Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 12 September 2024 at 10.00 am

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings online, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Membership

Chair - Councillor Jane Hanna OBE
Deputy Chair – Katherine Keats Rohan

Councillors:	Nigel Champken-Woods	Nick Leverton	Freddie van Mierlo
	Jenny Hannaby	Michael O'Connor	Mark Lygo
District Councillors:	Paul Barrow	Dorothy Walker	Elizabeth Poskitt
	Susanna Pressel		
Co-optees:	Barbara Shaw		

Date of next meeting: *21 November 2024*

Notes:

For more information about this Committee please contact:		
Scrutiny Officer	-	*Email: scrutiny @oxfordshire.gov.uk*
Committee Officer	-	*Scrutiny Team* *Email: Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

September 2024

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 no later than 9 am on the working day before the date of the meeting.**

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 - 10)

To approve the minutes of the meeting held on 02 August 2024, and to receive information arising from them.

The Committee is recommended to **AGREE** the minutes as an accurate record having raised any necessary amendments.

4. Speaking to or Petitioning the Committee

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection.

To facilitate 'hybrid' meetings we are asking that requests to speak or present a petition are submitted by no later than 9am four working days before the meeting i.e., 9am on Friday 6th September. Requests to speak should be sent to scrutiny@oxfordshire.gov.uk and omid.nouri@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that your views are taken into account. A written copy of your statement can be provided no later than 9am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

5. Chair's Update (Pages 11 - 18)

Cllr Hanna will provide a verbal update on relevant issues since the last meeting.

There are two documents attached to this item:

1. A report containing recommendations from the Committee on Palliative Care Provision in Oxfordshire.

2. A brief statement from the BOB Integrated Care Board Director of Urgent and Emergency Care for Oxfordshire, which outlines the redesignation of the Urgent care centres on the Horton General Hospital and John Radcliffe hospital sites.

The Committee is recommended to **NOTE** the Chair's update having raised any relevant questions.

In addition, no details of the outcomes of discussions between the Council and BOB ICB in regards to the latter's restructure since the last HOSC meeting have been submitted. Stephen Chandler will be invited to update the Committee on the current situation.

6. Warneford Park Hospital Redevelopment Project (Pages 19 - 22)

The Oxfordshire Joint Health Overview Scrutiny Committee has been closely involved in scrutinising and reviewing the Warneford Park Hospital Redevelopment Project. Oxford Health NHS Foundation Trust have approached the JHOSC with a view to brief the Committee on the proposals for the redevelopment, as well as to seek endorsement and support for the Trust's bid for government funding to redevelop the hospital.

The purpose of this item is two fold:

1. For the Committee to **AGREE** to the HOSC endorsement report (which is attached as a document to this item in the agenda papers). This endorsement report will then be sent to Oxford Health NHS Foundation Trust to support the bid for funding from government to redevelop the hospital.

2. For the Committee to **AGREE** that the Warneford Redevelopment Project does NOT constitute a Substantial Change.

7. Response to HOSC Recommendations (Pages 23 - 30)

The Committee has received Acceptances and Responses to recommendations made as part of the following items:

1. GP provision in Oxfordshire (held during the 18 April 2024 HOSC meeting).

2. Integrated Neighbourhood Teams in Oxfordshire (held during the 06 June 2024 HOSC meeting).

The Committee is recommended to **NOTE** the responses.

8. Winter Planning (Pages 31 - 60)

Dan Leveson (BOB ICB – Place Director, Oxfordshire) and Lily O' Connor (BOB ICB Programme Director Urgent and Emergency Care for Oxfordshire), have been invited to present a report on winter preparedness.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

9. Adult and Older Adult Mental Health in Oxfordshire (Pages 61 - 76)

Rachel Corser (Chief Nursing Officer BOB Integrated Care Board) and Dan Leveson (BOB Integrated Care Board Oxfordshire Place Director) have been invited to present a report on Adult and Older Adult Mental Health in Oxfordshire. Also invited to be in attendance are: Chris Wright (Assistant Director of Partnership Development, BOB Integrated Care Board) Catherine Sage, Lola Martos (Head of Adult Services OUH NHS FT), Manny Jhawar-Gill (Commissioning Manager, Adult Social Care, OCC) and Pippa Corner (Deputy Director of Commissioning, Adult Social Care, OCC).

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

10. Healthwatch Oxfordshire Update Report (Pages 77 - 86)

Veronica Barry, Executive Director of Healthwatch Oxfordshire will present the Healthwatch update report.

The Committee is invited to consider the report and **NOTE** it having raised any questions arising from the contents.

11. Medicine Shortages (Pages 87 - 106)

To receive and discuss a report on Medicine Shortages and its impacts on Oxfordshire.

The following people have been invited to attend and present the report: Julie Dandridge (Head of Primary Care Infrastructure, Head of Pharmacy, Optometry and Dentistry, Lead for Primary Care across Oxfordshire BOB Integrated Care Board), Claire Critchley (Medicines Optimisation Lead Pharmacist, BOB Integrated Care Board), David Dean (Chief Executive Officer, Community Pharmacy Thames Valley), and Bhulesh Vadher (Clinical Director of Pharmacy and Medicines Management, Oxford University NHS Hospital Trust)

There are THREE documents attached to this item:

1. A report from the ICB on medicine shortages.

2. A report from OUH on medicine shortages

3. A statement on medicine shortages from Dr Leyla Hannbeck (Chief Executive of the Independent Pharmacies Association).

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

12. Epilepsy Services Update (Pages 107 - 124)

The Committee will discuss a report from the NHS on the current state of Epilepsy Services within Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

NB Please note that there is a statement from NHS England on this topic, which follows the main report.

