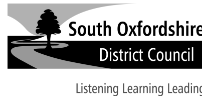
Notice of Meeting Public Document Pack



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 11 November 2010 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - Councillor Susanna Pressel

Councillors:	Tim Hallchurch MBE Jenny Hannaby	Neil Owen John Sanders	Don Seale Lawrie Stratford
District Councillors:	Christopher Hood Jane Hanna	Rose Stratford Hilary Fenton	
Co-optees:	Ann Tomline	Dr Harry Dickinson	Mrs A. Wilkinson

Notes: ***There will be a pre-meeting for members of the Committee at 9.00am on 11 November***.
Date of next meeting: 20 January 2011

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	Councillor Dr Peter Skolar E.Mail: peter.skolar@oxfordshire.gov.uk
Committee Officer	-	*Julie Dean, Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

November 2010

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.

Health Scrutiny complements the work of the Patient and Public involvement Forums that exist for each of the NHS Trusts and Primary Care Trusts in Oxfordshire.

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes

To approve the minutes of the meeting held on 16 September 2010 (**JHO3**) and to note for information any matters arising on them.

4. Speaking to or Petitioning the Committee

5. Intermediate Care

10.10 am

In August this year, the County Council/NHS Pooled Budget Joint Management Group had decided to end a contract for short term Intermediate Care beds at Watlington Care Home. Following that, the County Council and the PCT had received a number of objections to the decision. In response to the objections, the Joint Management Group had decided to suspend the decision to end the contract, pending a review of the joint Intermediate Care Strategy.

The review will report its findings and recommendations to the next Joint Management Group on 12 November. The Joint Management Group will then decide how to proceed in respect of intermediate care in general and the Watlington beds in particular.

Paul Purnell, Head of Adult Social Care, Oxfordshire County Council, will attend for this item and members of the Committee will have the opportunity to scrutinise the policy decision and rationale.

6. Remembrance Day Service

10.45 am

There will be a 30 minute break for attendance at the Remembrance Day Service in the Common Hall Café, if wished.

7. Oxford Radcliffe Hospitals NHS Trust

11.15 am

As part of a series of items of business aimed at bringing members of the Committee up to date on the position of local NHS Trusts, Sir Jonathan Michael, Chief Executive of the Oxford Radcliffe Hospitals NHS Trust will give an update on both the current situation and how he sees the future for the Trust.

8. Creating a Healthy Oxfordshire

11.45 am

Oxfordshire's NHS organisations and the County and District Councils are working together to try to ensure the continued provision of high quality and sustainable health and social care services. In the face of reductions to funding, the health and social care services need to respond to increasing demand, patient expectations and advances in technology and medicines. The plan is to improve the quality and value for money of health services provided in Oxfordshire in a way that will keep the system in financial balance. This will involve re-designing the wide range of health care services currently provided throughout Oxfordshire. Catherine Mountford, Director of Strategy & Quality, Oxfordshire PCT, will bring the Committee up to date on developments.

A report, produced by Catherine Mountford, is attached at **JHO8.**

9. The Future of the LINk Contract

12.25 pm

Lisa Gregory, Social & Community Services, Oxfordshire County Council, will talk about the future for LINk and HealthWatch. The host organisation's contract is due to finish at the end of March next year, but HealthWatch (the replacement for the LINk - as outlined in the Health White Paper) is not due to come into existence until April 2012. This item should provide an opportunity for members to express a view on the future of the contract, in particular during the period between the end of the present host contract and the start of HealthWatch.

10. Chairman's Report

12.55 pm

The Chairman will report on the meetings he has attended since the last meeting.

recycled paper

Declarations of Interest

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

The duty to declare …

You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

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

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

Whose interests are included …

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

When and what to declare …

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

Taking part if you have an interest …

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

"Prejudicial" interests …

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

What to do if your interest is prejudicial …

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

Exceptions …

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

Seeking Advice …

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

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 16 September 2010 commencing at 10.00 am and finishing at 2.40 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair Councillor Tim Hallchurch MBE Councillor Jenny Hannaby Councillor Neil Owen Councillor John Sanders Councillor Don Seale Councillor Lawrie Stratford Councillor Susanna Pressel (Deputy Chairman) District Councillor Dr Christopher Hood District Councillor Rose Stratford District Councillor Hilary Fenton Ann Tomline Dr Harry Dickinson Mrs A. Wilkinson
Co-opted Members:	Ann Tomline Dr Harry Dickinson Mrs A. Wilkinson
Other Members in Attendance:	Councillor Larry Sanders (for Agenda Item 5)

Officers:

Whole of meeting	Julie Dean and Roger Edwards (Corporate Core)
Part of meeting	Dr Jonathan McWilliam and Shakiba Habibula.

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

49/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

An apology was received from Councillor Jane Hanna OBE.

50/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

51/10 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 8 July 2010 were approved and signed, subject to the word 'two' being amended to 'ten'; in Minute 44/10, page 6, line 1 and Councillor Pressel being added to those who attended the meeting with Sir Jonathan Michael, Chief Executive, ORH, as noted in Minute 47/10, page 12.

With regard to Minute 44/10, first bullet point, page 6, Dr McWilliam reaffirmed his hope that spending on family support would be an ongoing topic of interest for the Committee. He added that he had requested data from Linda Watson, Chief Executive, Oxfordshire Rural Community Council, in a bid too tease out types of deprivation, whether that be of a poverty nature, or housing, rural access to services etc.

52/10 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to a request from Councillor Larry Sanders to address the Committee at Agenda Item 5.

53/10 LIBERATING THE NHS - THE WHITE PAPER ON HEALTH

(Agenda No. 5)

The recent White Paper and other related consultation papers set out a whole series of radical proposals for change to the NHS. The White Paper was now out for consultation with responses required by 11 October 2010.

