re-instate the pipework was taken back to his Trust Board and revised estimates had been requested. This had amounted to £450k (including vat). He explained that the problems with the plumbing had been due to various additions to the Hospital structure over the years, and therefore, legionella had grown in a haphazard manner. Stuart Bell stated that it would not be appropriate to undertake remedial works before any decisions had been made about the future of services at the Hospital site. However, there was a commitment to make the investment to replace the plumbing for whatever services were identified. He added that the Midwifery service had been kept and the Health Visitors and school nurses had been moved into the Hospital due to the need for more space for primary care. He added that the Trust was happy to continue to use the Hospital's space until such time as it was known what to use the Hospital for in the future.

Questions from Members of the Committee and answers received were as follows:

In response to a question asking which services would not require a consultation process prior to delivery, and could thus be delivered more speedily, Louise Patten stated that if there was a significant service change then formal consultation would be required. For example, there would have to be if specifically addressing overnight bed provision. However, should there be services to which improvements would be made then formal consultation would not be required. All change had to be based on evidence, which required some analysis. The Chairman clarified for the Committee that what the NHS termed 'engagement', the local authorities called 'consultation'.

A member commented that whilst she recognised the need for services in Wantage and Grove as soon as possible, it may be advantageous for members of Save Wantage Hospital Campaign Group to visit the new Townlands Hospital in Henley-on -Thames to see the more up-to – date services provided there. Stuart Bell stated that Townlands was working very well and it was his view that if a community hospital was to have a secure future, then this was the way forward, as this was the way in which services were developing. He added that he would be pleased to invite people along to see the newly developed outpatient services which included 14 specialities, with consultants from the Royal Berkshire Hospital coming out to Henley, if that would be helpful. He stated also that this Hospital was now able to provide a wider set of services and also supported the nursing home from the hospital. He pointed out that the Hospital did not start off with these specialities, this had grown.

Stuart Bell also pointed out that the beds created at Abingdon Community Hospital were dedicated for patients suffering from a stroke, in a specialist ward, giving better

outcomes as a result. He added that the drive now across the world was to support patients in their own home for improved clinical outcomes, bed-based care causing more harm than good for frail, bed-based older people. Ten days in bed was the equivalent of ten years loss of muscle function.

In response to a question, Louise Patten confirmed that there would be an evaluation framework as part of the process. She added that an evaluation was also about what people felt about their services and this information would also be built in, to enable this to be shared with the system.

A member asked if the CCG felt it had a legal duty to consult when services had been temporarily closed on a long-term basis? Louise Patten undertook to circulate a legal view to the Committee.

A member commented that the public did wish to engage and thanked the CCG for this, however, there was a need for clarity about the precise locality in which the paper was directed. The paper talked about discussion with stakeholders around the locality of Grove and the surrounding villages. However, residents were concerned about the population growth in that area, which was 45k in 10 years. Louise Patten replied that work had already been done with stakeholders to establish the need for GP practices. With regard to services, there was a need to define the population needs in relation to population size and what was required. Therefore, the first tranche was about defining that particular locality. The CCG had listened to the frustrations voiced by the public about not being listened to with regard to the establishment of services in the past and was addressing that. In response to a further question asking for clarity on what population was the basis for the papers, Jo Cogswell explained that it was the CCG's intention to work locally to determine this whilst engaging with the public and the community, and developing in a transparent manner. Louise Patten added that definitely by May 2019 the CCG would have some idea of what services could look like. The CCG was already talking to other services and looking at providers in relation to what could be done. This timetable was reasonable, especially as it was the first time the framework would be used, but there was no wish to over-promise and under-deliver.

The Chairman, responding on behalf of the Committee, stated that Members had been very disappointed to read the report, in that its request to accelerate the timescale had not shortened the proposed timeframe for decision. However, it was felt that the overall approach for health and care needs was a good one. He added that the Committee was keen that there was no further delay and so proposed, and the Committee **AGREED** (unanimously) the following:

(a) that this Committee is not prepared to endorse the plan for the Wantage Locality against the current timetable and to request the CCG to come back to the next meeting of Committee with a shortened timetable;
(b) to request the legal officers at NHS England to scrutinise their interpretation and advice in relation to the issue of purdah as a reason not to embark on the process and the impact of this on the timescales for the work to begin; and
(c) to form a task and finish group in relation to Wantage Hospital.

..... in the Chair

Date of signing .....

HOSC Actions from 29th November 2018

Item no	Item	Action	Lead	Progress update
50/18	Forward Plan	Amend forward plan to include: a) GP Federation scrutiny b) Consider the relationship and links with District Councils for social prescribing	Sam Shepherd	Complete
51/18	Health Visiting and School Nursing Services	a) HOSC to receive the performance measures and targets for the Services.	Donna Husband	In progress
		b) Liaise with Scrutiny Chairman to ensure performance of health visiting and school nursing services are effectively c) HOSC to offer support for services where necessary- possibilities may include: • Future funding for school health nurses • Expansion of family nurse practitioners; and • Assistance in moving forward the apprenticeship model from 2020 onwards	Cllr Fatemian	Scrutiny Chairman's meeting on 13th of December was scheduled to discuss health visiting and school nurse scrutiny
54/18	HWBB	a) HWBB to take back HOSC comments on proportionality of democratic representation on the main Board and its transparency for a response (by Feb 2019). b) HWBB to take back HOSC comments on the transparency of the Integrated Systems Delivery Board (by Feb 2019). c) Draft HWB Strategy to come back to HOSC for further debate in February, sitting alongside CQC feedback on system progress.	Kieran Collison/ Kate Terroni	On the agenda for the 7th of February
46/18	Review of	a) CCG to seek a formal view from NHSE on	Catherine	On the agenda for the 7th of

HOSC Actions from 29th November 2018

Item no	Item	Action	Lead	Progress update
	local health needs	the implications of purdah on the process of consultation and engagement. b) HOSC to receive an update on progress of the work with an updated, condensed timetable for completion	Mountford	February
		c) HOSC Task and Finish Group to be established on the Review of Local Health Needs in the Wantage Locality	Sam Shepherd	Draft Terms of Reference in the Chairman's Report for the 7th of February

HOSC Forward Plan – February 2019

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
April 2019	Transition of LD services	• HOSC to receive a report on the benefits of the changes to LD services for patients	CCG
April 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	HWBB

Updated: 11 Dec 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		reported to HOSC every six months to ensure health inequalities remains a priority).	
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	
Future Items			

Updated: 11 Dec 2018

Meeting Date	Item Title	Details and Purpose	Organisation
	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? • Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored?	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 Federations	• The local GP Federation landscape. • How effective are Federations at delivering high-quality, accessible and sustainable services for residents across Oxfordshire? • What are the challenges and opportunities for Federations in Oxfordshire? • Federation funding and governance for public transparency and accountability.	Federations/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: 11 Dec 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) • How District Councils and other partners link with and support social prescribing	
	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

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 7 February 2019

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:

- GP practice procurement decision tree
- Cogges Surgery
- NHS Long Term Plan
- Vasectomy survey

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

Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. GP practice procurement decision tree

The challenge of not having a national guide for making decisions when an existing practice contract ends or when significant population growth is planned was discussed at HOSC and all agreed a local process should be explored.

Two workshops have taken place to develop a process for Oxfordshire and Buckinghamshire to guide the CCGs' decision-making. The aim was to co-produce a decision-tree 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
- Patient member of Oxfordshire Primary Care Commissioning Committee
- Local Medical Committee
- NHS England
- Oxfordshire CCG and Buckinghamshire CCG
- Healthwatch

At the first workshop the various options available to the CCG were considered and scenarios were then discussed in small table groups with the intention of identifying the questions needing to be asked and the possible ordering to create a decision tree.

The output of these discussions was taken away and used to create a draft decision tree. A further workshop was organised to review this draft and to test the scenarios. Several changes were made to refine the decision tree. The complexity of the task was acknowledged and it was agreed that the decision tree would be re-drawn to incorporate the necessary changes.

The draft decision tree produced through this work will be shared with the Oxfordshire Primary Care Commissioning Committee and the Oxfordshire HOSC members. Owing to the size of the poster, it is not practical to share via email or via the website. It will be displayed at the meetings and feedback is welcome.
The decision tree will then be professionally designed so it is in in a more practical format. It will then 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.

2. Cogges Surgery

HOSC members will be aware that the GP partners at Cogges Surgery in Witney gave six months' notice to hand back the contract they held for providing GP services to around 7,700 people in the town and some surrounding villages.

Increasing workload demands and challenges in maintaining high quality services, along with uncertainty faced by smaller practices, had all contributed to a failure to recruit new GP partners to the practice.

The CCG received notice in July 2018 and immediately briefed key stakeholders that our main aim was to ensure the sustainable provision of quality primary care service to the patients registered with the practice.

A clear and transparent process for finding a new Provider was established, using the CCG's relatively new Collaborative Commissioning Framework, which actively encourages local services integration. We had good engagement from stakeholders and local GPs as well as the local PPG Groups.

Towards the end of the process set up by OCCG to find a new provider, Cogges Surgery requested to cancel their notice. The Surgery was asked to submit an application in a similar way to other applicants, in order to demonstrate that it had long term solutions to challenges such as staffing and sustainable quality. The application was assessed by the same Stakeholder & CCG panel that undertook the first round assessment. It was important that the CCG completed the process of assessment to ensure we were confident that the arrangements being put in place at the practice would deliver sustainable services of a quality that would be expected.

We are delighted to say that the Stakeholder and CCG Panel agreed the information provided by the Cogges Partners demonstrated resilience and as a result the practice team will continue to run services from Cogges Surgery. This decision has been widely supported by the neighbouring practices in West Oxfordshire.

We appreciate this has been an unsettling time for patients registered at the practice and have written to them to confirm they can remain registered with the practice and continue to benefit from the services provided there.

3. NHS Long Term Plan – a summary

NHS England has published details of its Long Term Plan, following the Prime Minister's announcement last summer to commit an extra £20.5 billion for the NHS in England by 2023/4.

The plan aims to ensure the NHS is fit for the future, providing high quality care and better health outcomes for our patients and their families, through every stage of life.

The NHS Long Term Plan will:

- ensure local NHS organisations increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere
- boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services
- redesign and reduce pressure on emergency hospital services
- give people more control over their own health, and more personalised care when they need it
- ensure digitally-enabled primary and outpatient care will go mainstream across the NHS.

Central to the realisation of all of these ambitions will be the need for us to continue the work we have already started whereby whole health and care systems come together to plan and deliver real improvements for patients in crucial areas like mental health, cancer and stroke care, and more support for our increasing older population.

As a system in Oxfordshire we will be working together over the coming months to determine what the NHS Long Term Plan will mean for people in Oxfordshire, building on progress we have already made together, and in partnership with those who know the NHS best – patients, our staff and the public.

4. Vasectomy Survey

We have previously updated HOSC of the issues relating to the Oxfordshire Vasectomy Service including OCCG considering decommissioning of the service except where there are exceptional circumstances. A survey is currently being undertaken and is available on the CCG's website. The survey asks for the public's views about stopping the service or introducing criteria on the number of men who can get the surgical contraceptive procedure. People who take part in the survey will remain anonymous.

The survey will run for six weeks and will be advertised through GP practices, sexual health clinics, CCG newsletter, social media and the media. The CCG will also do outreach engagement to those groups identified as being impacted by a change in the service.

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of Meeting: 7 February 2019

Title of Paper: Wantage planning for population health and care needs update

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

Purpose and Executive Summary:

Health and Wellbeing Board partners continue to progress work in the Wantage and Grove area to look to the future design and delivery of health and care services. This paper provides an update on progress since the 29 November meeting.

Members of the Joint Health Overview and Scrutiny Committee are invited to note the progress of the Wantage Community engagement using the Health and Wellbeing Board's framework specifically:

- That the scope of the work will extend to the OX12 postcode area as suggested by local community representatives
- That a project group, made up of Health and Wellbeing Board partners has been established
- That a stakeholder analysis was completed with the support of local community representatives and that the first stakeholder reference group will take place on 13 February 2019
- That the stakeholder reference group will consider the proposed timetable
- If a specific need or gap is identified as a result of the analysis and engagement work system partners will work to address that gap ahead of completion of the framework approach

The JHOSC is asked to consider how local politicians can be supported to be involved in and informed of the approach.

Executive Leads:
Louise Patten, CEO Oxfordshire CCG
Stuart Bell, CEO Oxford Health NHS Foundation Trust

Author: Jo Cogswell, Oxfordshire CCG

1. Introduction

At the 29 November meeting of the Oxfordshire Joint Health Overview and Scrutiny Committee Members considered the timetable in which Oxfordshire Clinical Commissioning Group and Oxford NHS Health Foundation proposed to use the framework approach (recently adopted by the HWB) to identify health and care needs in the Wantage and Grove area. The framework advances work to address all aspects of local population health and care needs and future service requirements, setting important context around the matter of the temporarily closed overnight beds at Wantage Hospital.

Since the last JHOSC meeting, work has continued with respect to implementing the framework approach. This paper describes progress to date.

2. Local Progress

OCCG and OH staff met with a small group of representatives from the Wantage and Grove area on 19 December. The purpose of the meeting was to consider the early stages of the framework approach and to compile an appropriate list of local stakeholders to inform development of a stakeholder reference group for the work.

In preparation for the meeting system partners shared both the local Wantage and Grove population profile and the Vale of White Horse population profile. This enabled review of what we already know about the populations, how they will grow and other insights such as age ranges.

2.1. Agreeing the Scope

Informed by this background those present took the time to consider two key points essential to the early stages of the framework approach:

- What is the area that we will look at?
- Who are the key stakeholders to engage and how can we work to ensure suitable representation and involvement?

The group were very clear in their views that the focus of the approach should cover Wantage, Grove and the surrounding villages. The group suggested that the OX12 postcode area is the area that should be the main focus of the framework approach. It was agreed that from now on when we are looking at the main area of focus of the work it will be the OX12 postcode area and that we will use that descriptive term so that people understand that we are talking about Wantage, Grove and all villages in that area.

2.2 Establishing the Stakeholder Reference Group

The meeting considered the age profile of the OX12 area and some of the initial observations from the population health profiles. The group were encouraged to use their local knowledge and experience to identify a comprehensive list of possible

stakeholders, reflective of the population and some of the key health and care needs we already know of in the area. The group, given their interests and links into the local community, were asked how they might support system partners in accessing organisations or groups of people.

This outcome of the meeting is valuable and insightful local information that is the basis for our work to establish a stakeholder reference group. We also have information on useful links to local publications and websites that will enable us to ensure good engagement with the right people as we take the project forward.

At the meeting the group were concerned that work on the health and wellbeing needs of OX12 is taken forward in partnership with the District and County Councils as well as key health and care providers. We have provided assurance that this will be the case.

Further progress has been made on the establishment of a stakeholder reference group. Outline terms of reference and the draft timetable for implementation have been prepared. Invitations have been sent out to groups and individuals identified by the 19 December working group. The stakeholder reference group meeting will meet on 13 February.

2.3. Implementing the framework at pace

A project group has been established to drive forward this work, at pace, on behalf of health and care commissioners and providers. Representatives have been confirmed from:

- Oxfordshire County Council – commissioning and public health
- Oxfordshire CCG
- Oxford Health – clinicians and managers
- Oxford University Hospitals
- Vale of White Horse District Council
- GP practices in OX12 – GP and practice managers
- Communications and engagement lead, on behalf of the system partners

Each of the organisations above has committed resources to support the delivery of the work to identify the health and care population needs in the OX12 area and to work together using the framework approach to develop future service models designed to meet those needs.

The project group will manage the implementation of the framework approach and work closely with the stakeholder reference group to ensure effective involvement and engagement with local people and groups.

3. Timeframe for delivery

The Health and Wellbeing Board approved the framework approach in November 2018. The OX12 area; Wantage, Grove and surrounding villages is the first area to trial the planning framework.

The draft engagement plan will be presented to the local stakeholder group for agreement at the meeting on 13 February, including agreement on the timeframe in which it can be delivered, similar to the timescale previously presented to this Committee. This plan describes working together (co-production) to determine and understand the population health and care needs and to describe service solutions within the context of innovation and best practice.

Health and care system partners remain committed to developing future options as soon as possible for the people of OX12, recognising the need to balance this with ensuring all local parties feeling involved and engaged in exploring together the population health challenges and the potential service solutions.

The stakeholder and project groups will look for opportunities to accelerate responses to identified needs that surface and to pilot new approaches ahead of the full completion of the framework approach. This means that if a specific need or gap is identified early, system partners will work to address that gap and keep both the local stakeholders and JHOSC updated of progress.

4. Engagement and involvement of local politicians

System partners recognise that the use of local assets such as Wantage Hospital is a subject that is of great importance to local people and to the Councillors that represent them. We are keen to involve and inform local politicians in the implementation of the population health and care needs framework in OX12. We are open to suggestions, as this is the first time that we have approached planning for future health and care needs in this way.

Oxfordshire Joint Health Overview & Scrutiny Committee
7 February 2019

Health & Wellbeing Board Membership and Strategy
Briefing from Integrated System Delivery Board

1. Introduction

This paper addresses the questions raised by HOSC members at the meeting on 29 November 2018 regarding:

1. The proportionality of democratic representation on the Health & Wellbeing Board (HWB) and its transparency.
2. The transparency of the Integrated System Delivery Board (ISDB)

It also includes the draft Health and Wellbeing Strategy for feedback from HOSC members.