For the purposes of this Committee, consideration of the White Paper was addressed in relation to three major areas:

Adult Social Care - A paper by the Director of Social & Community Services entitled 'Health White Paper' was circulated (**JHO5(a)**)**;**

Public Health – A paper by the Director of Public Health was circulated (**JHO5(b)**)**;**

Implications for Oxfordshire County Council and the Implementation of the Proposals – to include the implications for this Committee and for the Health & Well Being Partnership Board – current and future. A paper by the Health Scrutiny Adviser was circulated at **JHO5(b).**

A wide range of speakers from Health, Oxfordshire County Council and other interested organisations had been invited to address the Committee on the issues raised by the proposals. The speakers are listed as follows:

- Councillor Arash Fatemian (Cabinet Member for Adult Services – Oxfordshire County Council (OCC));
- John Jackson (Director of Social & Community Services - OCC);
- Joanna Simons (Chief Executive – OCC);
- Fred Hucker (Chair, Oxfordshire Primary Care Trust (PCT) Board);
- Sonia Mills (Chief Executive – Oxfordshire PCT);
- Dr John Galuszka (Acting Medical Director – Oxfordshire PCT);
- Dr Jonathan McWilliam (Director of Public Health);
- Dr Peter Von Eichstorff (Practice Based Commissioning consortia representative);
- Dr Paul Roblin (Local Medical Council (LMC) representative);
- Mark Ladbrooke (Secretary – Oxfordshire Unison – health branch);
- Dermot Roaf (Oxfordshire Link); and
- Olga Senior (SHA Director of Communications & Corporate Affairs).

Prior to the above business, Councillor Larry Sanders addressed the meeting prior to the above as follows:

- His view that the overarching themes of the White Paper would create risks and his hope that these would be minimised in Oxfordshire;
- The ongoing 'Keep our NHS Public' campaign had aired their concerns about the 'privatisation and fragmentation' of the NHS;
- He advocated that there should be one sole commissioning consortia for Oxfordshire, adding that it had only been a short while ago that 5 PCTs had been reduced to one and the ensuing costs had been substantial;
- In the past, similar PBC consortia had proved very expensive to run. He asked what would be the consequences if they should run into financial difficulties;
- He warned of the alleged 'power and unscrupulous working practices' of the private sector;
- He asked what would happen if a Foundation Trust should run into financial problems. The Government had indicated that any organisation could bid for services and expressed a hope that a cautious stance be taken with regard to outsourcing any commissioning responsibilities.

John Jackson – introduced his paper (**JHO5(a)**) informing the Committee that the Cabinet deadline for responding was 5 October and for its supplementary papers was 12 October. He added that the OCC response would focus on a package which was intended to be part of a continuing debate within OCC with regard to future services. The Chairman added that this Committee had the task of making two responses, one appropriate for health related OCC services and a separate response was to be made to the Department of Health.

Dr Jonathan McWilliam introduced his paper (**JHO5(a)**) making the following comments:

- Within the White Paper it clearly stated that local authorities would have the lead role to play in joining up the three leading pillars of public health ie, that of the local authority, the local Health function and the national Public Health

service. Strong emphasis had been placed on the Health & Well-Being Board as the organisation which would effect this unity;

- At the local level, there were advantages to be gained in local government joining the pillars as long as it is managed efficiently. A safe transition was required in order to maintain the gains which had been made in Oxfordshire over the last four years in public health;
- The role of the Health & Well-Being Board performs a facilitative role in the creative working together of the Health/Local Government and Public Health. It was his view, and the Director of Social & Community Services view, that the Health Scrutiny function was invaluable to this Council and therefore should not be merged with the Health & Well-Being Board.

Joanna Simons put forward the following views:

- There was a long history of good joint working with the Oxfordshire NHS , with good outcomes. This placed it in a good position in the future;
- Oxfordshire's Joint Needs Assessment had been commended;
- Oxfordshire had seen some very positive outcomes from the decision to employ a Joint Director of Public Health. The priorities of OCC's Communications Strategy was now very different to those of its predecessors. There were inequality 'hot spots' which were being addressed. This would have taken place without the Director of Public Health;
- Health Scrutiny within Oxfordshire had worked well. There was a need to revise the current arrangement, but care must be taken not to 'throw the baby out with the bath water'. It was her view, therefore, that a recommendation should be made to Government to implement an arms length arrangement on a local basis, to enable the Committee to continue into the future;
- There was a need for OCC and the GPs to adopt a more formal way of working. The PCT would play a key role in this over the next year or so;
- There was a potential to come closer with regard to joint commissioning, though this may not be easy, as funding was squeezed with national targets. When the scale of public spending reductions was known, then systems would be looked at in a more integrated way. There was a need to find ways of looking holistically to make more effective, locally, the role of GPs , social service authorities and children's services;
- The primary risk regarded capacity. Colleagues in the PCT had a less secure future and it was important to hold on to key people in order to mitigate this risk;
- It was important to find the means of making sure that OCC and Health worked together with a clear end goal; and
- In conclusion, Oxfordshire was better placed than other colleagues, but the work that was required to implement the above should not be under-estimated.

Councillor Arash Fatemian concurred with Joanna Simons that OCC and Health were well placed in Oxfordshire to deal with some of the recommendations coming out of the White Paper. OCC and Health already held a genuine, advanced pooled budget. He echoed his colleagues in stating that this Committee had undertaken some important and valuable work within the County and welcomed the possibility that its functions could continue in some form, in a separate capacity from the Health & Well-Being Board. He added that all the changes to Adult Services needed to be joined

up. There were challenges ahead but real opportunities as long as it was approached in a constructive manner.

In response to a question from the Committee if OCC was adequately resourced to undertake the above, Councillor Fatemian responded that undertaking it was a necessity, but that there was a need to look at it in a different way, to look at how best placed resources were to meet the challenge. Dr McWilliam also commented that the Public Health Transition Group would have six channels of work, one of which would be to look at how well placed the information was at the centre.

Olga Senior stressed the following:

- The White Paper was an opportunity to influence the Government on change;
- The SHA had run six sessions on the White Paper across the Thames Valley region, linking with partners ie. the District and County Councils, Thames Valley Police, NHS organisations, GPs etc;
- The framework all were waiting for was still to be developed nationally. It was hoped that national frameworks were not hugely prescriptive; and that there would be sufficient flexibility to suit local need;
- At the sessions, the SHA were given a strong message that there should be a consistency across the county;
- As the budget reductions hit, the tariff dictates that it is important to shape the future on outcomes rather than inputs so that the patient is at the centre;
- With regard to Dr McWilliam's 'three pillars', there is a need for careful relations between the three so as not to cause a mismatch.

Fred Hucker commented as follows:

- The PCT was created four years ago. The Board is totally committed to whatever takes place in the future. It will be legally responsible until 2013 for public expenditure and will retain its accountability until then. The PCT would continue with the 'day job' focussing on its usual business and on issues of major concern such as finance, the practicalities of bed blocking , mergence of the CHO and the OBMHT, savings required by the ORH etc. The Board was intent on ensuring the success of these projects and that they would be handed over to the consortia in a right and proper manner;
- Although the legislation had not yet been finalised, there would be time to deliver what the PCT thinks best in the interests of Oxfordshire. For example, on ensuring that there was sufficient staff for the Paediatric/Maternity services at the Horton Hospital, Banbury;
- He was unsure if there would be one consortia for PBC in Oxfordshire, or a number of them. He did however assure the Committee that Public Health funding would be ring-fenced, which was right and appropriate for Oxfordshire.

Sonia Mills commented as follows:

- During the transition to any new structure there was a need to capture and protect skills and experience. The PCT would ensure that this would take place. GP colleagues recognise the need for this;

- Work would also be ongoing in relation to the transfer of functions to the local authority, the transfer to more local structures for the NHS Commissioning Board and also to providers who would be in a more ‘stand alone’ role;
- The number of consortia would be put where they would be best placed, following discussion, and then their legality, accountability and support functions would be slotted in afterwards. The PCT is listening to what people want and will then marry suitable expertise for the future;
- There would be £200m cash to effect the change, The cash element would not grow and therefore it was important to find the best way of releasing it to the best effect. There is a need to set out the direction which will be a very different configuration. There will be no choice about what is spent.

Dr Galuska gave feedback on plans for the implementation of the White Paper proposals commenting that:

- GPs wanted to ensure a maximum quality of services as possible within the available budget;
- GPs were keen to work collaboratively and feel the need to be a little more radical, more relaxed and even a little ‘more parochial’ in respect of some services;
- The endeavours to maintain their current workload was very much an issue;
- GPs were trying to be as efficient as possible and were constantly evaluating what they should be doing;
- There were benefits to the smaller PCTs;
- The localities work well, though there were partnership issues;
- GPs wanted to ensure that vital services were retained. There was a wish not to spoil aspects of services which were working well, but they needed to know what they were;
- GPs had the impression that the PCT would prefer to use the NHS providers if at all possible;
- Maximum input was required – at present, many GPs invested in services on a much smaller scale.

Peter von Eichstorff put forward his personal views as follows:

- He felt confident the new arrangements would work effectively provided GPs, OCC, the voluntary sector, Public Health and the PCT all worked together;
- The PBC had been working together for three years and was already responsible for £290m of the budget. It had already seen success in the development of new services and changes in the management of some services. They had, however, kept some of the same, which was difficult given the ‘push to the private sector’;
- The consortia had already begun efforts to engage the public regarding future structures via Oxfordshire LINk;
- There were many practices still not engaged or aligned with the consortia;
- A small number of consortia were overspending and thus some were ‘bailing out’ others. Therefore an overarching management structure was an effective ay forward;
- The messages for the consultation were that (1) the GPs were keen and ready to help and keen not to commission services which were not fit for the future:

(2) CHO and Out of Hours would be reviewed to see how they were operating:
(3) the functions of Payment by Results systems needed to be teased out and renumerated;

- There was a need to look at information systems in light of the abolishing of NHS Direct;
- In conclusion, he was optimistic that the new systems could improve equity and excellence in Health using simple and pragmatic solutions, avoiding duplication.

Paul Roblin expressed the following views:

- He was pleased with what he had heard to date with regards to the direction of travel;
- The White Paper did not contain much detail and was subject to local determination – thus it was possible to tailor services to suit Oxfordshire;
- The White Paper stood for vast change, as significant as in previous decades;
- There had been variable support for the changes;
- There would be vast change at the time of financial constraint – it would be important therefore to maintain services in times of constriction;
- Consultation must take place on all aspects;
- There would be a dramatic change in the workload portfolio for some GPs;
- There had been variable enthusiasm from GPs - in the face of this it was hoped that change would be delivered;
- The Consortia was driven by 'bottom up' developments;
- The best of the present system would be taken and the 'not so good' would be circumvented;
- The PCT would continue to exist acting as an agency for the development of the GP consortium development. It was important to map PCT functions and tasks to decide on their destination;
- There must be local determination to ensure that a system is developed that works, GP need considerable local management. It cannot be done at a distance;
- The consortia should be of a size to ensure a balance to cope with risk management; and
- The opportune and transaction costs in making the changes must not be so vast that the 'day job' does not get done.

Mark Ladbrooke raised the following concerns expressed by the Branch:

- The common concern across NHS unions was that of the development process, the changes happening and public engagement issues;
- The abolition of the PCT was a 'bolt from the blue' and this had 'shaken the public to its roots'. The Government was doing the public a disfavour in 'de-stabilising the PCT';
- The national Union thought it important that there was strong engagement with the public and staff. There was a concern that this was ' not just another weakening of the NHS' but had a real potential for changing the NHS 'into a mere logo';
- Oxfordshire MPs should be well informed of change/developments in Oxfordshire;

- There should be no underestimation of how difficult the mechanics of change will be;
- The Union would be delighted to work with local councillors in order to effect the best possible solution. The Union was well aware of the importance of accountability and of the changes in the future to the powers of this Committee. There were many big issues, such as how the consortia would access the general population for their views; on financial stability; staff insecurities and potential loss of skills for staff; and
- He concluded by urging councillors to facilitate public discussion with the NHS.

Dermot Roaf commented as follows:

- The pooled budgets had proved to be a great success in Oxfordshire; and
- The Oxfordshire LINk had valued enormously the opportunity to work closely with this Committee. He hoped that this Committee retained its powers. Even without its powers, he hoped it would still exist.