2. Health & Wellbeing Board Membership

Ahead of the CQC Local Area Review in November 2017, the Chair and Vice-Chair of the HWB began a full review of the board's membership and governance arrangements.

The review included an engagement exercise with key stakeholders to help shape the revised HWB terms of reference, this included:

- Organisations currently represented on the Health and Wellbeing Board
- NHS Foundation Trusts
- NHS GP Federations
- Other providers of health and social care services
- Voluntary Sector Organisations
- Representatives of Patients' and Service Users' Groups

During this exercise the Chair and Vice Chair considered many views about how to get a wide range of opinion into the Board, particularly from the public, interest groups and voluntary organisations.

The paper 'Oxfordshire Health and Wellbeing Board Function and Governance Review' which was taken to full council on 15 May 2018, described the consensus view that the HWB membership should be as small as practically possible, and should contain members who already have key decision-making powers on behalf of organisations.

The principles which shaped the membership proposals included:

- We should propose people with the skills and experience to deliver the functions of the board.

- We need to keep membership to a minimum to facilitate manageable discussion and decision-making.
- We need to achieve a balanced membership and should not be County Council top-heavy.
- We should favour representatives who already have significant delegated authority so that these can be aligned. In practice this means proposing Chief Executive Officers as opposed to Chairs or non-executive members.
- We should respect the views expressed to us by the voluntary sector and patient group respondents by engaging them through a reference group or on specific issues rather than through permanent seats on the Board.
- We want to strengthen the clinical voice of primary care provision as this has been lacking in the past
- We need to retain representation from the two upper tiers of local Government.

The revised membership, governance structure and Terms of Reference were agreed at the HWB on 10 May 2018 and subsequently approved on 15 May 2018 at County Council.

2.1. Stakeholder Representation

The issue of how the voice of the voluntary sector is heard at boards and committees is one which has been discussed at length over many years. Oxfordshire has more than 150 voluntary organisations providing valuable services in the health and social care sector. The sheer number of organisations makes it very difficult to fairly allocate places on boards and committees to speak for the voluntary sector. Regarding this point, the 'Oxfordshire Health and Wellbeing Board Function and Governance Review' paper which was taken to full council on 15 May 2018 states:

> *We are proposing to establish a reference group for the HWB. This will have wide membership and will include members of the Voluntary Sector and patient group representatives who all expressed a wish to be part of such a body. This body will meet six monthly and a wide range of topics will be discussed*

The Health & Wellbeing Board is working with Healthwatch on developing the Stakeholder Reference Group. It has been proposed by Healthwatch that this should be done through working with natural communities / localities.

In addition to the reference group it is anticipated that a wide range of speakers, including voluntary and community sector representatives, will be asked to collaborate in achieving an in-depth perspective of key topics which will inform the Board and its strategy. An example of this is the work underway to ensure that there is meaningful engagement with stakeholders on the revised Health & Wellbeing Strategy.

- A survey to gather people's views has been developed and can be completed via the council's online consultation portal, via email or in hardcopy and posted to a freepost address.

- A stakeholder event for up to 100 people, led by Healthwatch, will be held on 28 February.

A report on the views gathered during this engagement period will be used to inform the final strategy.

3. Transparency of Integrated System Delivery Board

In response to discussions at HOSC in November 2018, system leaders have considered questions raised about the level of transparency in relation to the work of the Integrated System Delivery Board (ISDB).

As a sub group of the Health and Wellbeing Board, the ISDB will provide an update and report on progress to each Health and Wellbeing Board meeting. ISDB aims to ensure the Oxfordshire health and social care system maintains a consistent approach, aligned with wider and at-scale system working. It will manage the programme of work to advance the integration of health and care in Oxfordshire. Much of the day to day business of ISDB is the progress reporting of this work and for the accountable Chief Executive Officers to meet to discuss and support this progress.

Partner organisations represented on ISDB have public facing meetings and Board level membership that include non-executive or lay member representatives.

Members of the ISDB discussed the points raised by HOSC in response to the terms of reference and understand that the integration of health and care is a subject that is of wider interest. Therefore, System Leaders agreed that the actions and notes of the ISDB meetings will be made publicly available from January 2019.

4. Draft Health & Wellbeing Strategy

The draft Health & Wellbeing Strategy is currently undergoing a process of stakeholder engagement and is attached to this paper in Annex 1. Members of HOSC are welcome to make comments on the draft strategy, these will be collated as part of the stakeholder engagement and will help inform the final strategy. It is expected that the final strategy will be signed off at the Health & Wellbeing Board on 14 March 2019.

Kate Terroni
Director for Adult Social Care

Contact Officer: Darren Moore, Strategic Improvement Lead (Strategy); Tel: 07557 082586

January 2019

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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*.

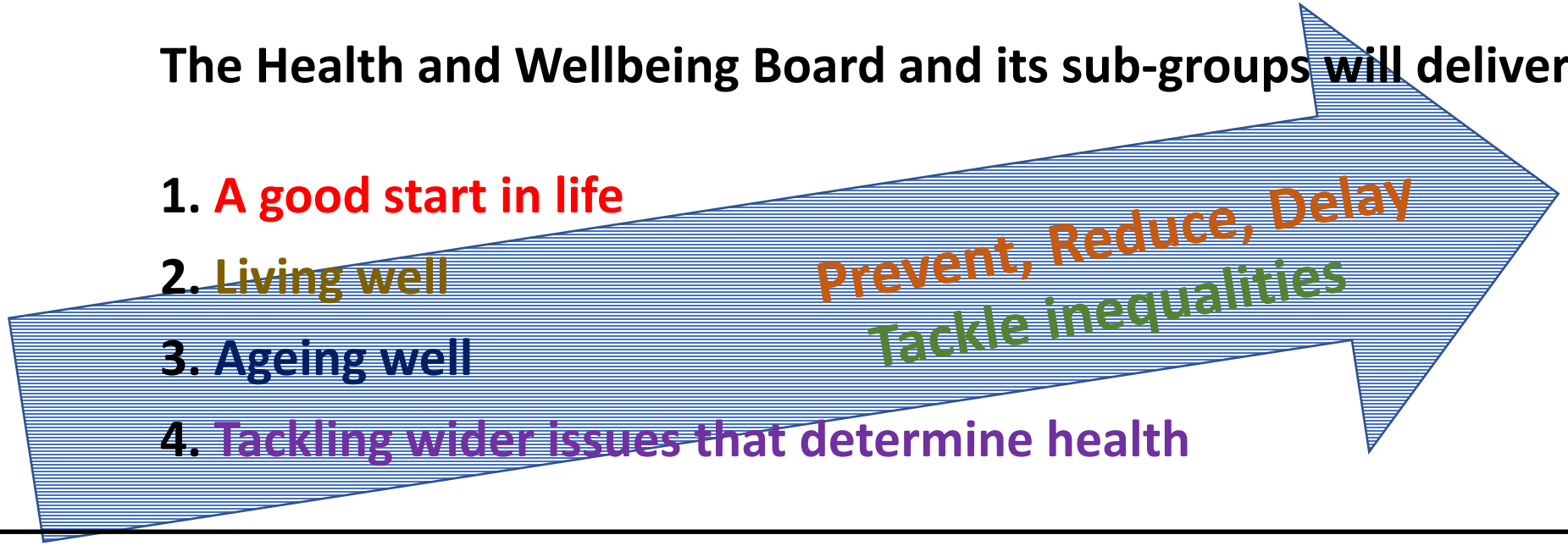
We hope our approach piques your interest, and look forward to sharing our ideas with you in the pages that follow…….

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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Oxfordshire Joint Health Overview & Scrutiny Committee
7 February 2019

CQC System Review:
Update from Integrated System Delivery Board

This paper is provided as an update to HOSC after the recent CQC local system follow-up review.

System Leaders welcome comments and feedback from HOSC on the CQC report.

1. Background

The CQC returned to Oxfordshire in November 2018 to review the progress the system has made against our action plan following the initial CQC Local Area Review of Oxfordshire's Health & Social Care System in November 2017.

The primary focus of the original review was to find out how well older people move between health and care in England. The findings were published in a report in February 2018, in response to which the Oxfordshire system leaders developed an action plan in response to the CQC's recommendations.

2. The on-site visit

The CQC spent two days in Oxfordshire to talk to us about our progress with the action plan that was created after the previous review. This visit was on a slightly smaller scale than before with a team consisting of 8 people, some of whom were part of the previous CQC review team.

During the two days they:

- Attended a presentation from system leaders, which gave us the opportunity to tell them of the progress that had been made since they were last with us
- Interviewed 34 people from across the system, including representatives from Healthwatch and the voluntary sector
- Spoke to 40 people at focus-groups with care providers, front-line staff and commissioners

The CQC were interested in exploring how the actions we had agreed had developed and whether things were improving for people who use services.

3. The follow up report

The CQC produced a report following the on-site visit and published it on 9 January 2019. On 29 January the report was presented to the Health & Wellbeing Board who are responsible for overseeing the delivery of the ongoing CQC Action Plan.

The report recognises the progress made by the system and it identifies many areas in which improvements have been made since the last local area review.

The report found that since the initial review system leaders have worked to change the culture within their organisations and develop better relationships. This had enabled a sense of shared purpose, and a willingness to take a system based approach to resolving challenges and planning for the future.

Inspectors found solid, practical examples where improved relationships had led to better outcomes for people. For example, improvements in patient flow leading to a reduction in "delayed transfers of care" and our joint approach to winter planning.

Specifically, the report praises:

- A stronger strategic approach emerging that embodies the principles of co-production, for example in the development of the Health & Wellbeing Strategy.

- The inclusion of wider partners on the Health & Wellbeing Board including the chief executives of health partners and the Clinical Commissioning Group. The CQC consider this crucial to the resolution of system-wide issues such as affordable housing, and in supporting the development of community models and local hubs.

- The systemwide approach to dealing with winter pressures, including the evaluation and learning opportunities from the previous winter, which were applied to improve system capacity and anticipate risks for this winter.

- Improved support in primary care in relation to hospital avoidance, and planning for a wider approach to preventative services.

- Practical examples where improved cross-system relationships had improved outcomes for people. For example, work had been undertaken to successfully reduce the numbers of people who remained in hospital unnecessarily.

- Improved practice regarding the development of a workforce strategy.

Professor Steve Field, Chief Inspector of Primary Care Services, said:

> *Since that last visit, our inspectors have found system leaders had improved how they work together to co-operate, to plan and deliver health and social care services for older people in Oxfordshire - and while is it not fully developed it is showing signs of improvement.*
>
> *We found a stronger strategic approach which allowed for closer working and co-production. Carers' representatives also felt that engagement had*

improved and this was demonstrated in the development of the older people's and Health and Wellbeing Board strategies. We found that the element of partnership working had strengthened and people felt listened to by system leaders.

As the CQC note in their report, we are eight months into the 18-month action plan. It is to be expected that at this stage there is still work to do to deliver the remaining actions in the plan. Including:

- Continuing with the work to simplify care pathways to ensure people only stay in hospital for as long as they need.

- Review our commissioned services to consider design, delivery and outcomes and to reduce and avoid duplication

- Delivering the co-produced Older People's strategy by the end of March 2019 as set out in the CQC Action Plan.

- Increasing engagement with the VCSE sector, an example of this is setting up an independently led Carers Forum with which we will work collaboratively to co-produce our future Carers Strategy.

- Developing revised market position statements in-line with national guidance and best practice examples, working closely with providers and with people who use services to produce the information required by providers to help plan and deliver their services.

- Delivering a brokerage function and improved information, advice and guidance to support people who fund their own care

The areas for future focus noted in the report are covered by existing workstreams within the action plan. Additional tasks have been added to workstreams where required to ensure the further recommendations are fully delivered.

System leaders welcome this report by the CQC and are confident that the fundamental building blocks are now in place that will enable the system to fully deliver the action plan.

The Integrated System Delivery Board will continue to monitor the action plan and will report to the Health & Wellbeing Board as part of the agreed reporting framework.

Kate Terroni
Director for Adult Social Care

Contact officer: Darren Moore, Strategic Improvement Lead (Strategy): Tel: 07557 082586

January 2019

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 7 FEBRUARY 2019

MUSCULOSKELETAL SERVICES TASK AND FINISH GROUP REPORT

Report by Councillor Monica Lovatt,
Chairman of the MSK Task and Finish Group

1. Introduction

1.1 In response to concerns raised by residents and patients, on the 8th of February, the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) agreed to establish a Task and Finish Group to look in detail at Musculoskeletal Services (MSK) across Oxfordshire. The aim of the Task and Finish Group was to provide assurance that:

MSK services for people in Oxfordshire are provided in a way that achieves the highest possible quality within the available resources.

1.2 The Task and Finish Group was led by Cllr Monica Lovatt (District Council for the Vale of White Horse), who at the time was the Deputy Chairman of HOSC. Additional members of the Task Group were HOSC members, Cllr Laura Price and Dr Alan Cohen. Support was provided by the Strategic Lead for HOSC; the Director for Public Health; and a Senior Policy Officer.

1.3 This report is a collaborative report, co-produced between the Task Group, the commissioner of the service, Oxfordshire Clinical Commissioning Group (OCCG) and the provider of the service, Healthshare. It presents the Task Group's approach, findings and recommendations for review by HOSC, it also includes detail of the response to the Group's recommendations.

1.4 The Task Group notes that throughout the process, including transition and the early days of the contract, OCCG and Healthshare have been working to identify and address issues with the service. OCCG and Healthshare were aware of and already tackling most of the issues outlined in this report.

2. Task Group Background

2.1 MSK conditions involve the muscles, ligaments and joints. This might be an injury with your muscles, bones, or joints or may be a condition such as osteoarthritis; it also includes rarer autoimmune diseases and back pain.

2.2 In 2015, OCCG commissioned a review of its commissioned MSK services with a view to addressing a number of patient and GP concerns with the service including long waiting times.

2.3 After extensive patient and clinical involvement, OCCG produced a new clinical model and Business Case that set out how MSK services were operating at the time and made a recommendation to implement a new integrated service that

made improvements in several areas, including access, self-management, a person-centred approach, networking with third sector and the integration of assessment with triage, assessment and treatment, as well as signposting to lifestyle services and Talking Space[1].

2.4 OCCG engaged people who had used the service to develop the new service model, which informed the new service specification. A contract to provide MSK services in Oxfordshire was retendered (after working with the incumbent providers to give them an opportunity to provide the newly specified service) and a new provider was awarded the contract in June 2017 and the service started on the 1st of October 2017. The new provider for MSK services in Oxfordshire is Healthshare, which is a clinical stakeholder organisation working within the NHS and is solely funded through NHS contracts.

2.5 In the autumn of 2017, Oxfordshire HOSC asked questions of the CCG regarding the process, outcome and transfer of MSK services to the new provider. The CCG has provided the Committee with the original Business Case, a briefing note and answers to all questions asked. In November 2017, members of the HOSC committee were being contacted by residents with concerns about the MSK service. On the 8th of February, HOSC agreed to establish a Task and Finish Group to look in detail at MSK across Oxfordshire

3. Context

3.1 More years are lived with musculoskeletal disability than any other long-term condition. There are more than 200 musculoskeletal conditions which:

- affect 1 in 4 of the adult population (many being young and of working age) which is around 9.6 million adults and 12,000 children in the UK
- account for 30% of GP consultations, in England
- have an enormous impact on the quality of life of millions of people in the UK; 10.8 million days are lost as a consequence of musculoskeletal conditions
- are associated with a large number of co-morbidities, including diabetes, depression and obesity;
- account for over 25% of all surgical interventions in the NHS, and this is set to rise significantly over the next ten years;
- account for £4.76 billion of NHS spending each year[2].

[1] TalkingSpace Plus is an NHS service that is easy to access, offering a confidential service for adults aged 18 and over who are registered with an Oxfordshire GP. It offers a range of talking treatments and wellbeing activities that help people to overcome their depression and anxiety and stay well.

[2] Information from https://www.england.nhs.uk/ourwork/clinical-policy/ltc/our-work-on-long-term-conditions/musculoskeletal/

3.2 Oxfordshire CCG spends £118 per weighted head of population on MSK services, this is £20 cost per head over and above the England average of £98 for MSK conditions. When the MSK review and development took place, Oxfordshire CCG recognised the need to reduce expenditure and improve outcomes. The key areas of change include:

a. Self-management
b. Self- referral
c. Person centred care approach (care planning, shared decision making and patient centred outcomes)
d. Networking with third sector
e. Integrated Information Management system with viewing access for appropriate clinicians and patient
f. Primary and secondary care interface meeting
g. 'One stop shop' Integrating triage and assessment with primary care treatment
h. Oxfordshire spinal pathways to be aligned with Pathfinder national spinal pathways.

3.3 One of the areas the new MSK service wanted to influence was to reduce the long waits for Orthopaedics. Orthopaedics have one of the longest national waits for appointments both for outpatients and surgery. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. (92% of patients should be seen with 18 weeks is the standard). Oxfordshire was therefore not meeting the NHS Constitution standard for Referral to Treatment (RTT) on orthopaedics.