Issues and questions raised by Committee members during the question and answer session, and responses received, where appropriate, are as follows:

- Cross border GP consortiums? – (response) It is important to address more pressing issues first;
- GP training? - (response) The SHA is addressing this;
- GP training in Public Health? – (response) It is an integral practice;
- Will services be free at the point of use? What can the patients expect? (response) We are taking ten patient journeys and 'road testing' them. We will try to bring patients closer together with the clinicians, led by GPs;
- How will patients gain access to GPs to ask questions and voice their concerns? (response) The new arrangement will be very patient focussed as services may have to be changed in light of developments such as the joint working of CHO and the OBMHT services;
- What has happened to localism? (response) It was hoped that this would happen within the framework, there were challenges to be faced;
- The Committee would like to see an audit of all current areas of PCT work – (response) The transition organisation planned for this will be carried out as a core strategy obligation: to ensure that it is entered into the new legislation and the old is either repealed or has somewhere to go. She added that it would be a challenge for all to take out £1.3b of cost over the next three years. Assurances would have to be given that some services were to be maintained. GPs would be commissioning services, some of which might not look the same. The Committee were assured that there would be consultation on each major change;
- Who would pick up the commissioning for primary care in relation to rural dispensing? (response) It was clear in the White Paper that a National Commissioning Board would undertake pharmacy, patient care and maternity services. The Committee were advised that there should not be a narrowing of its focus solely in relation to the implementation of the services, the Government were also interested in hearing the comments of HOSCs on the content of the White Paper also.

The Committee thanked all those who took part in the discussion for being frank and open. It was **AGREED** to support the recommendations contained within the papers submitted by the Directors of Social & Community Services and Public Health. The Committee's response to the proposals, for consideration by the Cabinet, is set out below:

Response to the White Paper – Equity and Excellence: Liberating the NHS

The Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) has considered the White Paper. The HOSC understood from the White Paper that the consultation is on "how best to implement the changes" and not on the overall strategy. Having said that members expressed their concerns that the proposals to scrap PCTs and pass most commissioning to GP consortia could create significant dangers for the provision of health services.

In particular they were worried about whether GPs would have the capacity and knowledge to undertake the level of commissioning involved. Issues of financial stability, democratic accountability, loss of existing knowledge and expertise by the dissolution of PCTs and the adequacy of resourcing also caused concern.

Furthermore the White Paper left a number of major questions unanswered.

These concerns are reflected in the comments below. The first section sets out general responses to the White Paper that will be communicated to the Secretary of State. The second section contains specific recommendations for the Oxfordshire Cabinet.

Response to the consultation:

1. The focus on reducing inequalities and the plan for targets to be based on outcomes are welcomed.
2. The proposal for Public Health and health improvement to once again be a local authority responsibility is also welcomed. However, it will be vital that, the service be fully resourced to ensure that local authorities are funded adequately to undertake those responsibilities.
3. Scrutiny should not be included in the responsibilities of the Health and Wellbeing Board. The Board members, being responsible for overseeing the commissioning agenda and the provision of health improvement and social care, should not be placed in a position whereby they would, in effect, be scrutinising themselves.
4. Health Overview and Scrutiny Committees should be retained with all of their existing statutory powers being extended to cover all organisations involved in the provision of health services whether in the NHS, local government or the private sector.
5. The White Paper contains little reference to children. It is the HOSC's view that the Health and Wellbeing Boards should include representation from services for children as well as adults and older people.
6. If GPs are to undertake the role of being the main commissioners of health services they must be made statutorily accountable to local communities through elected representatives. This should also apply to Foundation Trusts

and Monitor. The NHS Commissioning Board will be unelected and too remote to undertake this role effectively and the HOSC should have the power to refer concerns to the Commissioning Board as well as to the Secretary of State.

7. It is important that GP commissioners should be adequately trained and resourced, in the widest possible meaning of this term, specifically to include time and administrative and clinical support.
8. There is a need for greater clarity around what would happen if the GP commissioning groups were to fail to carry out their clinical, managerial and/or financial responsibilities properly.
9. Legislation should be introduced to ensure that joint commissioning and pooled budgets are used effectively and appropriately wherever possible.
10. The role of HealthWatch, both national and local, and how it will work, must be clarified as should the issue of their funding. It is questionable whether the CQC will have the necessary expertise to oversee such a complex national organisation.
11. The costs of restructuring should not be detrimental to front-line services.
12. It has taken a number of years for co-terminosity to be established between local authorities and the NHS and the development of GP consortia threatens to undermine that. Steps should be taken to ensure that co-terminosity should be re-established as soon as possible.

Specific recommendations for bodies in Oxfordshire:

The HOSC:

I. Supports fully the recommendations of the Adult Services Scrutiny Committee (ASSC) and those of the Director of Public Health (DPH)
II. Requests that the Cabinet should endorse the comments above directed to the Secretary of State
III. Advises the Cabinet that the HOSC considers that:

- The high-level steering committee proposed by both the ASSC and the DPH should be led by the County Council and include major public sector stakeholders, in particular GP representatives, and elected members. It should be set up as soon as practicable and liaise with national and regional bodies as necessary. The committee's role would be to ensure that public sector organisations in Oxfordshire work closely together to further the development of a reconfigured NHS that will ensure the continuation and sustainability of high quality health services.
- The above committee could be developed subsequently into the Health and Wellbeing Board. The Board Chairman should be a Cabinet Member level appointment.
- The levels of joint working that already exist within Oxfordshire should be developed and improved further.
- The commissioning expertise that has been built up over many years by the County Council, much of it in joint commissioning with NHS colleagues, should be drawn upon in developing and providing support for the new GP consortia.

54/10 LESSONS FROM THE IRP REVIEW: THE IMPORTANCE OF COMMUNITY ENGAGEMENT

(Agenda No. 6)

The Better Healthcare Programme for Banbury and the surrounding area has been a major community engagement project. With the advent of the NHS White Paper, and talk of a 'Big Society', the Committee has wondered how can lessons learnt locally help to ensure that health services are designed and delivered with, and for, patients and the public? Julia Cartwright, Chair of the Community Partnership Forum, will share insights into the benefits of, and barriers to, collaborative working.

The Committee had before them a copy of Julia Cartwright's presentation entitled 'Lessons from an IRP Review: The importance of Community Engagement' is attached at **JHO6**.

The Committee thanked Julia Cartwright, Chairman of the Community Partnership Forum, for attending the meeting and for her insights to their questions on lessons which could be drawn from the IRP review in relation to community engagement, in light of the White Paper and talk of a Big Society. They congratulated her once again for her excellent leadership skills and the exemplary role she and members of the Forum played in co-ordinating the community response to the Horton proposals.

55/10 NUFFIELD ORTHOPAEDIC CENTRE (NOC) - UPDATE

(Agenda No. 7)

Jan Fowler, Chief Executive, Nuffield Orthopaedic Centre (NOC), together with Sarah Randall, Director of Operations & Performance, had been invited to speak to the Committee on the Centre's current position and its possible future.

Jan Fowler made the following points:

- She had been in discussion recently with the Chairman of this Committee and Roger Edwards;
- The last time she had attended the Committee it had been to discuss the underlying issues relating to a shortfall of £8.5m. Since then and significant amount of work had been undertaken and high levels of performance had been delivered;
- The Board had considered what would constitute the best clinical and financially sustainable service in the future which was most unique to the NOC, but also wide reaching;
- The decision to merge with the ORH to form a new acute organisation for Oxfordshire had been taken within the context of the NHS White Paper and its inherent financial pressures;
- There would be a new name, which was symbolic of the new organisation, but individual sites would retain the same name;
- The change was not about changing services – they would continue to be delivered from the present site – but there would be better resilience for the service;

- A new business case was now being developed which would be signed off by the Trust Boards at the beginning of next year. It would then need further approval by the SHA and finally by the DoH;
- A new Foundation Trust application would hopefully be submitted in 2012/13;
- The merger would be likely to happen in mid 2011;
- The NOC Trust Board had decided to run a public consultation from September to the end of November, even though the SHA had advised that this was not required. The NOC had very strong stakeholder support. The Chairman commented that whilst this Committee did not require the NOC to hold a public consultation, it required continuous informal consultation.

Questions asked, and issues raised by the Committee and responses received were as follows:

- What savings would be made by the merger? (response) There would be one Board. The NOC were already cross working with the ORH looking at opportunities to deliver improvements within a larger organisation – the merger would enable them to be provided more cost effectively. The NOC's contribution in the face of huge financial pressures have been made very clear to staff;
- What would you be consulting on? (response) Plans to create a clinical division within a bigger organisation which would work in a semi-autonomous way. An exploration of what it would look like and what is important to the clinicians;
- By merging, will the patients be seen quicker? (response) We will be working with the JR to support more complex cases. There will be a requirement to be confident that there is a strong clinical infrastructure in place. We will be streamlining trauma cases with the JR, giving better access for patients;
- Do you envisage sharing staff with the ORH? (response) Specialist staff will continue to provide services on site. We already share staff and give specialist support. There will be opportunities to look at pathways of patient experience with the ORH and identify where we can provide the expertise. We will be sharing skills across both organisations;
- Will the GP consortiums have an impact on the NOC? (response) This will be an opportunity to look at the patient pathways. Staff were coming up with ideas about how we can deliver services in a different way and how they can be better managed;
- Could the transport facilities be better organised? (response) This is a very valid point – we need to take that forward;
- What are the major threats and weaknesses to the new plans? (response) The major concern would be of staff recognising the ORH itself and impact on the current quality of services the NOC provides. The new Chief Executive of the ORH has a good track record of bringing organisations together. There will be much tension for staff, particularly for those working in corporate services as there will be some rationalisation;
- What is the total PFI repayments? (response) For the NOC it is £6m per annum, the ORH £34m in total. Approximately £40m per annum will be top sliced off the budgets. The NOC and the JR offer excellent facilities, but the

ability to generate savings will be limited. It is an issue and part of the challenges we face.

The Committee thanked the Chief Executive and the Director of Operations & Performance for attending and explaining the situation with regard to the merger with the ORH to form a new, acute organisation for Oxfordshire.

56/10 THE DISCHARGE OF PATIENTS FROM ACUTE HOSPITALS

(Agenda No. 8)

Representatives from Patient Voice (a group of members of the former Oxfordshire presented their report, which had been commissioned by the Oxfordshire LINk, on Discharge Procedures. Copies of the papers submitted by Patient Voice were attached at **JHO8**.

The Committee thanked the representatives from Patient Voice and from the Oxfordshire LINk for attending to present their report on discharge procedures from acute hospitals. They also thanked Susan Brown, Communications Manager for the ORH for her input to the discussion.

It was noted that the LINk were keen to revisit the recommendation in Spring, 2011 to ascertain whether the plans, systems and implementation had taken place. The LINk had also requested Patient Voice to carry out some research with regard to the quality of food, the appropriateness and presentation of food, and the enablement to eat accorded to patients, in an acute setting.

57/10 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 9)

Adrian Chant presented an update of the latest Oxfordshire LINk activity (**JHO9**).

The Committee thanked Adrian Chant for his report.

58/10 CHAIRMAN'S REPORT

(Agenda No. 10)

The Chairman reported on a number of meetings which he, the Deputy Chairman and Mr Edwards had attended. These included meetings with the Chief Executives of the Nuffield Orthopaedic Centre, the Oxford Radcliffe Hospitals Trust and the Oxfordshire Primary Care Trust.

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Date of signing ....

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NHS
Oxfordshire

Quality, Innovation, Productivity and Prevention Plan (QIPP) including Creating a Healthy Oxfordshire
Report to the Health Overview and Scrutiny Committee November 2010

1. Introduction

This short paper gives an overview of the scale of the financial challenge facing the NHS in Oxfordshire over the next three years. It outlines the main elements of the Quality, Innovation, Productivity and Prevention (QIPP) Plan which indicates the main areas of work being taken forward and the associated productivity gains.

2. Productivity Challenge for the NHS in Oxfordshire

The Comprehensive Spending review settlement increases overall NHS funding in real terms every year with a 0.4% increase in real terms by 2014/15. However the review acknowledges that the NHS will need to make efficiencies to deal with rising demand from an ageing population and the increased costs of new technology. At a national level the NHS has committed to make up to £20 billion of annual efficiency savings by the end of the Spending Review period

Within this national context the productivity challenge for the Oxfordshire system over the next few years is the combination of savings necessary to enable investment to fund demand increases and the delivery of the national efficiency target of 4.5% in main providers.

The challenge under a 3% demand growth assumption and a 4.5% national efficiency target is shown in the table below.

Oxfordshire System wide Productivity Challenge	2010/11	2011/12	2012/13	2013/14	Total
	£m	£m	£m	£m	£m
Base allocation to PCT 2010/11 including growth	873.68				
Pay and price pressure on 2010/11 base – pressure on tariff efficiency in providers		37.28	31.36	30.49	99.13
3% demand growth/pressure on 2010/11 base – commissioner pressure		26.47	26.74	27.01	80.22
Total Productivity Challenge		63.75	58.10	57.50	179.35

It is important to emphasise that over the three years of this plan the amount of money spent on services for Oxfordshire residents will increase slightly from the 2010/11 base of £874 million (the amount of additional funding will be known in December). The funding released through achieving the efficiency gains will be reinvested in services.