3.4 The new provider for MSK services in Oxfordshire is Healthshare, which is a clinical stakeholder organisation which works within the NHS and is solely funded through NHS contracts. Healthshare provide:

<u>General physiotherapy, including:</u>

- Manual therapy
- Advice, guidance and provision of tailored exercise regimes
- The provision of appliances, i.e. crutches
- Advice on weight management and referral to additional support if required
- Signposting to other agencies that can help the patient's holistic health, i.e. Achieve

<u>Specialist physiotherapy, which provides all of the above for:</u>

- Paediatric physiotherapy
- Woman's health, inc. bladder and bowel conditions
- Hands
- People with mild to moderate chronic pain

<u>General Exercise Classes</u>

These take a holistic approach to aid both a specific injury/problem and improve general health and movement.

Specialist classes for pelvic girdle pain

This is for pregnant and post-natal patients

Specialist orthopaedic opinion, including;

- The ability to requests and review
- Ultrasound
- MRI
- X-ray
- Nerve conduction studies

The provision of

- Ultrasound guided injection (USGI)
- Landmark guided injections
- Direct onward referral to secondary care for consultant led opinion and consideration of surgery
- Specialist rheumatology opinion, provided by a GP with a special interest in rheumatology, and who also works at the Nuffield Orthopaedic Centre allowing integration between the two services

Musculoskeletal podiatry services, including;

- The provision of 'off the shelf' and bespoke orthotics as required
- Ultrasound guided injection
- Landmark injection
- Interaction and referral to other agencies, i.e. secondary care, council services, voluntary and charitable organisations

3.5 Healthshare does **not** provide services for:

- Children under 1 year old
- People with suspected serious pathology or red flag symptoms
- People who are housebound and require a home visit which is provided by Oxford Health
- Treatment for people requiring specialist neurological physiotherapy
- Two week wait referrals for cancer
- Oxford Health and Oxford University Hospitals NHS Foundation Trusts provide:
- Stroke rehabilitation physiotherapy

3.6 The Healthshare sites and opening hours are as follows (NB- a plinth refers to a treatment bench):

- East Oxford Health Centre, 13 plinths, open Monday to Friday, appointments between 0800 and 1730
- Horton Treatment Centre, Banbury, 4 plinths, open Monday to Friday, appointments between 0800 and 1730
- Chipping Norton Health Centre, 3 plinths, Open Monday to Friday, appointments between 0800 and 1730

- Bicester Community Hospital, 5 plinths, open Monday to Friday, appointments between 0800 and 1730
- Deer Park Medical Practice, Witney, 7 plinths, open Monday to Friday, appointments between 0800 and 1730
- Wallingford Community Hospital, 5 plinths, open Monday to Friday, appointments between 0800 and 1700
- Townlands Community Hospital, Henley, 5 plinths open Monday to Friday, appointments between 0800 and 1630 (have potentially secured a new starter today that will extend that, but for now….)
- White Horse Medical Practice, Faringdon, 2 plinths open Monday to Friday (currently excluding Thursday but that will change from September), appointments between 0800 and 1700
- Woodlands Medical Centre, Didcot, 2 plinths Wednesday and Thursday only, appointments between 0800 and 1700
- Park Club Leisure Centre, Milton Park, Abingdon, classes only Tuesday and Friday afternoons

4. Task and Finish Group: Terms of Reference

4.1 To undertake a detailed piece of scrutiny on behalf of the committee, HOSC agreed that the Task and Finish Group would:

- Understand the intended benefits of a single and integrated MSK service provider for Oxfordshire;
- Understand and report on patient waiting times, experience, self-referral and outcomes (pre and post contract change).
- Understand and report on GP referral experience, including the management of the interface with primary care (pre and post contract change).
- Evaluate the performance of the new provider to date, in terms of patient experience, clinical quality, return on investment and patient outcomes.
- Understand and report on how provider performance will be monitored, evaluated and reviewed through the duration of the contract.

4.2 The Task and Finish Group was established in consultation with OCCG, in-line with the HOSC and Health Protocol, which works in the spirit of a ‘no surprises’ approach. The Group was set up by Oxfordshire Joint HOSC to provide oversight to and assure the development of the new MSK services. The Committee authorised the Group to conduct this work and report back formally to the Committee. It was agreed the Task Group would not have permanency, and would exist until such time as the work concluded.

5. Method of review

5.1 Between June 2018 and November 2018, the Group gathered information and intelligence via the following methods:

a. *Reviewed the history of MSK services*, including the development of a new service specification and a procurement process to appoint a new provider to understand intended benefits of a single and integrated MSK service provider for Oxfordshire. This included a meeting with a previous provider.

b. *Meeting with patient representative body* (Healthwatch) to understand the issues with MSK services for patients including patient waiting times, experience, self-referral and outcomes (pre and post contract change)

c. *Meetings with GP representative body (Local Medical Committee)* to understand and report on GP referral experience, including the management of the interface of MSK services with primary care (pre and post contract change).

d. *Meetings with clinicians working along the MSK pathway* including consultants in medicine and surgery and physiotherapists working in the MSK service, to understand the views of clinicians and their patient's experience.

e. *Reviewed the performance of MSK services in Oxfordshire* to evaluate the performance of the new provider to date, in terms of patient experience, clinical quality, return on investment and patient outcomes. The Task and Finish Group reviewed this performance information after a full twelve months of the new provider's operation.

f. *Meeting with the commissioner and provider* to understand and report on how provider performance will be monitored, evaluated and reviewed through the duration of the contract.

6. Findings

Commissioning and transition process

6.1 The Task and Finish Group heard how the 2015 review of MSK Services was undertaken, including the patient and clinical engagement to develop a new model of care which included the providers of the service at the time, Oxford Health Foundation trust and Oxford University Hospitals Foundation Trust. The clinical model then informed a Business Case and subsequent service specification.

6.2 During the development of the original Business Case for a new MSK approach in Oxfordshire, it was identified that the county had one of the highest spends on orthopaedics in the country. This was one of many drivers in changing MSK services was to provide an alternative to surgery.

6.3 During HOSC's Task Group work, it was identified that the assumptions made in the development of the MSK Business Case contained errors regarding the activity (patient numbers through the system). To calculate activity for a single,

integrated service for all MSK services, the numbers of patients in the different pathways (community and secondary care) were combined. The double counting, following advice, was assumed to be 40%. The Business Case assumption which was used to develop the specification was that MSK services were needed for 43,000 people per year. This was subsequently shown to be inaccurate and is in reality more like 63,000 people per year needing the service. The double counting was therefore hugely overestimated and the actual demand massively underestimated. There is over referral in Oxfordshire to MSK services compared to other CCG areas.

6.4 Following the engagement process and development of the model of care a specification was developed and shared with all stakeholders (including providers) for comment over three months. Once this was agreed OCCG entered into a 'preferred provider' procurement process which was designed to support existing, local providers. This was unsuccessful as the proposals from the local providers did not meet the requirements set out in the new specification. The local providers did not share the view that the specified service could be provided within the available financial envelope. The Task Group heard how all stakeholders across the system believed a good model had been developed, which was progressive and would meet the needs of patients and clinical staff throughout the system. There was however an anxiety that the model would cost significantly more to deliver at the point of delivery despite the savings to be made further down the track on secondary care (orthopaedic surgery).

6.5 The views of the existing providers regarding delivery of the new specification within the available budget were shared with the CCG. Despite contrary views, the CCG were confident that the contract could be delivered within the financial envelope by a provider in the open market. So, without a provider secured for the new service through a 'preferred provider' route, the CCG moved to an 'open tender' process, which offered the opportunity to bid against the service specification to providers across the country. Following the open tender process, new provider was ratified, mobilised and the contract signing took place in September 2017.

6.6 The new provider, Healthshare[3] was awarded the contract for five years had not previously operated in Oxfordshire but is an NHS-only provider of MSK services in London, Hull, Hillingdon, Dartford, Gravesham and Swanley. The new services provided by Healthshare includes referral management, prevention (i.e. weight management, exercise, specialist exercises) as well as general and specialist physiotherapy, specialist orthopaedic and rheumatology opinion and MSK podiatry. They do not offer services to children under 1 year old, patients with suspected serious pathology or 'red flag' symptoms (symptoms of more serious conditions) , patients requiring community treatment (i.e. home visits), treatment for patients requiring specialist neurological physiotherapy, non-MSK podiatry or patients with a two week wait referral for cancer symptoms.

[3] https://www.healthshare.org.uk/

6.7 Before the transition period providers were given some funding to clear the backlog to a wait of 4 weeks. Despite transition responsibilities being an NHS contractual requirement, throughout transition to the new provider, there was confusion and insufficient capacity around the management of the transition. During this time, a number of issues came to light which ultimately impacted on the service patients received. The result of this situation was identified through the Task Group's work and through a report[4] provided to the Group by Healthwatch Oxfordshire; this included:

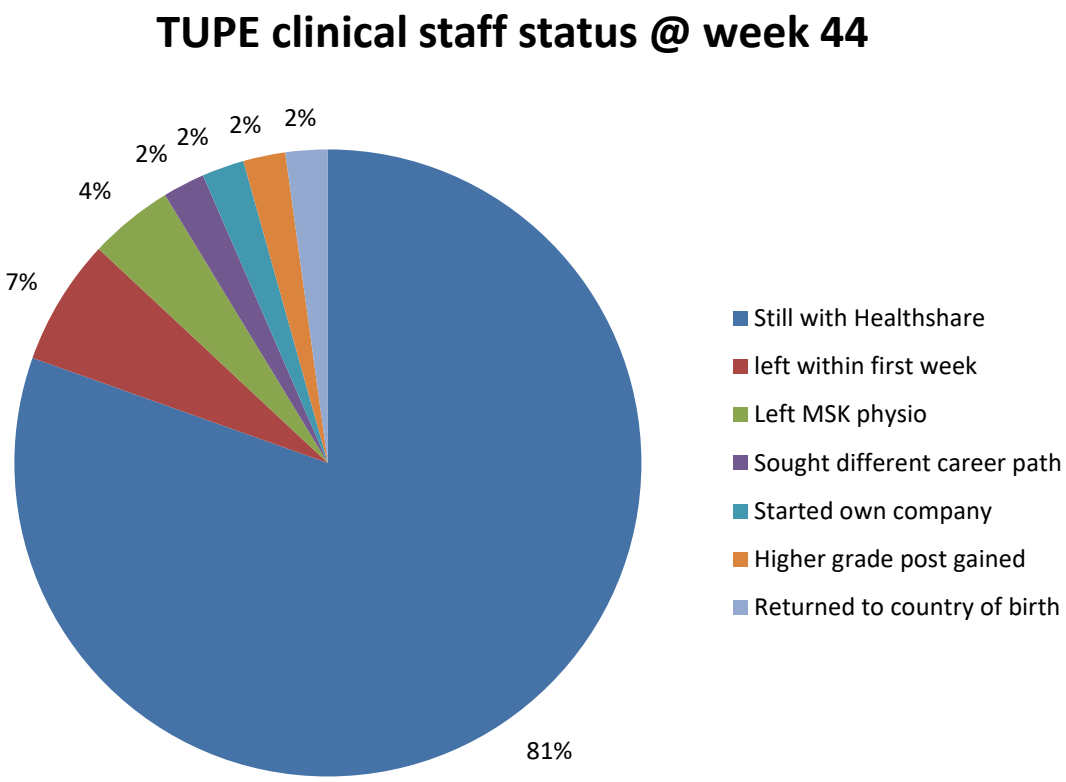
- Healthshare being unable to secure premises for the same clinic locations which had previously been in operation.
- Over 12,000 patient records were handed over to Healthshare on paper which needed to be input into a digital system.
- Healthshare had a large back-log of patients to see, with some patients booked into appointments by the previous provider without a record of the appointment made.
- 35% more new referrals came through to Healthshare than were forecasted, expected and planned for.
- There was lack of clarity over the roles and responsibilities of those involved in the transition process.
- Communications with patients and carers were not clear which created confusion. This is expanded upon in the section below ('Implementation').
- Communications with staff were not clear which created confusion.
- The transition timetable was accelerated mid-way through the process.

6.8 The Task Group found that the assumptions in the Business Case which were subsequently found to be inaccurate, led to a number of significant impacts for the new provider and patients. Despite additional payments made to providers to reduce back-logs and therefore demand on the new provider, demand was significantly more than had been anticipated. This meant the new provider's initial processes, staffing, appointments and patient flow were planned on forecasted figures rather than actual demand. The inaccuracies in demand calculation also led to an underestimation of the cost for delivering the specified service, which has thereby meant the original savings have been overestimated. Additional resourcing has now been agreed for Healthshare to cope with this demand; they have increased the numbers of administration staff and have implemented new processes to meet the demand. Similarly, to providers across the NHS, Healthshare have been asked to find efficiencies and different ways of working to ensure they meet the demand with the resources available to them.

6.9 For staff, the transition to a new provider was reported as being confusing and a time of uncertainty, with staff being unsure of their work location until very late in the transition process. There was also a reported knock-on effect for staff in clinically adjacent services in the previous provider. Those who were delivering in fixed locations for the previous provider were TUPE transferred across to Healthshare. Staff were consulted with and remunerated where there were

[4] https://healthwatchoxfordshire.co.uk/wp-content/uploads/2018/10/Healthwatch-Oxfordshire-report-to-HOSC-Healthshare-TFG-September-2018.pdf

changes to work locations that impacted on staff travel to work. There has been a retention rate of 81% or 4 out of 5 staff have remained with Healthshare. The following chart shows this:



6.10 Despite reported issues of uncertainty for staff throughout the transition, retention was good. With the workforce issues in Oxfordshire in terms of recruiting and retaining staff, the Task Group felt that the uncertainty and lack of clarity for staff, posed an unnecessary risk to the sustainability of the health and care system workforce. This is a risk that Oxfordshire cannot afford to underestimate and must prioritise.

6.11 Based on this information, the Task Group identified the following recommendations:

Recommendation 1:
The extensive and detailed engagement process to involve both patients and clinicians in the development of the model of care and subsequent Business Case for MSK services is commendable and should be an approach used for any similar future businesses cases

Recommendation 2:

During the Group's work, it was identified that the Business Case for MSK service provision was in-part, intended to improve the cost effectiveness of service delivery. However, there was insufficient and/or inaccurate consideration of the activity levels for MSK services, the local financial circumstances and local workforce implications within the final Business Case. This led to an underestimation of the actual cost and workforce impacts of the specified service. Future business cases would therefore benefit from being commenced and completed with:

a) Accurate activity modelling informed by robust testing and independent challenge of the activity assumptions.
b) By addressing (a), this would better ensure services are specified within the realistic confines of the local financial envelope.
c) A full understanding of the implications for the local workforce

6.12 The Task Group heard that the process of commissioning services in future would take a more collaborative approach. This is due to recent changes to national policy, which encourages system-wide integration (through Integrated Care Systems). There have also been changes to the local health and care landscape which is increasingly focusing on integration. Examples of this are seen in a commitment by the CCG to assess providers on their approach to collaboration but also in the development of new system-wide posts. This means that the approach to provision of services in future is likely to be collaborative and integrative. The Task Group supports this way of working to avoid some of the issues seen in the example of MSK service provision.

6.13 Despite the overall support for integration of services, it was identified that a healthy challenge on performance of providers needs to be maintained. A separation between the initial commissioning process and the subsequent contractual management is needed. The Task Group felt that a separation between the two processes would ensure swift and independent action, could be taken by a contract manager on any issues created by initial commissioning inaccuracies- such as the underestimation of demand. It would also introduce impartial performance management of a provider; again, to ensure fast and decisive action is taken to address any issues.

6.14 Based on this information, the Task Group identified the following recommendations:

Recommendation 3:

The Group felt a more collaborative approach to service provision would be helpful in future and it recognised the progress in Oxfordshire around this in recent months. However, to ensure there is sufficient challenge of provider performance, it is recommended that the process of a) commissioning and b) contract monitoring are performed as separate functions within the CCG.

Recommendation 4:

To more effectively manage the transition between providers in any future situation; the CCG could consider the temporary appointment of a dedicated Manager whose responsibility would be to manage all necessary aspects of a provider transition.

Implementation

Views of patients and clinicians:

6.15 As outlined in the section above, the reality of the demand had an enormous impact on the capacity of Healthshare to respond to the numbers of patients flowing through the service. This led to many problems for patients, staff and clinicians in navigating the transition. Healthwatch Oxfordshire reported in full on these issues and made recommendations to the Task Group which can be found in Appendix A. Healthshare and the CCG responded to the issues raised; these responses can be found in Appendix B and Appendix C. The Group therefore recommends that:

Recommendation 5:

All recommendations made by Healthwatch in their report are supported and endorsed by the Task and Finish Group. These are:

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.

6.16 Healthwatch and the GP representative body, the Local Medical Committee (LMC) reported that all the above issues had been raised directly with Healthshare on several occasions. Whilst Healthshare were said to be open to hearing feedback from Healthwatch and the LMC, they were said to be slow to take action unless issues were also raised with the CCG. Healthshare stated that this was because of the contractual nature of the relationship between the CCG and Healthshare, which means they look to the CCG to direct them. The Task Group were keen to ensure that the role of Healthwatch as a body which exists to provide a means for patients to influence services is supported. Similarly, with the LMC as the body speaking on behalf of GPs. The Group proposes the following:

Recommendation 6:
All providers in Oxfordshire, are recommended to have a meaningful understanding of the role of Healthwatch and the Local Medical Committee as representative bodies. Providers should be prepared to hear the concerns these bodies raise on behalf of those they represent and respond directly in a timely manner.