3. Quality, Innovation, Productivity and Prevention Plan

3.1 Introduction

Each PCT has produced a QIPP Plan. This builds on the work that the PCT has already completed, and consulted upon, in the development of the *NHS Oxfordshire Strategic Plan 2008-2013*[1].

The QIPP Plan replaces the annual strategy refresh process and will form the basis of further detailed work required for developing our 2011/12 Operational Plan. The QIPP Plan has enabled us to integrate work streams currently incorporated within the Creating A Healthy Oxfordshire (CAHO) Programme, as well as to reflect Provider Cost Improvement Plans (CIPs).

The resulting system wide plan therefore includes both the commissioning changes and provider plans, thereby ensuring that across the local health system the role of every organisation in delivering the level of change we need is understood and supported by all others.

3.2 Summary of Provider CIPs

£ millions	**2011/12**	**2012/13**	**2013/14**	**Total**
Providers*	**£m**	**£m**	**£m**	**£m**
Back office Efficiency	**2.96**	**2.33**	**2.07**	**7.36**
Procurement	**3.08**	**2.66**	**2.54**	**8.29**
Clinical Support Rationalisation	**0.18**	**0.11**	**0.06**	**0.35**
Staff Productivity	**25.28**	**21.43**	**20.79**	**67.50**
Medicines Use & Procurement	**1.23**	**1.03**	**1.00**	**3.26**
Other Provider efficiencies	**4.54**	**3.81**	**4.03**	**12.37**
Total	**37.28**	**31.36**	**30.49**	**99.13**

[1] Available on our website: www.oxfordshirepct.nh.uk

3.3 Commissioner Programmes of Work (including CAHO)

The table below summarises the contribution of the current commissioning work programmes to the required productivity improvement of £80million over three years. Further detail on the scope of the projects within each programme is included in the Appendix.

COMMISSIONING INITIATIVES	2011/12			2012/13			2013/14		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Impact of Initiatives on Commissioning Spend	Gross	Efficiency / Savings	Net	Gross	Efficiency / Savings	Net	Gross	Efficiency / Savings	Net
Planned Care	620	(7,266)	(6,646)	0	(4,875)	(4,875)	0	(4,320)	(4,320)
Quick & Responsive	1,288	(5,974)	(4,686)	110	(76)	34	110	(76)	34
Children & Young People - Maternity	360	(400)	(40)	400	(650)	(250)	150	0	150
Self Care & Patient Responsibility	2,721	(2,143)	578	2,253	(2,148)	105	976	(2,170)	(1,194)
Complex Needs	1,785	(2,400)	(615)	450	(624)	(174)	450	0	450
Integrated Community Service Provision	1,942	(2,647)	(705)	2,252	(1,979)	273	247	(1,764)	(1,517)
Mental Health	551	(706)	(155)	351	(281)	70	281	(281)	0
Acute	618	(2,520)	(1,902)	1,236	(5,721)	(4,485)	1,236	0	1,236
Enabling	1,228	(1,538)	(310)	2,856	(1,222)	1,634	1,190	0	1,190
Primary Care	200	(2,993)	(2,793)	0	(3,274)	(3,274)	0	(1,957)	(1,957)
Sub-Total	**11,313**	**(28,587)**	**(17,274)**	**9,908**	**(20,850)**	**(10,942)**	**4,640**	**(10,568)**	**(5,928)**
3% Demand based investment	27,050	0	27,050	27,219	0	27,219	27,466	0	27,466
Sub-Total	**27,050**	**0**	**27,050**	**27,219**	**0**	**27,219**	**27,466**	**0**	**27,466**
Unidentified Savings		(9,776)	(9,776)		(16,277)	(16,277)		(21,538)	(21,538)
Total	**38,363**	**(38,363)**	**0**	**37,127**	**(37,127)**	**0**	**32,106**	**(32,106)**	**0**
Note:			**0.77%**			**1.52%**			**2.26%**
Build up of 2% Headroom			***6,945***			***6,896***			***7,000***
Build up of 2% Headroom Cumulative						***13,841***			***20,841***

3.3 Underpinning Our Strategic Delivery: CAHO

Four of our ten work streams originate from the CAHO Programme; these are Self Care and Patient Responsibility, Primary Care, Integrated Community Services Provision and Acute.

The CAHO Programme is a medium/long term system wide programme, making stepped changes to create a better health and social care system for Oxfordshire, whilst responding to the strategic and fiscal challenge in the area.

The aims of the Programme are

- ✓ helping people to help themselves and prevent ill-health and hospital admissions
- ✓ integrating health and social care teams in the community to ensure patients can access the right treatment when they need it
- ✓ reviewing delivery of hospital care and bringing care closer to home, when it is clinically appropriate
- ✓ developing GP and associated services in the community
- ✓ reviewing the provision of services and treatments that are shown to be clinically ineffective and inefficient
- ✓ holding the system to account for delivery of identified service & financial plans

4. Conclusion

Though the NHS is receiving a real terms increase in funding over the next three years. However the NHS in Oxfordshire still needs to improve quality and make gains in productivity to release funding from current service provision to meet growing demand for services.

Catherine Mountford
Director of Strategy and Quality
NHS Oxfordshire
26 October 2010