New ways of working

6.17 The Task Group heard about the introduction of 'Extended Scope Practitioners' (ESP) into the MSK service in Oxfordshire by Healthshare. These practitioners are physiotherapists with advanced training who advise

physiotherapists and support additional treatment when needed. This may include using diagnostics and carrying out procedures such as guided injections with ultrasound. These practitioners are in eight of the nine clinics run by Healthshare in Oxfordshire. The benefits of having an ESP in the services were identified as:

- Patients can receive advanced or additional treatment within the same service; thereby reducing the need for referrals to other services and additional waits for treatment.
- There were opportunities available for staff learning by working with ESPs.
- Physiotherapists are given support with patients who need additional treatment.

6.18 The Task Group therefore identified the following recommendation:

Recommendation 7:
Having Extended Scope Practitioners (ESP) working within clinics offers opportunity for staff development and offers patients additional treatment options. This has been a positive change in service which should continue to be supported in future.

6.19 The Task Group heard how the introduction of an increased focus on prevention of MSK conditions has been designed to deliver benefits to patients, but will also prevent the need for further, more complex and expensive services in time. These are programmes to make lifestyle improvements with patients such as weight management and programmes which help support people with the mental health aspects of their conditions. The prevention approach was supported by the Group and the following recommendation made:

Recommendation 8:
Working with groups of patients on lifestyle and prevention activity within the MSK model is welcomed and supported; this aspect of the service should continue to be supported in future.

Evaluation of the service and outcomes

6.20 During the Task Group's exploration of how the success of MSK services are determined, it was understood that the following methods are used to assess the service. These assess the service as a whole, including how well patient outcomes are being achieved:

- Operational and clinical standards (e.g. NICE standards)
- Contract monitoring on Key Performance Indicators (KPI's)- as set out in the 'quality requirements' by the CCG
- Patient satisfaction questionnaire, which asks patients about how satisfied they are with the process of treatment that they receive from their clinicians
- EQ5D- is a well-established self-completed questionnaire that measures change in the quality of life. It is completed by the patient, at the beginning of treatment and then again at the end to understand the difference treatment made to a patient's quality of life.

6.21 In addition to ongoing monitoring above, a Quality Review was undertaken on Healthshare by the CCG in July 2018. This reported that there were many patient and clinician concerns raised about Healthshare and when benchmarked against similar sized providers, more issues arose with Healthshare from GP's than other providers. The initial issues were regarding some records not being transferred and the need for re-referral as a result. During this initial period the amount of telephone contacts were unable to be managed by Healthshare resulting in increased number of GP feedback reports and patient experience contacts. This was addressed by Healthshare improving the telephone system in October 2018; this action was reported to have significantly reduced issues and complaints with this. Another theme of reported issues occurred around April and May 2018 where patients were being sent to their GP to request MRI. The pathway was altered to allow this to occur straight from Healthshare.

6.22 Data collected on patient satisfaction with clinical care throughout Healthshare's first year was stated as positive by the CCG and Healthshare. Although there were many complaints regarding the process to get to a clinician, once patients did receive treatment, those completing a patient satisfaction questionnaire said they were happy with their experience. 89.91% of patients who responded to a questionnaire said they were extremely or very satisfied with their treatment between August and October 2018.

6.23 The only measure of health outcomes of the MSK service is the EQ5D questionnaire; the data obtained for this is therefore significant. During discussions with Healthshare, it was identified that the method being used to collect the patient assessment information for the EQ5D was not in-line with best practice. Surveys should be completed by patients (or their carer) on their first and last appointment. However, patients have been completing information for the first appointment, but the information for the final appointment has been completed by the clinician providing the treatment. This means that the data collected to date is therefore not a reliable measure of health outcomes. The Task Group felt all patients should be completing both the pre and post treatment assessment survey to ensure collection of accurate and reliable information. The following is therefore recommended:

Recommendation 9:
Using the EQ5D, health outcome questionnaire, is a recognised method of understanding the difference MSK services are making to patients. To better ensure reliability of the results of the EQ5D process, it is recommended that best practice methodology be applied to the gathering of this information so that patient outcome and quality information is recorded by the patient themselves (or a patient's nominated representative where necessary) at the beginning and at the end of treatment. It is also recommended that the Clinical Governance committee of Healthshare review the data obtained from EQ5D questionnaires in the light of the practice to date.

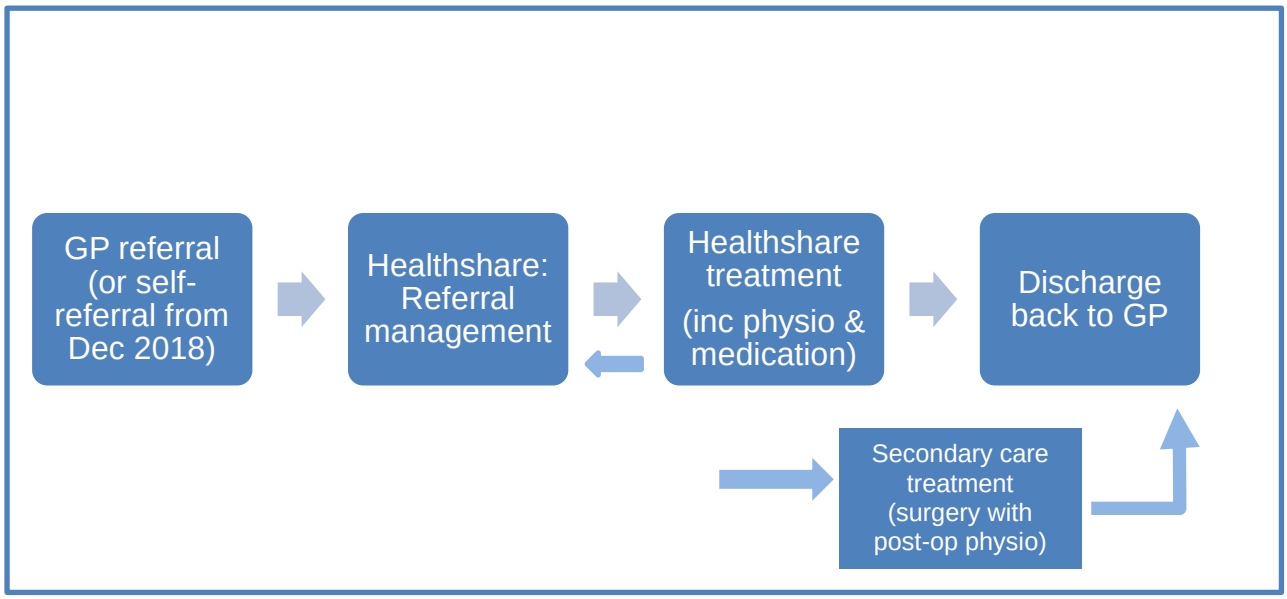
6.24 The Task Group explored with the CCG whether an alternative to the EQ5D questionnaire had been considered. A patient outcomes questionnaire has been developed by the University of Keele in collaboration with the University of Oxford and the Arthritis UK group[5] to specifically measure health outcomes. This resource and the expertise at Oxford University on the subject were felt to be of benefit to the CCG as they consider evaluation of the MSK service, so the following is recommended:

Recommendation 10:
The Group identified that national research on the evaluation of health outcomes of MSK services has not been used to the best advantage for a new service in Oxfordshire. National research on the evaluation of MSK services should therefore be reviewed and applied to the Oxfordshire system to understand the benefits for patients.

Triaging and governance

6.25 The Task Group identified that there was a willingness from Healthshare and from clinicians in secondary care to work together to find solutions to the issues being experienced by patients and clinicians. There was a clear desire to develop and streamline the pathway and make changes which could help ensure patients get to the right place in the pathway at the right time.

6.26 The following diagram illustrates how patients flow through the MSK pathway between Healthshare and secondary care. This shows that referral management triages patients to the correct part of the pathway.



[5] Arthritis Research UK (2016) The Arthritis Research UK Musculoskeletal Health Questionnaire. Developing and piloting a generic patient reported outcome measure for us across musculoskeletal care pathways.

6.27 Under the previous contract, the MSK hub, which was run by a secondary care provider, employed MSK consultant doctors. It was therefore a consultant-led service for the clinics and triaging process. As the service stands today, Extended Scope Practitioners (ESP) are now the most senior clinicians in undertaking the triage process in the MSK service. This was felt by secondary care representatives to be a valuable addition to the service, however, ESP's are now making decisions which physiotherapists, led by consultant doctors would have done in the past. The result of this is that patients are not always being referred to the right place at the right time. Those not appropriate for secondary care are being referred but those who should be in secondary care are being delayed and a further triaging of patients (by consultant-led staff) has had to be established in secondary care to review those patients who have been referred for their suitability.

6.28 The referral data shows that there have been some significant variances in referral numbers to secondary care and delays in getting patients to the right place at the right time. The data is shown in Appendix D and it demonstrates that there was a sudden surge in referrals from April to May 2018[6] when referrals jumped from around an average of 500 per month, to over 2000 patients per month. The cause of this was explained as a problem with staffing levels being under-capacity issue within Healthshare at the time. There was however no clinical review of this variance to understand the impact on patients. Secondary care clinicians highlighted that the variance and delays in referrals affected patients directly and indirectly. Examples stated were patients being on steroids for unnecessary amounts of time and that during the wait for treatment, patients were not having active management.

6.29 The Task Group identified the following recommendation to help address this issue:

Recommendation 11:
The Group recognised the valuable role that Extended Scope Practitioners play in the delivery of MSK services. However, having doctors involved in the triaging of patients would be more likely to ensure more patients get to the right place for treatment in a timely fashion.

6.30 The current arrangements for understanding and tackling the issues across the MSK pathway involves a monthly contractual meeting between Healthshare and the CCG. Healthshare also meet regularly with Healthwatch Oxfordshire and a further meeting occurs monthly between Oxford University Hospitals FT, Healthshare and the CCG to help work through issues and solutions. Whilst this way of working is helpful, the Task Group felt the governance arrangements around MSK services could benefit from a more formalised collaborative approach. Because of the complexities in managing patients between primary care, community and secondary care and in-line with the spirit of integrated

[6] NB- this data has subsequently been found to be inaccurate with double counting of referrals for the month of May 2018

working, the Task Group supports closer working between commissioners and providers in the MSK pathway. It therefore identified the following recommendations:

Recommendation 12:
Commissioners and providers are currently working together to improve service provision and resolve identified issues. However, commissioners and providers of all services on the MSK pathway could consider working together through a formalised, collaborative, partnership arrangement. It is recommended that primary and secondary care clinicians are considered as being part of this arrangement, as well as managers from the CCG and clinicians from HealthShare.

Recommendation 13:
In-line with the integration of the health and care system, any future collaborative partnership arrangement for overseeing MSK services could consider the future financial arrangements for the entire clinical service within its remit – thus ensuring that finances are aligned with clinical need.

6.31 Because of the identified issues with information collected through EQ5D assessments, the Task Group felt that there is a lack of reliable health outcome data. Outcome data is felt to be an essential part of understanding the impact of the service and whether the issues with demand management have had an impact on patient outcomes or clinical care. Therefore, in addition to recommendation above on EQ5D, the Task Group identified the following recommendation:

Recommendation 14:
To ensure MSK services provide the best possible outcomes for patients, it is recommended that any future partnership arrangement could oversee a clinical review of the care pathways, including those for orthopaedics.

Next steps:

6.32 It was clear to the Task Group that all stakeholders had worked to identify and resolve the issues encountered through the commissioning and transition to a new provider of MSK services, including dealing with legacy issues. Healthshare had acted on a number of points to improve services to patients, including the telephone issues. Healthshare have recruited and moved staff around and introduced a few other changes to ensure phones can be answered quickly. They are also addressing issues with the waits for an appointment through a new process, put in place in October 2018.

6.33 Despite the willingness to act and the actions taken to date, performance on service KPI's remain a concern for the Task Group. They are as follows:

Service KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Referrals triaged within 48 hours of receipt	>65%	7.36%	17.91%	74.30%	69.41%	70.56%	77.60%
Patients requiring diagnostics have treatment plan reviewed within 48 hours of result	100%	100%	42%	85%	93%	92%	71.60%
Referrals sent to secondary care within 3 working days of decision to refer	>75%	21.26%	8.02%	57.60%	12.61%	9.52%	20.60%
First urgent appointment offered within 5 working days	>80%	4.90%	17.90%	28.80%	12.00%	6.70%	6.90%
First routine appointment offered within 20 working days	>75%	6.9%	14.5%	16.8%	11.5%	9.7%	8.0%

6.34 Although performance around the triaging of patients is exceeding targets, the remaining targets around getting patients into the services they need in the targeted time, is not yet being achieved.

6.35 In November 2018, the CCG stated they were working with Healthshare to address these issues. The CCG stated that their Board were made aware of general performance issues with the service and that the CCG's Quality Committee, (a subcommittee of the Board) have received detailed reporting on performance. A draft joint MSK service improvement plan is shown in Appendix E and latest performance (October to December 2018) on secondary referral, urgent appointments are shown as improving in Appendix F.

6.36 To ensure that the performance issues are given sufficient priority and urgency, the Task Group identified the following recommendations:

Recommendation 15:
The Task Group acknowledges and supports how all organisations along the MSK pathway are working together to resolve the identified issues and that Oxfordshire CCG is now closely monitoring the performance of Healthshare. To assist this, it is recommended that

a) The CCG Board, as the commissioner, receive regular performance reports to gain assurance of performance improvements.
b) HOSC receive a report on how Healthshare are meeting their trajected performance against planned improvements in April 2019.

Recommendation 16:
The Task Group acknowledges that Oxfordshire CCG is working with Healthshare to ensure that performance improves. To assist understanding and contingency planning, it is recommended that the CCG Board receive a risk report on MSK services, along with clear contingencies to set out an Action Plan should risk levels escalate.

6.37 Because of the issues which have been raised throughout the work of the Task Group, it was felt that communication regarding the lessons learned by all those stakeholders involved should be shared. The Task Group also felt that the communications regarding how the outstanding issues are being tackled could usefully be shared with patients to offer them reassurance on the services the MSK services in Oxfordshire. The Group therefore make the following recommendations:

Recommendation 17:
There are lessons to be learned from the Task Group's work, for both providers and commissioners of MSK services beyond Oxfordshire. It is recommended that the results be shared with relevant organisations; thought to include Healthshare Ltd, relevant CCGs and relevant NHS England bodies.

Recommendation 18:
To improve the information flow to patients, GP's and stakeholders on the identified issues and proposed solutions with MSK service provision, it is recommended that Healthshare and the CCG work together to provide information through the CCG's website (similar to the model previously used around changes to Cogges surgery).

Learning for HOSC on Task and Finish Group work

6.38 The MSK Task and Finish Group was the first of its kind in providing a more detailed piece of scrutiny than is normally possible through the main committee meetings of HOSC. Throughout the process of conducting the Task Group, HOSC members reflected upon the experiences itself and therefore makes the following recommendations HOSC to consider:

Recommendation 19:
The changes made to MSK services in Oxfordshire were not assessed by HOSC (at the time) as a substantial change in service. However the subsequent impact on patients and the health system across Oxfordshire of the change to a new provider have been extensive. It is recommended that where there is going to be a significant, planned change to the way a service is provided, HOSC needs to be assured that the elements such as activity data, financial implications, impact on workforce and impact on patients have been addressed.

Recommendation 20:
There should be intermediary actions whilst the Task Group is in progress to prevent delays in tackling any issues identified

Recommendation 21:
Informal sessions to gather evidence is a helpful approach for future Task and Finish Groups.

Recommendation 22:
A process is needed where concerns over patient safety and care are identified as a result of the work of the Task Group.

7 CCG reflections on mobilisation of the MSK contract

7.1 Throughout the process, the CCG reflected upon the lessons learned from the process of commissioning and putting in place a new contract for MSK services, these are as follows:

- The mobilisation period was too short but we were tied by OUH refusing to continue with the Hub so giving a target start date which would have been achievable but then we had delays due to OH challenging the process and Purdah due to the election.
- Waiting lists were much longer than originally declared making mobilisation more complex and time consuming
- Providers were not open and honest about a number of things including waiting list size, referrals outstanding at transfer, staff to TUPE across, process, diagnostics etc
- Estates were very difficult to contact in all cases and there is no resource in the CCG to support this function. Estates are run by different organisations. PM spent a lot of time trying to contact people, being put off and then trying to contact someone else.
- IT was involved from the start and took part in the evaluation of the bids. They were not prepared or proactive in getting the IT elements mobilised, so the PM had to spend a lot of time trying to engage them to take ownership and influencing OUH. This should have been the CSU IT's role we felt.
- Diagnostics were engaged in the process early but were not prepared or willing to participate even though they had assured us referral was not going to be a problem. It was and has only been sorted out in December. ICE is still outstanding.
- Diagnostics should not have stopped referrals from GPs to them before we had agreed a date. A date should have been agreed at an earlier stage but we had agreed to deal with it after the start date in September when referrals were not being sent on.