Workstream & Initiatives	Description	Gross Savings £000's 11/12	12/13	13/14	Total
Self Care and Patient Responsibility Aligned to QIPP Theme: Prevention and Staying Healthy; Long Term Conditions	This workstream falls into two parts: 1. a public health led programme of screening, health checks, vaccination and weight management 2. a suite of projects designed to improve patient's ability to self manage	(2,143)	(2,148)	(2,170)	(6,461)
Breast Screening Age Extension	Expand screening programme from 50-70 year olds to 47-73 year olds				0
Bowel Screening full year pickup	Continue bowel screening programme for 60-69 year olds in Oxfordshire, age extending to 70-74 year olds after prevalent round complete				0
Weight Management Adults	Continue to develop the local programme and services for the prevention and treatment of adult Obesity				0
Abdominal Aortic Aneurysm Screening	Roll out the AAA screening programme across Oxfordshire once an agreed Vascular Network is in place and national pilot funding has been secured				0
NHS Health Checks programme	Develop and improve existing targeted CVD checks, depending on national policy direction				0
Increase Retinopathy screening	Continue to improve uptake of diabetic retinopathy screening in Oxfordshire				0
Increased Chlamydia Screening	The Oxfordshire Chlamydia Screening Programme will continue to be developed to ensure improvement in screening opportunities for young people aged 15-24 years so that long-term effects of the infection are reducec				0
Targeted testing for HCV and testing and vaccination of HBV (through pharmacies)	Pilot to perform 48 viral hepatitis tests amongst the highest at risk group to assess the feasibility and efficiency of providing on demand testing of primarily hepatitis c but also hepatitis b in a pharmacy setting for IVDUs in Oxfordshire	(14)	(19)	(41)	(74)
Telehealth COPD pilot	A pilot study using equipment and services used to remotely monitor ~150 COPD patients in their own home	(110)	(110)	(110)	(330)
telehealth for CHF patients	Mainstream application of remote vital signs monitoring for CHF patients	(104)	(104)	(104)	(312)
self management skills development programme	An extensive programme of self management skills development for clinicians, patients and carers	(1,915)	(1,915)	(1,915)	(5,745)
Personalised Health Plans	An expected output of initiative N is that staff trained will have the skills and abilities to help patients develop and deliver personalised health plans.				0
CVD and COPD pathway based self management	Review COPD and cardiac care pathways and ensure pathways deliver optimal opportunities for improved self management				0
Primary Care Aligned to QIPP Theme: Primary Care Commissioning; Contracting / Prescribing	Enable patients to access appropriate services in a setting closer to home, ensuring the services offered are of the highest quality and demonstrate efficiencies and productivity.	(2,993)	(3,274)	(1,957)	(8,224)
Driving efficiency in Primary Care	○ Develop productivity metrics ○ Review of enhanced services (ES) ○ Strengthen the contract monitoring functions ○ Develop a single point of delivery model for ES ○ Emergency Transport Avoidance ○ Patient access to online functions ○ Review of PMS contracts				0

Workstream & Initiatives	Description	Gross Savings £000's			
		11/12	12/13	13/14	Total
Driving Quality in Primary Care	○ Develop quality metrics / dashboards ○ Develop standard services and quality expectations ○ Develop partnership working arrangements with public health and prevention services	(972)	(627)	(610)	(2,209)
Strategic Development	○ Implement of models of shared practice management, back office functions and premises ○ Support a move towards larger practices ○ Develop of activity and population growth modelling				0
Pharmaceutical Needs Assessment	Used to determine the need for pharmacy services and control of entry to the market				0
Effective Medicines Management	○ Continue implementation of cost reduction schemes ○ Enhancing the use of community pharmacies ○ Reduction in waste medicines	(2,021)	(1,347)	(1,347)	(4,715)
Regional Enabling Group- Pathology Modernisation	Pathway rationalisation / improved efficiencies; manage workload, volumes of tests and requests through direct access and reducing waste		(1,300)		(1,300)
Integrated Community Service Provision (ICSP) Aligned to QIPP Theme: Long Term Conditions (inc. Learning Disabilities)	Development of locality based integrated teams covering health and social care needs, supported by community resource units and extending case management and enhanced self-care for people with LTC	(2,647)	(1,979)	(1,764)	(6,390)
Integrated Community Teams	Staff with skills to assess health and social needs, develop plans and deliver care .				0
Community Resource Units (CRUs)	Support the delivery of care in community settings, through access to diagnostics, diagnosis, treatment, consultation, planning, day services, bedded areas to provide 'sub acute' care.				0
Virtual Ward	Support people in care homes through better planning, earlier detection of deterioration and timely intervention	(810)			(810)
Community Respiratory Service	Review respiratory services and increase access to pulmonary rehabilitation for patients with COPD	(400)			(400)
Learning Disability	Re-commission Community Learning Disability Teams and specialist inpatient services	(1,283)	(1,314)	(1,337)	(3,934)
Implementation of Diabetes Service		(154)	(665)	(427)	(1,246)
Acute Care Aligned to QIPP Theme: Emergency /Acute care flows	Development of community hospital sub acute capacity as alternative level of care for patients currently occupying acute capacity	(2,520)	(5,721)	0	(8,241)
Integrated Community Team	Development of community hospital sub acute capacity as alternative level of care for patients currently occupying acute capacity	(2,520)	(5,721)		(8,241)
Quick and Responsive Aligned to QIPP Theme: Emergency & Acute Care Flows; EOL	Access to right high quality care, in right setting at right time in an emergency or need for urgent medical attention. More care outside hospital and close to home settings, so reducing unnecessary admissions to Secondary Care, A&E attendances excess bed days and lengths of stay	(5,974)	(76)	(76)	(6,126)
Care Outside Hospital					0
Virtual Ward	Under 'ICSP' workstream brief				0
Hospital at Home	Emergency multi disciplinary diagnosis and triage supporting adults safely in normal place of residence	(2,786)			(2,786)
Delayed Transfer of Care programme	Includes Community Hospitals & adult assessment & enablement service				0

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QIPP Programme of Work and Projects

Workstream & Initiatives	Description	Gross Savings £000's 11/12	12/13	13/14	Total
Integrated Front Door					0
Single point of Contact	24/7 single phone number to access all urgent care - linked to 'phone first' message and scheduling of urgent care.	(2,581)			(2,581)
GP Co-location	Primary Care Service co-located by A&E	(101)			(101)
Roving GP Service	GP 8/24 roving between A&E major and admissions units	(430)			(430)
End of Life Care					0
Rapid Response Service	Short term care at home in a crisis to prevent emergency admission				0
Matron service	Patients supported at home until death – jointly with Macmillan Care				0
Workforce development	Opportunities to access high quality staff education across all sectors to support EOL initiatives				0
Early identification of patients	Increased use of the Gold Standards Framework and linking up service systems				0
Bereavement review	Comprehensive review of current need and provision to inform developments				0
EOLC and dementia work-streams	Ensuring best outcomes for dementia patients at the eol				0
Advance planning development	Developing staff competencies in advance planning and record keeping processes and sharing				0
SARC – Sexual Assault Referral Centre	Immediate counselling and support, physical treatment and central resource for advice for clinicians	(76)	(76)	(76)	(228)
Complex Care Aligned to QIPP Theme: Right care; long term care; self care; continuing care; Mental health (for dementia)	Managing the over-reliance on acute hospital care and placements in intensive residential and nursing care by personalising care pathways redesign, re-focusing on rehabilitation and preventative services, using technology and integrating provision	(2,150)	(624)	0	(2,774)
Dementia	○ Early diagnosis for dementia ○ Improved dementia care in general hospitals ○ Targeting younger people with dementia, inc. learning disability ○ Older Peoples Mental Health Strategy ○ End of Life Care for Dementia	(287)	(574)		(861)
Stroke developments programme	○ Re-design of Acute pathway at the Horton ○ Stroke Rehabilitation Development ○ Long-Term Care for Stroke	(240)			(240)
Personal Health Budgets Pilot (PHB)	Implementation of Personal Health Budgets for people eligible for NHS continuing care				0
Continence services redesign	Re-design approach to delivering bowel and bladder services projects	(100)	(50)		(150)
Fragility Fracture pathway re-design	○ Development of integrated pathway ○ Pilot of new Hip fracture pathway ○ Secondary fragility fracture prevention ○ Fragility fracture treatment pathway ○ Non-conveyed fallers pilot	(1,523)			(1,523)
Development of responsive, skilled and productive rehabilitation	○ Development of a Whole System Model for Rehabilitation in Oxfordshire ○ Review of County Intermediate Care Services (Oxfordshire Access and Enablement services) ○ To commission an Older Peoples Exercise, Health & Wellbeing Service				0

Workstream & Initiatives	Description	Gross Savings £000's 11/12	12/13	13/14	Total
Carers	○ Early identification, recording and signposting of carers ○ "Carers awareness" training ○ Design and deliver preventative breaks/respite to carers through primary care teams				0
Excess bed days in the +65 age group	Reduce the number of excess bed days in individuals / conditions who do not require 24 hours consultant level care				0
Continuing Healthcare	Implement actions to address performance and reduce costs				0
Planned – Normal Care Aligned to QIPP Theme: Planned	Ensure that care pathways provide evidence based interventions that maximise overall health gain, deliver improved productivity and value for money	(3,625)	(1,685)	(1,100)	(6,410)
Threshold Management	Review and agreement of treatment thresholds	(1,338)	(350)	(400)	(2,088)
Embedding a Referral Management Culture	embedding robust referral management processes in primary care	(250)			(250)
Diagnostic Testing	○ Stopping tests of low clinical value ○ Changing the referral pathway (increasing/decreasing direct access) to support shifting activity from secondary care to the community	(500)	(500)	(500)	(1,500)
Productivity	○ Completion of work on outlying specialties ○ Direct booking onto day case lists for GPs. ○ Shift activity from daycase settings to outpatients and reducing OP activity (C2C) ○ Reducing number patients discharged from secondary care after one OP appt ○ Non-emergency patient transport – implement revised eligibility criteria ○ Ramsay (ISTC) utilisation	(1,537)	(835)	(200)	(2,572)
Planned - Specialist Care Aligned to QIPP Theme: Planned Care	Ensuring improved healthcare outcomes for people with specialist rare conditions and those with cancer, cardiac or neurological conditions by having the right treatment from the appropriate provider and by integration with non specialist services	(3,641)	(3,190)	(3,220)	(10,051)
Neurological Conditions	Improving access to Community Neurology Services to support individuals living with a LTnC.				0
Cancer	Establishing a Community Chemotherapy Service Meeting national NCAG recommendations in acute oncology Implementing LAEDI (cancer local awareness and early diagnosis initiative) Investing in increased radiotherapy fractions Reducing excess bed days via the Enhanced Recovery Programme (ERP). Implementing 23 Hours Stay Model for Breast Cancer Surgery and use of Drains as the exceptior	(284)			(284)
Cardiothoracic & vascular Services	Transferring Cardiac Rehabilitation to Community settings	(200)			(200)
Collaboration with South Central Specialist Commissioning Group (SCG)		(3,157)	(3,190)	(3,220)	(9,567)
Mental health Aligned to QIPP Theme: Mental Health	Ensuring people can stay well, that when they become unwell, they will get better quicker and effective and appropriate interventions will be delivered in a timely personalised way	(706)	(281)	(281)	(1,268)
Keeping People Well - KPW:	Universal Well-Being service offering stepped care according to need and structured recovery service				0
Supported to Independent Living – SIL (includes ERMO & Aspergers):	Provide clear housing pathway to recovery and independence with alignment of funding	(496)	(281)	(281)	(1,058)

Appendix 2 V2 - QIPP Plan Sep 2010
QIPP Programme of Work and Projects

JHO8

Workstream & Initiatives	Description	Gross Savings £000's 11/12	12/13	13/14	Total
Maximising Recovery Interventions and Outcomes - MaRIO (includes IAPT Phase 2):	Creating a clearer pathway through clinical services from early onset of symptoms to recovery	(210)			(210)
Improving Health & Well Being for All:	To promote mental well-being and prevent mild to moderate mental ill health				0
C&YP Aligned to QIPP Theme: Child health	Coordinated and integrated health and social care for infants, children, young people and their families in safe and familiar settings	(400)	(650)	0	(1,050)
Redesigning Paediatrics Services	Improving Urgent Care pathway & Expansion of Children's Community Nursing services	(250)	(400)		(650)
Community Equipment	Improving access for Children with Complex needs/disabilities placed either in or out of county who are Looked After Children				0
Children's Continuing Healthcare and cost-effective placements		(150)	(250)		(400)
Prevention and Early Intervention	Implementing Healthy Child Programme and safeguarding Weight management schemes Improving health outcomes by reducing the impact of risky behaviours Review and Improve the care pathway for young people who self harm Alcohol Initiatives Reducing inequalities in oral health in children				0
Maternity & Newborn Aligned to QIPP Theme: Maternity & Newborn	Modernising maternity services to ensure best clinical outcomes and a safe, sustainable and affordable maternity workforce	0	0	0	0
Reducing C-Section rates	Reducing variation rates across sites				0
Reducing unscheduled care	Adopt minimum set of operational standards, agree contract activity and standard service specification				0
Sustainable Maternity Workforce	Outcomes approach to workforce modelling and detailed work on skill mix, role definition and redesign				0
Enabling Aligned to QIPP Theme: System Enablers	System enablers	(1,538)	(1,222)	0	(2,760)
Review capacity and capability of workforce		(1,538)	(1,222)		(2,760)

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