- The letter to patients whose information needed to transfer to Healthshare was too complex. It should not have been written by committee (OH and OUH and us) and we should have been clear with providers that the letter should not be changed and must sent out on the agreed date. This was agreed at the mobilisation meeting but not adhered to.
- The transfer of notes did not happen in the way that was agreed as part of the mobilisation meetings which included incumbent providers and Healthshare. The process of uploading them onto the Healthshare system therefore took a lot longer than was necessary and caused a delay in them being able to start providing the service. This was delayed further due to the notes being transferred in paper form, in boxes, but not in alphabetical order.
- Contracts did a good job. Timetable and actions prepared and followed. Completed in time and to specification.
- The planned care project manager did a brilliant job given the complexity of the mobilisation and lack of support from incumbent providers and the timescales to mobilise
- The new provider was very professional and confident they could deliver on time and they chose to start early to ensure they could manage the service once 1st October was reached. This helped the transition enormously.

8 Recommendations summary

8.1 In summary of the section above and based on the Task and Finish Group findings HOSC, the following are RECOMMENDED to the Committee for its endorsement and onward recommendation to the appropriate bodies. This contains a response to each recommendation from OCCG and Healthshare as appropriate.

Recommendations summary table:

No	Recommendation	For who?	Response/progress
Theme: Commissioning and transition process			
1	The extensive and detailed engagement process to involve both patients and clinicians in the development of model of care and subsequent Business Case for MSK services is commendable and should be an approach used for any similar future businesses cases	OCCG	Noted; this would be the CCG's approach albeit proportionate to the issues and in line with the Health and Wellbeing Board adoption of the Framework for planning population health and care needs.
2	During the Group's work, it was identified that the Business Case for MSK service provision was in-part, intended to improve the cost effectiveness of service delivery. However, there was insufficient and/or inaccurate consideration of the activity levels for MSK services, the local financial circumstances and local workforce implications within the final Business Case. This led to an underestimation of the actual cost and workforce impacts of the specified service. Future business cases would therefore benefit from being commenced and completed with: a) Accurate activity modelling informed by robust testing and independent challenge of the activity assumptions. b) By addressing (a), this would better ensure services are specified within the realistic confines of the local financial envelope. c) A full understanding of the implications for the local workforce	OCCG	The Business case was shared with both providers who had an interest (OH and OUH) in the service both at the operational level involved in service redesign and at Executive level. The numbers in the business case were correct it was later that the assumption of 40% were duplicate patients was made and impacted the process. a) The CCG has agreed that the activity models and assumptions are widely shared and tested to ensure as accurate as possible. b) The CCG is looking at how to develop our approach in line with the new framework (as above) to consider population health management approach to better predict future need to support this process c) The development of stronger Oxfordshire system working and discussion about thinking about system cost and benefit will support better activity modelling and understanding of workforce implications

No	Recommendation	For who?	Response/progress
3	The Group felt a more collaborative approach to service provision would be helpful in future and it recognised the progress in Oxfordshire around this in recent months. However, to ensure there is sufficient challenge of provider performance, it is recommended that the process of a) commissioning and b) contract monitoring are performed as separate functions within the CCG.	OCCG	The process of commissioning and contracting are closely linked and there are benefits of doing the functions together. There is a need to have a good understanding of the service being commissioned when monitoring the contract. There are other functions within the CCG that are involved in contract monitoring such as finance and quality – this gives sufficient challenge within monitoring performance. Setting the right key performance indicators and having a clear and transparent approach to monitoring and addressing if performance is failing is key to this process.
4	To more effectively manage the transition between providers in any future situation; the CCG could consider the temporary appointment of a dedicated Manager whose responsibility would be to manage all necessary aspects of a provider transition.		With any transfer the CCG would have a manager who was responsible for managing all aspects of the provider transfer. This was in place for the MSK transfer. It is important to note that transition is a contractual requirement of the NHS contract so providers should have made people available to support the transition. OCCG held weekly meetings with all providers involved in MSK and support offered and not taken up.
5	All recommendations made by Healthwatch in their report are supported and endorsed by the Working Group (see Appendix A)	OCCG/ Healthshare	Progress underway – see appendix B
6	All providers in Oxfordshire, are recommended to have a meaningful understanding of the role of Healthwatch and the Local Medical Committee as representative bodies. Providers should be prepared to hear the concerns these bodies raise on behalf of those they represent and respond directly in a timely manner.	Healthshare and other non-Oxfordshire based providers	Healthshare recently met with Healthwatch and have requested regular quarterly meetings.
7	Having Extended Scope Practitioners (ESP) working within clinics offers opportunity for staff development and offers patients	CCG/Healthshare	Agreed

No	Recommendation	For who?	Response/progress
	additional treatment options. This has been a positive change in service which should continue to be supported in future.		
8	Working with groups of patients on lifestyle and prevention activity within the MSK model is welcomed and supported; this aspect of the service should continue to be supported in future.	CCG/Healthshare	Agreed
9	Using the EQ5D, health outcome questionnaire, is a recognised method of understanding the difference MSK services are making to patients. To better ensure reliability of the results of the EQ5D process, it is recommended that best practice methodology be applied to the gathering of this information so that patient outcome and quality information is recorded by the patient themselves (or a patient's nominated representative where necessary) at the beginning and at the end of treatment. It is also recommended that the clinical governance committee of HealthShare review the data obtained from EQ5D questionnaires in the light of the practice to date.	CCG/Healthshare	Healthshare have changed practice so the questionnaire is now filled out by the patient alone prior to the appointment both at their initial and final appointments.
10	The Group identified that national research on the evaluation of health outcomes of MSK services has not been used to the best advantage for a new service in Oxfordshire. National research on the evaluation of MSK services should therefore be reviewed and applied to the Oxfordshire system to understand the benefits for patients	CCG/Healthshare	Healthshare use the MSK-HQ in some of their other services and it was considered by the clinical team. However, because EQ5D is the most widely used multi attribute utility instrument for measuring health related quality of life, it allows greater benchmarking across different services. It also has the benefit of being shorter and quicker for patients to fill in which encourages greater levels of participation. As with all clinical decision this will continue to be reviewed.

No	Recommendation	For who?	Response/progress
		Triaging and governance	
11	The Group recognised the valuable role that Extended Scope Practitioners play in the delivery of MSK services. However, having doctors involved in the triaging of patients would be more likely to ensure more patients get to the right place for treatment in a timely fashion.	CCG/Healthshare/ Oxford University Hospitals	OCCG and Healthshare do not hold the same view as the HOSC Task and Finish Group. HOSC are requested to provide clinical evidence such that this recommendation can be substantiated and the CCG and Healthshare will undertake clinical review of this. Many services up and down the country have ESPs; the Oxfordshire service is no different. Healthshare are looking to work with consultants providing secondary care treatments to create a virtual multi-disciplinary team which would allow for patients that require discussion to do so without being referred to the consultant as happens now. The CCG are supporting this approach.
12	Commissioners and providers are currently working together to improve service provision and resolve identified issues. However, commissioners and providers of all services on the MSK pathway could consider working together through a formalised, collaborative, partnership arrangement. It is recommended that primary and secondary care clinicians are considered as being part of this arrangement, as well as managers from the CCG and clinicians from HealthShare.	CCG/Healthshare/ Oxford University Hospitals/Primary care	There is a bi-monthly MSK taskforce that has GPs, Healthshare, representatives from secondary care providers and secondary care clinicians from Orthopaedic, rheumatology and radiology specialities invited. The agenda for this group looks at pathway issues, problem solving e.g. digitalising diagnostics referrals etc and gives all parties an opportunity to raise issues and resolve them jointly.
13	In-line with the integration of the health and care system, any future collaborative partnership arrangement for overseeing MSK services could consider the future financial arrangements for the entire clinical service within its remit – thus ensuring that finances are aligned with clinical need.	CCG/Healthshare/ Oxford University Hospitals/Primary care	This would be the CCG's practice.

No	Recommendation	For who?	Response/progress
14	To ensure MSK services provide the best possible outcomes for patients, it is recommended that any future partnership arrangement could oversee a clinical review of the care pathways, including those for orthopaedics.	CCG/Healthshare/ Oxford University Hospitals/Primary care	Noted
		Next steps	
15	The Task Group acknowledges and supports how all organisations along the MSK pathway are working together to resolve the identified issues and that Oxfordshire CCG is now closely monitoring the performance of Healthshare. To assist this, it is recommended that a) The CCG Board, as the commissioner, receive regular performance reports to gain assurance of performance improvements. b) HOSC receive a report on how Healthshare are meeting their trajected performance against planned improvements in April 2019.	CCG	The CCG receives detailed reports each month on all aspects of the service from Healthshare. This is reviewed at contract monitoring meetings. Information relating to Healthshare's performance is also reviewed by the CCG's Executive Committee and Quality Committee both are committees of the CCG Board. Where relevant issues are reported to the Board. As agreed, OCCG and Healthshare are happy to use this recommendation list as a template to update the HOSC in the June. Therefore the planned improvements from April will be reported in June.
16	The Task Group acknowledges that Oxfordshire CCG is working with Healthshare to ensure that performance improves.. To assist understanding and contingency planning, it is recommended that the CCG Board receive a risk report on MSK services, along with clear contingencies to set out an Action Plan should risk levels escalate.	CCG	As above.

No	Recommendation	For who?	Response/progress
17	There are lessons to be learned from the Task Group's work, for both providers and commissioners of MSK services beyond Oxfordshire. It is recommended that the results be shared with relevant organisations; thought to include Healthshare Ltd, relevant CCGs and relevant NHS England bodies.	Task Group Chairman	
18	To improve the information flow to patients, GP's and stakeholders on the identified issues and proposed solutions with MSK service provision, it is recommended that Healthshare and the CCG work together to provide information through the CCG's website (similar to the model previously used around changes to Cogges surgery).	CCG	A section on the CCG website has been developed. The GP Bulletin is the usual means of communication with GPs.
Learning for HOSC on Task and Finish Group work			
19	The changes made to MSK services in Oxfordshire were not assessed by HOSC (at the time) as a substantial change in service. However the subsequent impact on patients and the health system across Oxfordshire of the change to a new provider have been extensive. It is recommended that where there is going to be a significant, planned change to the way a service is provided, HOSC needs to be assured that the elements such as activity data, financial implications, impact on workforce and impact on patients have been addressed.	HOSC/CCG	Noted by the CCG. The CCG has undertaken its own lessons learned from this process and this does include the system wide overview and confidence on impacts as described here.
20	There should be intermediary actions whilst	HOSC	

No	Recommendation	For who?	Response/progress
	the Task Group is in progress to prevent delays in tackling issues identified		
21	Informal sessions to gather evidence is a helpful approach for future Task and Finish Groups.	HOSC	
22	A process is needed where concerns over patient safety and care are identified as a result of the work of the Task Group	HOSC	

9 Conclusion

9.1 The HOSC Task and Finish Group on MSK Services, is the first of its kind in Oxfordshire. The Group was established in-line with the HOSC and Health Protocol, which works in the spirit of a 'no surprises' approach. The process of working through a Task Group and in a collaborative manner with the commissioner and provider of MSK services has provided the opportunity for independent, healthy and helpful scrutiny of health services which are important for the residents of Oxfordshire.

9.2 HOSC has worked to respond to concerns raised by the public and patients in establishing the Task Group, which has in turn been able to do a more detailed piece of scrutiny on MSK services than the committee's schedule of meetings allows for. This has enabled HOSC to get a more detailed understanding of the issues faced by the commissioners and providers of the service, including how they are working to resolve any identified issues with the service. The Task Group way of working has also allowed time for HOSC to gather the insights of patients, clinicians and staff.

9.3 The Task and Finish Group has understood that the development of a new clinical model for MSK in Oxfordshire was a robust process which delivered a new and improved model. The procurement process which followed on the agreed service specification was lengthy and difficult. This, coupled with the subsequent revelation that the activity assumptions for the specification were inaccurate presented a number of challenges in transition to, and the provision of, the new service. The processes, staffing and resources for the new service have had to be amended to address the reality of demand. This has limited the achievement of efficiencies and resulted in confusion and frustration for patients across Oxfordshire. The concerns raised by patients have been reported, documented and are being responded to by OCCG and Healthshare.

9.4 The recommendations made by the Task and Finish Group have been designed to be constructive in nature. They are intended to support and encourage performance improvements and solutions where they have been found to be needed. The Task and Finish Group seek to provide assurance to the HOSC itself and to the public that local health scrutiny in Oxfordshire continues to strengthen the voice of local people in the commissioning and delivery of health services.

9.5 It is **RECOMMENDED** that HOSC:

a) Agree the recommendations number 1-22 in section eight of this report for onward recommendation to the appropriate body and;
b) Receive an update on the progress against agreed recommendations at its meeting in June 2019, as part of the regular CCG update report and Chairman's report.

11. Acknowledgements

11.1 The MSK Task and Finish Group is grateful to all those who shared and presented information as part of its investigation into the provision of MSK services across Oxfordshire. In particular, the group would like to thank the following people for their openness and co-operation:

- Oxfordshire Clinical Commissioning Group
- Healthshare (Oxfordshire)
- Healthwatch Oxfordshire
- Oxfordshire Local Medical Committee
- Oxford University Hospitals Foundation Trust and the clinicians that participated in the process
- Oxford Health Foundation Trust

Councillor Monica Lovatt
Chairman of the HOSC MSK Task and Finish Group

Contact Officer: Sam Shepherd, Senior Policy Officer
January 2018

Appendix A - Healthwatch Oxfordshire Report on MSK services

Report to Health Overview Scrutiny Committee Task & Finish Group – MSK Healthshare

September 2018

1 Background

In September 2017 Healthwatch Oxfordshire started to hear from the public and patients about Healthshare. Concerns were raised following a letter to patients who had appointments for MSK services or had been referred for a service. Concerns were raised by patients contacting us by email and telephone, via Patient Participation Groups and their Locality Forums.

The letter told them that their appointments were cancelled and that Healthshare will be in touch to rearrange appointments. The letter was badly written, confusing, frightening to patients, vague about who Healthshare were, gave the impression that patients were no longer being treated by the NHS, no contact details, and left many patients worried about whether they would get a new appointment.

Healthwatch Oxfordshire contacted the Oxfordshire Clinical Commissioning Group (OCCG) and had meetings with representatives of Healthshare to convey the concerns that had been expressed and seek clarification as to what was happening. Specifically:

- the closure of the service at Wantage Hospital
- the poor communication with patients about where their next appointment will be and when – some patients have had their appointment cancelled and do not yet know when – or where – their next appointment will be
- the fact that people have been told their information will be given to the new provider which is a private company.

We subsequently asked for clear communication with the patients and public as to the exact situation. This was actioned by the OCCG and promoted by Healthwatch Oxfordshire through our website. Appendix A details what was posted on the Healthwatch Oxfordshire website on 22nd September 2017.

In early February 2018 we began to hear from patients and the public about issues with contacting Healthshare via their telephone number. This was raised with Healthshare via telephone and a follow-up meeting, and OCCG were informed. Healthshare admitted that they had a problem with the telephone line as they were waiting for a new system to be installed. We suggested that they put a note on their website and direct people to using email to contact them. This was agreed but it took further intervention by Healthwatch and OCCG for this to happen. OCCG informed us that the new telephone system had gone live and should solve these problems being faced by patients.

From February through to June 2018 Healthwatch continued to receive patient stories all of which were negative experiences of the system – referral to receiving the appropriate service. Occasionally we heard about negative experiences of care and signposted patients to the OCCG complaint's procedure and email address

for Healthshare. Most comments we heard were about the patient's journey from GP referral to physio / consultant.

Again, in June 2018 Healthwatch began to hear from patients that they could not get through to Healthshare on the telephone. We alerted the OCCG and met with Healthshare. We were told by Healthshare that they were aware of this issue and that it was caused by 'spikes' in calls for which they had no explanation. Again, we suggested they put the message up on their website directing people to their email address.

1.1 What we learned

The OCCG and Healthshare are receptive to hearing about patient experiences and act – if not always in a timely fashion.

Healthshare, when aware of communication issues, does not always communicate in a timely manner with their patients 'we are aware…' but had not done anything to ease the stress imposed on patients.

Patients and public were from the change over date in September became suspicious of Healthshare and are not shy in coming forward to Healthwatch Oxfordshire with their experiences.

Healthwatch Oxfordshire can effectively inform and influence changes in communication by the provider for the benefit of patients.

From information provided to us by OCCG in August 2018 the waiting times for patients and number of patients waiting is still extremely high. The Business Case – Integrating Musculoskeletal Services 2 March 2015 promised:

- Self-referral – this is still on hold
- Person centred approach
- Information management and technology
- Primary and secondary care interface meeting

Much of what we have heard does not reflect any of the above.

The Business Case also identified benefits (5.5.1 Benefits Table 2). Healthwatch Oxfordshire request that the Task and finish Group assess the attainment of these identified benefits against the quality of the patient experience.

2 Summary of what we heard

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 following sections detail what we have heard from patients about their experience of being referred to Healthshare by their GP. Generally, these experiences are of the process – the patient journey. They include:

- 37 telephone calls to Healthwatch Oxfordshire over a seven-week period July – August 2018
- 10 patient stories – many asking for help with making complaints.
- 8 reviews on Healthwatch Oxfordshire Feedback Centre

Information Healthwatch Oxfordshire has given to individuals including contact telephone number, email address, signposted to Healthshare Oxfordshire web page and 'How we are doing?' link, seAp details who provide advocacy to people going through NHS service complaints, Oxfordshire Clinical Commissioning Group how to make a complaint information.

During our outreach in Wantage in May and Abingdon in August we were approached several times by Healthshare patients (often in error as they thought we were Healthshare) complaining about the administration of Healthshare / appointments / referrals / distance travel.

3 Key concerns and recommendations

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.

4 Patient stories

The following ten patient stories have been sent to Healthwatch from patients or their relatives who either wanted help with seeking a solution to their problems or simply wanted Healthwatch to be aware of their experience of the Healthshare service. The stories are reproduced as written by the patient but dates and names have been deleted replaced by [xx] or blocked out in black to ensure anonymity.

In addition, sections 5 and 6 of this report details:

1. what we have heard from patients / members of the public / carers / relatives over the telephone in the past two months
2. extracts of patient feedback left on the Healthwatch Oxfordshire Feedback Centre since February 2018.

4.1 Hip replacement saga

Hip replacement saga - summary

After 20 months the patient met all criteria required for referral for hip surgery; in November 2017 their GP made referral, e-mailed form, to Healthshare. The following is taken from the patients report to Healthwatch Oxfordshire:

'It is not clear to [patient or relative] why a referral to Healthshare was required when the GP was quite clear that hip surgery was indicated, but the GP informed us that this was standard procedure and he could not refer direct to NOC.

The patient heard nothing from Healthshare and on [20 days later] decided to contact them direct via the phone number on the CCG website in that time. {xxx} answered the phone and after she looked at the email inbox, she confirmed that the Dr's [xxx] email referral had arrived on 03/11/2017 but had not been opened. She said that there were 45 emails in the inbox and couldn't understand why Dr x's was still there. She said she would message the "other office". It was unclear to us how the emails were treated as she could not just forward them. She said there was only mobile phone communication at that time, a landline not yet having been installed and we could not phone the "other office" direct as they did not give out mobile numbers to the public. However, she said she would chase up our referral and get back to us.

[She] rang at about 0910 the following day. She said that Dr x's email referral had now been seen by a clinician that morning and as the referral was outside the capability of Healthshare it had been forwarded to the NOC under the 'Choose and Book' procedure. She gave us the phone number so that we could follow this up. Later that morning we picked up a phone message from the NOC to hear that an appointment had been made for my husband to attend outpatient clinic at [xxx] on Monday 27th November! This he duly did – was assessed and placed on the 3 – 4 month waiting list for a hip replacement. We couldn't fault the NOC – very efficient, professional and courteous.

We do wonder what would have happened to the referral if we hadn't chased it up with Healthshare – we would probably still be waiting for the "other office" to do something!'

4.2 Podiatry problem

A colleague of mine from xxxx Patients' Panel wrote me the following email:

"I went today (xx January) to the follow-on appointment from last May when I saw the Podiatry service at Abingdon Hospital [pre Healthshare contract]. I have been waiting for a follow up since July (should have gone back 2 months after my initial May visit). Eventually I had the Health Share appointment today.

I went to a different place (East Oxford Health Centre) but saw the same man who I had seen in May.

He didn't have my notes from my last visit – "sorry we don't have the records, we have to start all that again now with HealthShare" – so I had to go through the whole history etc again.

In the course of giving him all the history, I reminded him how he had proposed treatment at my last visit ("you said you wouldn't recommend an operation as it can be risky"), and he said "the treatment pathways are all different now with HealthShare so what I told you about treating this condition last May is probably different to what I am going to say today". My condition hasn't changed!

Then he told me that the inserts for my shoes which he sorted for me last May (and seem pretty good to me) now have to be replaced by a different kind ("HealthShare use a different provider"). So I had to be all measured up again for something I've already got and works well!

All a bit frustrating – and what a waste of money and resources… Lost notes, changed treatment plans mid way through treatment and duplicate materials …

Added to which the carpet was filthy (on which I had to walk barefoot) and there were no proper consulting rooms – just a big open plan room separated into curtained off sections – so we could all hear each other.

In Abingdon hospital it was clean and pristine with proper clinical spaces and consulting rooms.

I felt a bit sorry for the podiatrist I saw and wondered what all this has done for motivation of staff."

4.3 Lack of physio

An instance of lack of physio - My husband broke a bone in his pelvis. He was told on his return home to organise urgent physio via his GP. This was offered six weeks later. When he could not keep the date offered he was offered one in Chipping Norton (from his home in [the south of the county]). My husband is 77 years old. Had he sat at home in a chair for that time he could have lost significant amounts of muscle. (We knew about bath boards and bought one for access to the bath. Our shower is only accessed by getting into the bath.)

The privatised MSK appears not to be catching up with the "back log."

4.4 March 2018 – 6 months cut off

I wanted to draw your attention to another issue with the MSK service that I hadn't heard about until contacted by a resident. He has an annual MSK podiatry review relating to shoe inserts however when he didn't receive his appointment he followed up to be eventually told by Healthshare that they had filtered out anyone who hadn't been seen in last 6 months and anyone outside that category was discharged from the service without their knowledge. This clearly must be having

an impact on large numbers of people - the extent to which we might not know yet.

He has also forwarded me the correspondence he had with Oxford Health (who he originally approached). Although very detailed, there is a worrying tone in the correspondence from Ox Health which is very unhelpful and confusing for patients who often have no concept of internal markets.

I wondered if you already knew about this issue and whether there could be some further discussion around the 6 months cut-off.

4.5 February 2018

I was referred to the MSK hub in January by my GP as I have a knee injury which is making it difficult for me to walk, weight bear and is incredibly unstable. I had my appointment on [beginning of] Feb. I was quite impressed with the physiotherapist. He seemed thorough and took my situation seriously. He thinks that I have ruptured my ACL and torn my meniscus. He referred me for an urgent MRI and advised me that it would be 2-4 weeks. He also advised me unofficially that I could access an MRI via A and E. He has advised me not to drive and to continue with the crutches.

I contacted the MSK hub today as I hadn't heard anything. They advised me that they had done everything 'their end' and to contact the JR radiology dept. I contacted the JR and they said they had not received anything. I went back to the MSK hub and a different lady advised me that they had not sent my referral yet and they would do it now and to contact the NOC tomorrow (Tuesday). She sensed my exasperation and said they were dealing with thousands of patients, which I do understand, but I wasn't given the right information on 2 occasions. I find this extremely frustrating and am concerned that I now have to wait another 4 weeks for an MRI scan. I previously contacted the Manor who will charge £542 for a knee MRI scan and require a referral. I seriously am considering this but am concerned that if the result goes back to the MSK hub it will get lost in the system again.

My situation has not improved with regards to instability and walking and am relying on friends [for transport etc].

4.6 Trapped nerve

Since October 2017 I have pain in my thighs when I am standing up, walking or reaching up. The pain is much reduced when I am sitting or lying down. In November 2017 my GP, [xxx], referred my case to the Nuffield Orthopaedic Centre.

The background history is that I had similar (but lesser) pain in 2015 which the Falls Clinic identified (after an MRI scan on xx June 2016) as due to a trapped nerve coming out of my spine. While waiting for a triage consultation at the NOC, I started treatment by a physiotherapist, [xxx]. I did exercises under his direction and the pain reduced and I found that I could walk increasing distances without pain. At the NOC triage consultation on xx September 2016 I was advised to

continue physiotherapy and was told that NOC surgeons felt that surgery was not indicated at that time. Over the next year the pain reduced and I found that I could lead a fairly normal life.

But on [xx] October 2017 the pain returned – even worse. I went back to the physiotherapist who reported to my GP that he could not improve the flare up symptoms and suggested reference to a spinal specialist. I was then referred to the NOC in November 2017.

I received a "welcome" on 23 November from Healthshare promising further contact later. This occurred in February 2018 when I was offered a consultation in Oxford in June or in Faringdon in April. I chose to see [xxx] on xx April 2018 in Faringdon. He told me that he would accept me on his Support Programme consisting of advice on pain management and access to a blog on managing spinal problems. I accepted this offer and was promised a confirmatory letter in three weeks. No such letter came, so I telephoned Healthshare on 23 May 2018. The woman who answered said she knew nothing about this programme, but would ask [xxx] to telephone me at 9.10am on 19 June 2018. No such call was received.

I went on holiday from 4 to 11 June 2018 and when I returned I found three messages on my answering machine asking me to come to see [surgeon xxx] on xx June. I then saw him on [xx] June and asked why I had been summoned. He said that I had been referred to him for surgery. I pointed out that in September 2016 the NOC had said that surgery was not indicated. [xxx] said that I should not have been so advised and that, if I changed my mind, I should contact him.

When I returned home and opened the letters which had come while I was away I found a letter from the Churchill Hospital inviting me to a Pain Management Clinic on xx July and a letter from the NOC inviting me to a Spinal Surgery Clinic on xx June. This was rearranged for [xx] July (to be after the Pain Management Clinic).

[Since found out that Healthshare referred patient to NOC and Churchill BUT did not inform the patient. Patient only found out when received letters inviting to attend clinics].

4.7 June 2018

I am writing to you to express my concerns about Healthshare. I have been receiving physiotherapy for a trapped nerve from one of their practitioners, [xxx], who has seen me 3 times of the last three months. Her work seemed to be helping, but then the problem reoccurred, and my GP referred me for an **urgent steroid injection using an ultrasound scan.** (A previous injection without ultrasound had been ineffective.)

When I saw [xxx] I mentioned the referral. She checked on the computer and it was displayed as **a routine referral** and I was offered an appointment in mid-July. I expressed my surprise and dissatisfaction and was told they would check with the GP. I raised the matter with her myself and she confirmed that it **was** an urgent referral and asked her secretary to contact Healthshare. I have learned today from

[xxx] that she had established that the referral was triaged by someone at Healthshare who had never met me and was unaware of my medical history but had nevertheless downgraded it to routine without consulting either my GP or the physiotherapist treating me.

I find it unacceptable that my GP's clinical decision based on her long familiarity with my long-time health needs should be arbitrarily overridden in this manner.

I have now three weeks after the original referral been offered an initial consultation with [xxx] at the Horton Treatment Centre, because Healthshare are unable to offer me an urgent appointment. I find it difficult to believe that Healthshare are fulfilling their contractual obligations satisfactorily.

July update – re response to complaint

Getting a response from either Healthshare or the CCG has like drawing teeth! I have finally received a letter from Healthshare, which I find totally unsatisfactory. I have discussed it with my GP, who was clear that as she did not know which physio was treating me, she could not have contacted her direct. Secondly it was only on the initial referral form that she checked a box about distress ie before the referral was downgraded and not, as they suggest, afterwards.

The CCG have not responded to my concern about whether the contract is being adequately met. When I spoke to someone about this, I was told that they had not realised that I saw it as a commissioning issue, though I think I made this very clear.

The outcome for me was that I received the guided injection on **July [xx]th,** a very long and painful delay, which impacted seriously on my mental health [xxx].

I shall see [xxx] on August [xx]th. He is considering a referral to a spinal surgeon. The saga drags on.

I am very dissatisfied with it all, but I don't have the emotional strength to pursue it any further. I must leave it in your hands.

4.8 Having physio (Healthshare) following joint replacement surgery

April – July 2018

- Pain – suspected DVT
- Physio stopped referred to advanced physio at another site
- Referred to Manzil Way for scan
- Following scan advised see GP asap
- Saw duty GP on day

August 2018

- Saw consultant at JR, after numerous tests including a more in depth ultrasound (I was there all day) was advised I needed to see a [xxx]

specialist at Nuffield and was sent home with morphine for the pain and advised to rest for 6 weeks.

- xx August – received letter form Healthshare asking me to call them to make an appointment – which I was really puzzled about!
- Rang Healthshare was told needed to go to Deer Park to have an injection - queries why as I knew nothing about this and who had requested the injection. Was told to ask at my appointment.
- Attended Deer Park physio -they knew nothing about any injection. I asked why I was there they said for an assessment, I was really puzzled as I had already had an assessment and I explained that I was waiting to go to the Nuffield to see a [xxx] specialist.
- I was told that I would not get an appointment at the Nuffield unless Healthshare deemed it appropriate and was told I had to go for a scan. I asked what about the diagnosis the consultant at the JR had given me, I was told that further investigation was needed before a referral to the Nuffield.
- At this stage I was really upset, in enormous pain and dosed up on morphine. I said I was not going to have an x-ray as I was told by a hospital consultant that I needed to see a [xxx] specialist. I was told that nothing further would be done until I had an x ray as in their opinion they disagreed with the consultant at the JR.
- I agreed to have an X-ray and was then told that the physio I was talking to did not have the authority to sign the X-ray request form and could I pop back in a couple of days to pick up the signed form!!

I am appalled at such a waste of money referring me back where I started in April to be re-assessed for a problem I had in April. I have worked in the NHS and understand the pressures but if what happened to me is replicated many times over then no wonder its in such a mess locally.

Story taken end of August 2018

4.9 Patient Story

Concerned about delays to treatment because of the way the system is set up

I saw my GP in January because I was having further problems with my knee/hip (both of which have been replaced over the years). I asked if I needed to be referred to see the consultant I had previously been under at the NOC and the GP said, “it doesn’t work like that now”.

My GP made a referral to Healthshare for “triage” and sent me for an X-ray and a scan on my knee/hip.

After a long delay I finally saw a “senior physiotherapist” at Manzil Way and she said – “can’t do anything for you its bones, you need to go to see a consultant at the hospital”!!”

I asked if she had looked at my X-ray and scan results -“no, we don’t have access to them”. I asked how she could treat me as a whole person if she didn’t know what my results were?

Following this I was given a form to enable me to choose and book an appointment to see a consultant, however, between seeing my GP in January and getting to see a consultant will take ten months and if I had chosen to go to the NOC to see a consultant it would be 11 months.

The system seems to be set up to delay people getting the best treatment for them by routing them through a "triage" system even when not appropriate. And when you are in the "triage" phase the people responsible do not have access to your test results which makes a nonsense of the whole thing!

4.10 Healthshare Patient story

August 2018

Under Nuffield (NOC) as I had problems with my feet this was in 2016 an I had treatment and medication. Over the last 18 months the medication has not worked so I called the NOC and asked to be seen again. They informed me that I must be re-referred to them as I am no longer under the clinic!

I made an appointment and saw my GP who said he could not send me to the NOC as I had to have an assessment by Healthshare first even though the problem was exactly the same as in my previous visit to the NOC. The GP referred me to Healthshare in early June and some 11 weeks later I am still waiting for an appointment.

I have tried ringing, emailing and to be honest it is all a waste of time you wait on the phone and wait and wait…..

I have written to Healthshare to complain and to the OCCG and I am dissatisfied as it appears that Healthshare is blocking the system and I think the OCCG have commissioned a very poor contract and should be looking at their commissioning practices.

5 July and August 2018 – Healthwatch Oxfordshire telephone contact with public / Healthshare patients

Issue	Comment & action
Wrong number	Googled Healthshare and called Healthwatch – 18 calls in this period. Gave Healthshare number and email address Advised about Healthwatch Oxfordshire Feedback Centre
Contacting Healthshare	Wanted to contact Healthshare and didn't know how to - GP had referred them.
	Had lost letter from Healthshare and googled physio Manzil Way and got our number - gave number for Healthshare and advised to feedback any experiences on the Healthwatch website
Telephone system not working / no reply etc	Has been ringing number for a week, but never picked up...just message so can't get through (2 callers)
	Cannot get any answer on telephone been trying for one week on and off. Gets an automated message saying you are in a queue and then after a period of time gets told no one here to take your call. Very angry and frustrated said commissioners of these services should be ashamed of themselves because they are not fit for purpose. Was going to get in car and drive to Manzil Way to make an appointment with the receptionist.
	Couldn't get anyone at Manzil Way to put him through to physio
	Patient could not find number for Manzil Way
	Caller couldn't find number for Healthshare physiotherapy in Witney. Gave number. Called back as got no such number tone when she dialled it. Gave email address as an alternative
	"Is that the Manzil Way physiotherapy centre". Gave him the central Healthshare number.
Appointments	Had an appointment made by Faringdon Physio and was not given any information such as a card with the appointment time Monday. Caller forgot the time and needed to contact Healthshare but had no contact details.

Issue	Comment & action
	Tried to book appt with orthopaedic surgeon following Healthshare appt. was told need PIN number from Healthshare…has not received. Tried to ring them to find out how to get but can't get though so stuck
	Couldn't find number to contact Manzil Way physio centre (2 callers)
	Caller couldn't find number for Deer Park Physio centre Frustrated because could not find number for Deer Park physio centre (2 callers)
	"I was trying to get through to the physiotherapy department"
	Couldn't get through on the phone, no one available to take his call. Wanted to confirm appointment was going ahead as had been given on the phone with no letter confirmation.
	Woman phoned Healthwatch Wednesday evening. Had been trying to get through to Healthshare at Manzil Way since Monday. Worried as had been trying to change appointment which she had now missed. Phone rings then cuts caller off. Had tried emailing but got automatic reply saying appointments could not be dealt with on this email address.
	Caller had confused us with Healthshare. Gave them correct number ad email. Wanted to change appointment.
	A man called to say his wife has been given an appointment for physio at Townlands, Henley. They live in Bicester and she has had two previous appointments at the Community hospital there so does not understand why they have to trek to Henley. Also, no postal letter confirming the appointment yet- so he says they wouldn't have any idea where to go if he hadn't lived near Reading before. (I gave him the Healthshare email address to contact them to follow this up).

6 Healthwatch Oxfordshire Feedback Centre (web based)

Rating	Title	Review
1	Appalling, disorganised bad service	Unacceptable long wait for appts, no continuity of care as difficult to see same physio who knows you so have to go over problems again so feel there is no progress. The central number for appts is not patient friendly, over 20min wait to speak to someone to simply change an appt. it was far better when you could ring the clinic you were attending. Too many services going through 1 phone number. I also found it confusing as my GP had also referred me to Rheumatologist but the letter said it was a referral to the MSK Assessment Triage and Treat Physiotherapy & Podiatry Service, I was put on hold (having already waited 15mins to be connected) when I queried that I was already having physio for her to read my notes to find out this was the referral the Rheumatology Consultant!!!
1	Five months to get an appointment	I had a knee injury and have got an appointment after five months for Healthshare physiotherapy. My knee has got worse and it affects my work. Still two weeks away from the appointment I was offered in January 2018.
2	Not a joined-up service	My contact with staff was good, however I had to chase appointments and results every step of the way. I got the distinct impression if I had not followed up on results, my case would have disappeared in the system. I started the process in Dec 17 requesting the GP to refer me back to the surgeon who performed an operation on my knee several years ago. My GP said this wasn't possible and that I had to go via a triage system. Six months and 3 face to face appointments, 1 possibly unnecessary MRI, multiple phone calls later guess what! I ended up in the clinic of the surgeon who initially operated on my knee.
5	Trying in vain since Monday 13th to cancel appointment	I have tried since Monday 13th to get through to 01865 238108 to cancel my appointment for the Podiatrist. The phone is answered by an answering machine saying my call is being dealt with, then says there is no one to take your call please call back. It is now 15th and

Rating	Title	Review
		I am getting the same message. This is very bad to have such a service for the Oxfordshire health service
2	Long wait, little communication	It was a very long wait to be seen. I had a very challenging injury that didn't respond to physio, at that point I didn't feel listened to.
	Dire appointment system over 5 months delay	The worse medical experience I've ever had. Appointment system is pathetic. The consultant rushed through my assessment ignored back problems offered a steroid injection for a hip which he said had excellent movement didn't discuss my medical history which inc. diabetes & thin bones & discharged after 4.5 minutes with no further advice or follow up. [xxx]
3	Too far from home	Live in Grove but was referred to Wallingford for physio. Too far.
3	Appointment cancelled last minute	Physio I saw was good. Sent fit MRI and three weeks later I'm waiting for results when told it would be two. Cannot contact anyone. Cabt leave messages. Have requested contact from online message service not heard anything. I'm in a lot of pain and debating taking myself to A&E totally disgusted does not even describe how I feel. Absolutely dreadful aftercare.
1	Very Unhappy	Not impressed i was sent for an xray by es practioner. Waited at hospital for 2 1/2 hours then to be told she had not filled ut the request form correctly.
1	Unable to speak to anybody in 8 days	You as a body are a complete shambles
2	Complete waste of a days leave	Waited months for an appointment for a steroid injection and they refused to do it. Accused my doctor of misdiagnosis and refused to accept that a person with Hypermobility Syndrome could have the problem I was diagnosed with. Left there feeling humiliated, in pain and in tears.
3	Treatment for knee pain	After an extended period of physio for knee pain which was only partially successful I was referred to a senior physio in November 2017. I was offered aspiration and corticosteroid injections. After the second injection in February it was clear that this treatment was not successful. I had to wait for 10 weeks for a further appointment at which I was told I was being referred to a surgeon. In fact I was not referred then, but put on a waiting list to be referred. I waited a further 6 weeks before receiving the referral letter. since then things have progressed more quickly and I will have surgery in the next few weeks. When I was already 'in the system' I fail to understand why it took so long to be referred to a surgeon. I have no complaints about the treatment offered by the physios. Unfortunately it happened as my knee was deteriorating more rapidly and the best efforts would not have made any difference.

Appendix A

Healthwatch Oxfordshire – public statements

Physiotherapy services in the county – response from Healthwatch Oxfordshire 22 September 2017

Healthwatch Oxfordshire has heard from many patients that they are concerned about what is happening to their appointments with the new physiotherapy service.

People have told us they are concerned about:

- the closure of the service at Wantage Hospital
- the poor communication with patients about where their next appointment will be and when – some patients have had their appointment cancelled and do not yet know when – or where – their next appointment will be
- the fact that people have been told their information will be given to the new provider which is a private company.

We understand that the new service will mean shorter waiting times for appointments, but at the moment some patients are feeling that the service will be worse with longer travel times to appointments especially in the South West of the county.

Healthwatch Oxfordshire is speaking to all concerned – Healthshare Ltd (the new provider), Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust – to find out what is actually happening.

In the meantime, we urge all concerned to work together so that patients are properly informed about what is going on and that appointments are made as soon as possible.

For further information about where services will be delivered please see the Oxfordshire Clinical Commissioning Group web site – follow this link http://www.oxfordshireccg.nhs.uk/news/physiotherapy-services-in-oxfordshire-an-update/37687

Appendix B - CCG Response to Healthwatch Oxfordshire Report on MSK services

Oxfordshire
Clinical Commissioning Group

Oxfordshire CCG response to Healthwatch review of HealthShare
4 October 2018

Oxfordshire CCG thanks Healthwatch for their report on HealthShare's service, and the follow up conversation with our head of planned care and long term conditions.

We recognise the content of the report and service issues many of which arise from long standing challenges to offer timely care for patients, and have been working with HealthShare to improve the newly commissioned service.

The following details the actions that are underway or will be taken to address the recommendations in the report.

1. Constant problems with accessing HealthShare telephone number issues raised:

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

Response to date:

HealthShare currently receives a high number of calls daily, reported to range between 300 and 1,400 calls/ day.
It has been recognised that the administrative system requires restructure to improve response times/rates to meet the enquiry demand and better meet patient booking needs. Addressing recommendations 2-7 will also relieve the telephone system pressures. The following specific measures have been taken will directly relieve pressure on the phone system:

i. HealthShare have commenced booking a first patient appointment and sending out an appointment letter to the patients directly following processing the referral (after triage), this aims to be within 7-10 days.
ii. HealthShare have automated certain administrative functions to increase staff allocation to answer and process calls
iii. Additional staff are being employed to handle calls
iv. Plans are underway to make a Choose and Book process, available to all HealthShare patients, enabling patients to book online and match a preferred location, with a preferred date.

Review and monitoring:

OCCG plan to work with HealthShare to support improvement and to monitor call response rates and call abandonment rates.

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

Response to date:

i. HealthShare have commenced booking a first appointment and sending out an appointment to the patients directly following processing the referral (after triage)
ii. The appointment letter is followed by a text message reminder for the appointment

Review and monitoring:

Time frame to first appointment will continue to be monitored in routine reporting from HealthShare.

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

Response to date:

HealthShare currently provide services in the following Oxfordshire Locations for MSK services:

- East Oxford Health Centre, open Monday to Friday, appointments between 0800 and 1730
- Horton Treatment Centre, Banbury, open Monday to Friday, appointments between 0800 and 1730
- Chipping Norton Health Centre, open Monday to Friday, appointments between 0800 and 1730
- Bicester Community Hospital, open Monday to Friday, appointments between 0800 and 1730
- Deer Park Medical Practice, Witney, open Monday to Friday, appointments between 0800 and 1730
- Wallingford Community Hospital, open Monday to Friday, appointments between 0800 and 1700
- Townlands Community Hospital, Henley, open Monday to Friday, appointments between 0800 and 1630
- White Horse Medical Practice, Farringdon, open Monday to Friday (currently excluding Thursday), appointments between 0800 and 1700
  Woodlands Medical Centre, Didcot, Wednesday and Thursday only, appointments between 0800 and 1700

- Park Club Leisure Centre, Milton Park, Abingdon, classes only Tuesday and Friday afternoons

i. For secondary care referral (on to other services) patients are now offered their appointment via a Choose and Book process, enabling patients to book online and match a preferred location, with a preferred date
ii. Plans are underway to make a Choose and Book process, available to all HealthShare patients, to further increase patient choice

Review and Monitoring
Oxfordshire CCG is aware of further need. This need and capacity to meet it will be assessed through coming contract review processes.

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.

Response to date:

i. A patient workshop was held by HealthShare in Cowley on 28 September, contribution from the workshop confirmed the need for a brochure and website link, to outline the point above, regarding HealthShare's identity, it's links to the NHS, the fact that the service is offered free of charge (not private), the nature of the services offered and who the service delivery team are (professional skill mix).
ii. The need for this leaflet to contain clear and responsive contact details was also highlighted
iii. In addition to the Healthwatch's suggestion of providing this to GP's to be given to patient, the suggestion was made at the patient workshop, to attach this to the first appointment letter
iv. Planning for patient self-referral is progressing

Review and Monitoring
This will be reviewed and progressed through operational review meetings and processes

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.

Response to date:

i. HealthShare will add their complaints procedures to their website and practice resources, with clear information on how to make a complaint.
ii. Addition of a link to the Healthwatch website for leaving comments and feedback.

Review and Monitoring
This will be completed by task by Friday 19 October 2018

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.

Response to date:

i. OCCG have requested addition of "How are we doing ?" to evaluation data reported on in the contract.

Review and Monitoring
This will be completed by Friday 19 October 2018

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.

Response to date:

Additional questions will be included in the patient evaluation related to the referral process and communication between HealthShare and the patient. Sample questionnaire will be shared with HealthShare.

Review and Monitoring
This will be completed by Friday 19 October 2018

Conclusion

Oxfordshire CCG recognises the problems some patients have experienced and will continue to monitor the issues raised in the Healthwatch report and those experienced by patients and ensure that the actions outlined are implemented and the areas of concern improved upon, to ensure a more joined up and streamlined patient experience.

Appendix C - Healthshare Response to Healthwatch Oxfordshire Report on MSK service

Healthshare Report – Healthwatch Oxfordshire response Oct 18

Introduction

We welcome the report prepared by Healthwatch Oxfordshire on the Healthshare MSK service in Oxfordshire, prepared in September '18, and are pleased to able to respond to the concerns raised. We take very seriously the patient voice in our services, and the report will form part of the extensive feedback processes both in place and in development as part of our service provision. We acknowledge the concerns raised and would like to outline actions in response. We are very proud of the work and service delivered by our team thus far for the vast majority of patients and are keen to further develop the service with the support of the CCG, GP's and patients.

In order to provide a full response, and place the service in context, we will here:

1. Briefly summarise the situation inherited by the Healthshare Oxfordshire team
2. Respond to Healthwatch's Key Concerns and recommendations
3. Outline development plans in place and planned as a further response

1.

- Healthshare were tasked with taking over and integrating several separate services, with widely divergent cultures and systems across teams from two organisations, into one new referral stream.
- We inherited a backlog of 12,500 patients, with waiting times of up to 7 months for routine treatment.
- The previous providers had continued to book patients into appointments after the transfer date, without a coherent record transfer, making it extremely problematic to respond to patient queries.
- Some clinic sites were not made available to Healthshare
- We have received 56,000 new referrals in our first year, which represents circa 35% more than planned during commissioning.

2.

Healthwatch - Key concerns and Recommendations

1. Healthshare Telephone access:
   We are aware that access over the telephone has not been acceptable and agree that further improvements are required. It is not sustainable to manage calls in the region of 1,600 per day, and are putting in place more robust email contact

and changed the way we book patients with appointment letters issued within 7-10 days. We are also putting in place new software, developed jointly with PS Health, to automate some of the administration processes. We are also investing in more administration staff, with the proviso that within finite funding we will prioritise clinical risk and staff.

We are trying to establish more control over the phone system at our main administration hub, which is controlled by OUH, to allow more flexibility and immediacy to modifying patient messages and wait times on the phone.

2. Written confirmation of appointment:
   We have now changed the booking process to include a letter of confirmation. We have been working with a company called MJog, who specialise in automated appointment reminder systems, and who have this week confirmed that the module is compliant with our Patient Administration System. This will allow immediate and automated appointment reminders in the very near future, with options to change that appointment by return.

3. Distance to appointments:
   We would very much like to improve access in some areas where it has not been possible to provide continuity of service from the previous provider. As previously described certain sites were not made available to Healthshare on service transfer and there continues. We are continuing to explore options for accommodating the service with the CCG to allow further access, but there are also considerable availability and cost pressures within Oxfordshire estate.

   Patients are given, as far as has been possible, the option of both the first available appointment and the nearest available appointment, as a matter of choice.

4. Information on Referral
   We have provided each GP with a full A5 booklet detailing the service and will take the recommendation to modify this and provide a one-page summary information sheet that is more accessible for patients.

5. & 6. Complaints procedure
   We note that we will check accessibility to paper and web complaints process. We will review the 'How are we doing' tab and look at making this more explicit

as a complaints procedure, whilst maintaining the requirement for all types of feedback. Our complaints policy is to respond as stated; we will audit this on a regular basis to help ensure compliance.

We are very happy to embed the Healthwatch widget on the service portal.

Healthshare report complaints and compliments, from whatever route, to the CCG as part of standard reporting frameworks.

7. Satisfaction surveys
   We will review the satisfaction survey with the CCG and add content regarding the referral process and communication.

3.

The following are initiatives and development plans in place with regard to engagement. We would welcome dialogue with Healthwatch in delivering these programs.

- Patient engagement days are underway in each locality
- A virtual patient group is being developed to capture feedback from those patients under-represented at organised, face-to-face meetings.
- We have in place a series of GP engagement days
- We are assisting in putting together a regular PPG for the service

In conclusion we would like to share our Friends and Family data as part of the published report which shows that of close to 1,000 respondents in April, 93.1% would be likely or extremely likely to recommend the service.

We hope to work more closely with Healthwatch and patient groups to continually improve the service, and thank Healthwatch for the report, which will inform several immediate improvements.

Neil Cook MMACP SRP
Director
Healthshare

Appendix D: Healthshare Referral Data

Activity		Backlog	Sep-17	2018-19 Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018/19 YTD
Referrals	**Total received**	**8,737**	**4,015**	**6,645**	**6,799**	**3,928**	**5,295**	**4,968**	**5,230**	**5,656**	**5,723**	**5,569**	**5,200**	**4,766**	**5,031**	**31,945**
Patients triaged and referred without being seen in service	Orthopaedic department	157	720	486	594	369	326	369	555	779	2043*	1132	1148	957	569	**6,628**
	Pain rehabilitation	1	7	6	0	0	0	1	1	1	0	2	4	11	3	**21**
	Refer to pain clinic	58	56	85	98	33	10	66	61	75	148	105	79	76	46	**529**
	Referral to falls service	0	0	1	5	0	0	4	1	1	4	1	1	2	1	**10**
	Referral to fracture clinic	0	1	4	5	1	1	1	2	2	3	1	3	0	1	**10**
Service referred to	Referral to neurology service	0	2	4	2	4	2	12	18	2	16	11	9	3	5	**46**
	Referral to Other services	32	48	86	113	103	132	87	94	78	0	304	156	0	101	**639**
	Referred to podiatry	9	81	35	8	11	20	36	30	34	27	5	4	3	2	**75**
	Rheumatology	50	166	289	237	174	167	221	203	190	374	278	224	205	228	**1,499**
	Suspected sarcoma	2	6	5	0	0	3	0	2	1	0	0	1	1	3	**6**
	Total referred on from triage	**309**	**1087**	**1001**	**1062**	**695**	**661**	**797**	**967**	**1163**	**2615**	**1839**	**1629**	**1258**	**959**	**9,463**
	Percentage accepted referrals referred on	3.54%	27.07%	15.06%	15.62%	17.69%	12.48%	16.04%	18.49%	20.56%	45.69%	33.02%	31.33%	26.40%	19.06%	**36%**

*NB: the data for the month of May 2018 has been subsequently found to be inaccurate- with referrals being double counted.

Appendix E: Draft - Joint MSK service improvement plan

Last updated 18/01/2019
How we will get there

Strategy	Action plan (how)	Timing – Completion Date	Responsibility	Status	
				Active	Completed
			Overall OCCG monitoring role		
Waiting times improvement	Target >95% of referrals to secondary care sent to external provider within 5 working days of decision to refer **(minimum cut off 75% for no payment**	1st November 2018	HS		
	Target 95% Urgent referrals that are seen within 7 working days (from date of referral across all services) **(minimum payment cut off >80%)**	1st February 2019	HS		
	Target >95% of people seen within 30 working days (from date of referral) when their condition is routine (Across all services) **(minimum payment cut off >75%)**	1st June 2019	HS		
Provider responsive service	• Phone response • Appts sent post triage • Complaints process clear on website • Improved – ongoing monitoring	November 2018 and ongoing monitoting	HS		
Mobilisation of full specification service	• Mob. of outcome reporting full schedule 6 data reporting • Development of data quality improvement plan Dec 18 • Shared decision making for all patients referred on to secondary care (F:F or on the phone - ? other)	November 18 - February 2019	OCCG /HS		

Strategy	Action plan (how)	Timing – Completion Date	Responsibility	Status	
				Active	Completed
Clinical triage	• Review onward referral data - on agenda for Nov. MSK taskforce meeting • Consultant to Consultant referrals - reviewed Sept 2018	September 2018	OCCG		
GP liaison, support and education	Seek to improve primary care management in collaboration with GPs - consultation with locality meetings underway – 3 completed – ongoing activity	30 Nov 2018	OCCG /HS		
	Improve GP understanding of service, to help avoid GP's trying to bypass our service and go straight to secondary care, via 1. Increase understanding of the scope of Health Share services, via patient leaflet, posters, presentation of case studies, practice support and education. 2. Increased responsiveness of service 3. Demonstrate increased responsiveness of service	Planning for November 2018 – April 2019	HS		
	Develop GP education process and look to get a GP feedback survey in place for new year	March 2019	HS		
	GP education and support to provide first contact physio in primary care	March 2019	HS		
	Practice level MSK education sessions	March 2019	HS		
	Further provision of resource material – patient leaflet, team profile, key reference information	February 2019	HS		
	HealthShare to hold one to one visits to review guidelines	Ongoing	HS		

Strategy	Action plan (how)	Timing – Completion Date	Responsibility	Status	
				Active	Completed
Self -Referral	Self -referral - Plan agreed and in process	November 2018 – February 2019	HS		
Patient engagement -	First consultation process completed	October 18	HS		
	Patient leaflet in draft to be provided as per previous action.	November 2018 – Rescheduled to February 2019 to coincide with self referral launch	HS		
Advice and guidance - for GP's	Currently GP's have access to a direct email, which will respond within 48 hours, Healthshare feel that this is working well	Under review – assess February-March 2019	HS		
Reporting	Docman, does it need to be implemented? HS currently using SPINE email - reported to be working well- understand triage process better	Ongoing	OCCG		
Pathways	OUH Rheumatology – Check that Rheumatology triage in HS is fit for purpose and clinically resourced – may need more. MSK TF have asked, KB has offered consultant to support at cost £	Ongoing Audit in planning phase scheduling for February –March	OCCG /HS		

Strategy	Action plan (how)	Timing – Completion Date	Responsibility	Status	
				Active	Completed
		2019			
	Spinal pathway – incorporating actions of clinical pathway meeting	December 2018	HS/O CCG		
	Previous history of cancer checkbox added to referral forms	December 2018	HS/O CCG		
	Improve GP eRS visibility over patients in their pathway Check with GP's and David Chapman	For review February 2018	HS/O CCG		
Waiting times and KPI reporting improvement	Diagnostic pathway to be improved with clear process on imaging results - ICE to be implemented to enable clear and timely communication of Imaging results to GP's	ICE use now successful in pilot phase	HS/O CCG		
Website and communication process	Signposting to website incorporated into patient leaflet, patient letters and posters	Rescheduled to 1 February 2019 All resources in final draft for printing			

Ongoing actions/reporting/monitoring from previous plan – In relation to Healthwatch draft recommendations					
Strategy	**Action plan (how)**	**Timing – Completion Date**	**Responsibility**	**Status**	
				Active	**Completed**
			Overall OCCG in monitoring role		
Call response times for patients	First phase completed Monitoring program underway	See above ✓	HS		

Ongoing actions/reporting/monitoring from previous plan – In relation to Healthwatch draft recommendations					
Strategy	**Action plan (how)**	**Timing – Completion Date**	**Responsibility**	**Status**	
				Active	**Completed**
Patient information regarding appointment and waiting times	Continued monitoring of KPI's Improved letter and communication process for patients Patient information leaflet	See above ✓	HS		
Distance travelled to attend appointment (F:F/Imaging)	Initial report received November 2018 Establish periodic reporting process	See above ✓	HS		
Information provided to patient via GP	Dissemination and use of patient leaflet Dissemination and use of electronic (PDF) leaflet	See above ✓	HS		
Information provided to the patient via Healthshare	Leaflet, and weblink provided in addition to appointment letter letter	See above ✓	HS		
Complaints procedure activity	Include item in weekly meeting with Healthshare and OCCG non Datix issues	✓	HS/ OCCG		
Complaints report to OCCG	Reporting included in performance report	✓	HS		
Patients satisfaction survey update	To include questions on administration, referral process and communication between Healthshare and patient	Survey updated – for review	HS		

Adhoc actions and targets will not be recorded unless of particular significance

Please note, this is a dynamic working document

Operational Meeting Standing Agenda

1. Operational issues
2. Complaints/issues
3. Action plan review – action log
4. Performance – Trajectory

Appendix F: Latest performance for Healthshare MSK contract

Area	Service KPI	Target	Apr-Jun '18 monthly average	Jul – Sep '18 monthly average	Oct '18	Nov '18	Dec '18
Outcomes	% of patients with an improvement in at least one dimension of EQ5D	85%	91%	92%	86%	81%	90%
Process and onward referrals	% of patients triaged within 48 hours	95%	33%	73%	69%	95%	83%
	% of patients referred on within 5 working days to secondary care (where required)	95%	29%	14%	59%	67%	90%
Access and waits	No. new urgent patients seen (and proportion of those within 7 days of referral)	75%	513 (17%)	610 (8%)	976 (5%)	504 (12%)	815 (14%)
	No. new routine patients waiting (and proportion of those within 30 days of referral)	75%	2,123 (13%)	3,598 (9%)	1,623 (24%)	2,031 (10%)	3,123 (10%)
	Total no. patients waiting			N/A (not reported)	6,196	8,258	3,892

In the table above there has been an improvement in the number of people and percentage of people triaged within 48 hours which is important in order to identify those people requiring early referral or treatment. The improvement can also be seen in the number and percentage of people referred within 5 days when they require secondary care.

Outcomes vary slightly but are generally good and within the threshold set.
The waiting times remain high but Healthshare have a minimum target to deliver 75% of urgent referrals by 1st February 2019 which they are on track to do. The target has changed from urgent referrals being seen within 5 working days to 7 days. With an improvement in urgent referrals comes a temporary deterioration of routine referrals until capacity can be balanced out. Routine referrals will be seen within 30 days (previously 20) by 1st August 2019. This is because with the increase in referrals and the CCG available resources we need to target on the greatest need. New targets were negotiated as a result. These were renegotiated in October and November 2018.

Oxfordshire Joint Health Overview and Scrutiny Committee.
7 February 2019

Chairman's Report

1. Health liaison

1.0 Committee members have been involved in the following activities since the last Chairman's report.

1.1 GP contract decision pathway workshop

1.2 On Wednesday the 21st of November, 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 was a follow up to one held on the 21st of September and included GP representatives, members of Patient Participation Groups and patients themselves. The meeting was held as a result of contract notices given in Oxfordshire practices and recognition of the need to have a more planned approach to such situations.

1.3 During the meeting, a 'decision tree' was shared which was a result of work done in the previous workshop to determine the factors to consider when determining an appropriate solution to contract notices.

1.4 It was noted that the decision tree would not only apply where a practice gives notice, but would also apply where significant growth was going to occur and new patients needs to be registered. A number of background or 'contextual' factors were recognised as needing to be considered before and during the process outlined by the decision tree, this includes factors such as the demographics of the population concerned, the buildings in question, the quality of services being provided and the public transport options available in the area.

1.5 In discussion, the group largely agreed that the decision tree which had been drafted was a helpful process and ensured the right steps were taken to consider how best to provide primary care services in an area where there was population growth of a contract notice situation. It was felt that the most important question to begin the process with was 'must services continue to be provided at the site in question'.

1.6 The solutions generated previously by the group were broadly felt to be sensible and realistic solutions. The solutions for larger practices were clear to see, and similarly the potential solutions for small practices. The practices of a patient list size of around 3,000-8,000 were determined to be a) most likely to be the least financially viable and b) the most complex to find solutions for. Some initial ideas for solutions for this cohort were suggested by the group and the CCG were tasked with taking these suggestions away and working up some proposed solutions that would be feasible. Some suggestions could be unpalatable to all and would therefore become a position of 'last resort'. They were felt to be important to identify to ensure the full consequences of being unable to find alternative solutions were clear to all.

1.7 The engagement of public, patients and stakeholders were discussed. It was felt to be important to be transparent about the situation and process as early as possible. Routes to achieving this included holding full public meetings, drawing together a stakeholder reference group (standard Terms of Reference for such a group will be drafted by the CCG for future reference), working with the Patient Participation Group representatives and communicating all information through the CCG's website; this is alongside existing stakeholder engagement (e.g. HOSC).

1.8 The results of the workshop are being fed into a further draft of the 'decision tree', which the group will feedback on. The CCG will do some additional work to draft Terms of Reference for the stakeholder reference group, they will also do the work to develop solutions for the 3,000-8,000 practice size and share this with the group. The decision tree will be tested with examples, with amendments made as necessary from the learning points of this. The tested and draft tree will be presented to HOSC (in February 2019).

2. The Horton HOSC

2.0 Two meetings of the Horton HOSC have taken place since the last Chairman's report. All papers are published for these meetings on the Council's website at:

http://mycouncil.oxfordshire.gov.uk/ieListMeetings.aspx?CId=1070&Year=0

2.1 The below provides a summary of the information presented to the Horton HOSC:

- Monday 26th of November
  During this meeting, the CCG and Oxford University Hospital Foundation Trust presented a paper which set out a revised and updated programme plan following the initial Horton HOSC meeting on the 28th of September 2018. It included an Engagement Plan for stakeholder engagement and a revised timeline for the work which altered the planned meetings of the Horton Joint OSC which are now planned for February and June 2019 (previously January and April 2019). The committee also considered a paper on the key issues around recruitment and retention of staff.

- Wednesday 19th of December 2018.
  During this meeting, Horton HOSC members heard from many interested parties around obstetric services at the Horton General Hospital. This included members of the public, MP's, Council Leaders and Cabinet members, NHS England, South Central Ambulance Service, the Royal College of Midwives and the Keep The Horton General campaign group. The purpose of this session was to inform the committee's future scrutiny as the work progresses and options are proposed.

2.2 The next meetings of the Horton HOSC are scheduled for:
- Monday 25th of February 2019
- Thursday 11th of April 2019 (provisional)
- Monday 24th June (provisional)

3. Task and Finish Group on Local Health Needs Assessment in the Wantage Locality

3.1 Following consideration of a draft Local Health Needs Assessment Framework at HOSC on the 28th of September 2018 and subsequent approval of this Framework at the Health and Wellbeing Board in November 2018, HOSC considered a timetable for the roll-out of this Framework in the Wantage Locality at its meeting on the 29th of November 2018.

3.2 During the HOSC November meeting, the committee requested that the CCG look to accelerate the timetable for the work in Wantage due to the extended period of time since the temporary closure of Wantage Community Hospital (which took place in July 2016). HOSC also requested that a Task and Finish Group be established to do a more detailed piece of scrutiny on the Framework and its implementation in the Wantage Locality. The following presents a draft Terms of Reference for such a Group

3.3 HOSC is **RECOMMENED to approve the Terms of Reference for a Task and Finish Group on the Local Health Needs Assessment in the Wantage Locality**:

Draft Terms of Reference: Task and Finish Group on the Local Health Needs Assessment in the Wantage Locality

1. Purpose

1.1 The purpose of this document is to define the Terms of Reference for the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) Task and Finish Group on the roll-out of a Local Health Needs Assessment Framework in the Wantage Locality.

2. Background

2.1 In April 2016 members of Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) met representatives from the Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health Foundation Trust (FT) to consider whether the following proposals constituted a substantial variation in service:

- Temporarily close Wantage Community Hospital (to deal with a legionella outbreak in the hot water system),
- Set aside capital funding (in 2016/17 financial year) for plumbing works,
- Delay the commencement of the capital works until a public consultation on the future use of the community hospital has been determined.

2.2 After considering the proposals HOSC stated that it recognised the closure of the hospital as a substantial change in service. HOSC also noted the commitment of OCCG and Oxford Health FT to a full transformation programme, initially planned for Autumn 2016.

2.3 In July 2016 Oxford Health FT temporarily closed the Wantage Community Hospital on safety grounds (due to the legionella issue). The community hospital has yet to be reopened.

2.4 The public consultation on the hospital was initially due to conclude in Spring 2017. However, after a delay in launching the consultation HOSC were later informed that the consultation over proposals contained within the overall transformation programme would take place across two phases. The future of the community hospital was due to fall into phase two, planned to take place in May 2017.

2.5 In March 2018 the NHS in Oxfordshire issued a joint statement from the System Chief Executives signalling a change to the approach to service transformation. This was a result of learning from phase one and CQC emphasis on better health and social care planning.

2.6 OCCG were tasked with outlining a timetable and framework for working with local communities in the June 2018 HOSC meeting. This included how they intended to review the local health needs, current and projected demographics and local assets to inform service change.

2.7 In the HOSC meeting in September 2018, OCCG presented a draft Local Health Needs Assessment Framework which was designed to set out how commissioners and providers of health and care services in Oxfordshire would work together to meet the health and care needs of the population today and in the future. The CCG proposed that this framework be used in the Wantage locality first to address the issues with Wantage Community Hospital in a holistic way.

2.8 During the meeting in September, HOSC was clear that the proposed framework was a helpful way of considering the health needs of the population. They wished to see greater clarity over the ways in which county-wide services would be planned, but were supportive of the framework as whole. Despite the Committee's approval of the framework, both residents and members of the committee raised concerns about the length of time elapsed since the temporary closure of Wantage Community Hospital and urged OCCG and Oxford Health FT undertake the work as a matter of priority.

2.9 The Local Health Needs Assessment Framework was agreed by the Health and Wellbeing Board in November 2018. The CCG then reported to HOSC on the 29th of November that they intended to use the agreed framework in Wantage with an immediate start. The Committee remained unhappy about the proposed timescales for this work to be undertaken and requested an acceleration. However, to provide effective local health scrutiny into the new framework process, HOSC requested that a Task and Finish Group be established to work in more detail than is possible through Committee meetings.

3. Aims and objectives

3.1 The aim of the Task and Finish Group is to provide:

Scrutiny throughout the process of implementing the Local Health Needs Assessment Framework and its timely roll-out, to take account of the needs of residents in Wantage and the local area.

3.2 To achieve this the Group will.

- Understand the approach to ensuring all resident's needs, current and future, are being considered, by taking a more detailed look at the proposals.
- Understand and report on how the needs of the local residents are being considered.
- Ensure there is sufficient openness and transparency in implementing the proposed approach and subsequent reporting of results.
- Provide feedback to local health system partners as part of their work under the Health and Wellbeing Board on the effectiveness of the Local Health Needs Assessment process, to aid their future transformation work.

3.3 The Task and Finish Group has been established by Oxfordshire Joint HOSC to provide oversight to, and assure the timely and thorough completion of the Local Health Needs Assessment Framework. The Committee has authorised the Group to conduct this work and report back formally to the Committee. The Group does not have permanency, and will exist until such time as the work has concluded.

4. Membership

4.1 The core membership of the Task and Finish Group is as follows.

- Four HOSC Members, comprising of:
  - Lead Member for Vale of the White Horse
  - Two further Cllrs
  - Co-opted Member

The Group will be Chaired by ## who has been appointed by the members of the Group. The Group may draw in expertise and stakeholders as necessary.

Additional attendees may include;

- Oxfordshire CCG
- Oxford Health Foundation Trust
- Healthwatch Oxfordshire
- Patient representatives
- GP representatives.

Additional attendees may be necessary.

5. Frequency

5.1 The Task and Finish Group will meet as the Chair shall deem necessary.

6. Secretariat

6.1 The Task and Finish Group Secretariat function will be provided by the Policy Officer for HOSC.

7. Agenda and papers

7.1 The agenda and all papers will normally be distributed via email to members and those in attendance in advance of the meeting by the Secretariat.

7.2 The actions to be taken will be recorded in the Task and Finish Group's minutes which will be circulated to all members of the Group.

7.3 The Chair is responsible for ensuring that the minutes of meetings, produced by the Secretariat, and any reports to HOSC accurately record the decisions taken.

7.4 Minutes will be formally approved at the subsequent meeting (or by email where this would be more than one month later).

8. Reporting line(s)

8.1 A report from the Task and Finish Group on the work will be provided at each HOSC Committee meeting.

8.2 The Group will make recommendations to the Committee, the CCG Board and/or to the provider where appropriate.

4. Cogges Surgery

4.0 Following contract notice from Cogges Surgery in Witney to OCCG in the summer of 2018, the CCG worked with stakeholders and patients to explore the options for the future of the practice. On the 27th of September, the Chairman received the following letter notifying that the Cogges Practice will continue to provide services to their registered patients.

NHS
Oxfordshire
Clinical Commissioning Group

To all stakeholders

Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford
OX4 2LH

Telephone: 01865 337017

27 December 2018

Dear Colleague

Cogges Partners to continue providing services at Cogges Surgery

I am pleased to confirm that OCCG has agreed to cancel the termination notice for Cogges GP practice. We therefore expect the Cogges GP partners to continue to provide primary care services to their patient list going forward.

When the CCG received notice in July 2018 that Cogges partners wished to no longer provider services at Cogges, our main aim has been to ensure the sustainable provision of quality primary care service to the patients registered with the practice. Towards the end of the process set up by OCCG to find a new provider, Cogges Surgery requested to cancel their notice. As a result Cogges Surgery was asked to submit an application in a similar way to other applicants and this was assessed by the same panel that did the first round assessment. It was important that the CCG completed the process of assessment to ensure we were confident that the arrangements being put in place at the practice would deliver sustainable services of a quality that would be expected. We are delighted to say that the information provided by the Cogges Partners demonstrated this and as a result the practice team will continue to run services from Cogges Surgery.

Further information on the process the CCG followed can be found here. This decision has been widely supported by the neighbouring practices in West Oxfordshire.

We appreciate this has been an unsettling time for patients registered at the practice and we will be writing to them to confirm they can remain registered with the practice and continue to benefit from the services provided there.

Yours sincerely

Julie Dandridge
Deputy Director of Delivery & Localities
Head of Primary Care & Localities

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