13. Forward Work Plan (Pages 125 - 128)

To **AGREE** the Committee's proposed work programme for its upcoming meetings.

14. Actions and Recommendations Tracker (Pages 129 - 184)

The Committee is recommended to **NOTE** the progress made against agreed actions and recommendations having raised any questions.

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Friday, 2 August 2024 commencing at 11.00 am and finishing at 3.20 pm

Present:

Voting Members: District Councillor Katharine Keats-Rohan – in the Chair

Cllr Jane Hanna (present virtually)
Cllr Jenny Hannaby (present virtually
Councillor Nick Leverton
Councillor Freddie van Mierlo
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Susanna Pressel
Councillor Joy Aitman
Cllr Dorothy Walker
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Co-opted Members: Barbara Shaw

Other Members in Attendance: Councillor Damian Haywood

By Invitation:

Officers:

- Hannah Iqbal- BOB ICB Chief Strategy and Partnerships Officer.
- Matthew Tait- BOB ICB Chief Delivery Officer.
- Stephen Chandler- Executive Director, People and Transformation, OCC.
- Ansaf Azhar – Director of Public Health, OCC.
- Sylvia Buckingham- Trustee for Healthwatch Oxfordshire.
- Olly Glover- MP for Didcot and Wantage.
- Dr Michelle Brennan- GP and chair of Oxfordshire GP Leadership Group.

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

51/24 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

The following members tendered their apologies:

Cllr Nigel Champken-Woods

The following members were not able to attend in person but attended virtually (meaning they verbally participated in the discussions although were not permitted to formally contribute to decisions or recommendations made by the Committee):

Cllr Jane Hanna
Cllr Jenny Hannaby

52/24 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

No declarations of interest made.

53/24 MINUTES
(Agenda No. 3)

The minutes of the committee's meeting on 6 June 2024 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record of proceedings and that the Chair should sign them as such.

54/24 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

The Chair invited the registered speakers to address the Committee.

1. **Statement by Olly Glover, MP for Didcot and Wantage:**
Glover expressed his concerns about the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's (BOB ICB) proposed reorganisation. He found the proposal difficult to follow due to its jargon-heavy nature and lack of clear diagrams. Glover focused his remarks on the needs of the Didcot and Wantage constituency, highlighting his worries about the removal of a dedicated director position for place and joint commissioning for Oxfordshire. He feared this change would dilute the focus on Oxfordshire's specific needs and create misalignment with the County Council.

Glover also criticised the lack of proper consultation time, especially since the proposals were introduced during the summer when many people were away. He pointed out the exceptional population growth in Didcot, Wantage, Grove, and Wallingford, which had strained local healthcare services; including general practice, community pharmacy, and NHS dentistry. He praised the progress made by the Committee and the ICB Director of Place in addressing urgent care needs and prioritising projects like the new GP surgery in Didcot and the refurbishment of Wantage Community Hospital.

Glover concluded by expressing his hope that the new restructure would not undermine the promises made to local residents and urged for reassurance that efforts to protect progress in Oxfordshire would continue.

2. Dr Michelle Brennan

Dr Michelle Brennan, Chair of the Oxfordshire GP Leadership Group, acknowledged the potential for legislative changes to provide a platform for improvement but stressed that these alone could not facilitate the necessary cultural and systemic changes. She noted that Oxfordshire had many excellent individual providers but had historically struggled with system-wide collaboration, resulting in complex and difficult-to-navigate healthcare services.

She viewed the establishment of Integrated Care Systems (ICS) and place-based partnerships as an opportunity for collaborative work to improve health outcomes, practice sustainability, and staff well-being. However, she expressed concern that the proposed operating model represented a shift towards centralisation, which she believed was contrary to the principles of subsidiarity and the current political vision. Dr Brennan feared that the hierarchical model would fail to support the transformational changes needed to meet residents' needs.

She praised the progress made by the place-based partnership, particularly the development of urgent treatment centres and integrated neighbourhood teams. Dr Brennan emphasised the importance of maintaining clinical leadership within the ICB to address local health inequalities and drive local projects. She warned that a reduction in clinical leadership and corporate knowledge posed a critical risk to the organisation's effectiveness.

Dr Brennan concluded by stressing the need for a proactive health system focused on prevention rather than a reactive one. She called for a balanced approach, with some initiatives led at the ICB level and others at the place and neighbourhood levels, to ensure the development of the ICS.

3. Sylvia Buckingham

Sylvia Buckingham, a trustee and former Chair of Healthwatch Oxfordshire, welcomed the model's renewed emphasis on working with people and communities and the commitment to allocate more resources to support this aim. Sylvia highlighted the importance of closer communication and engagement with the public and patients, as well as clearer information from BOB ICB to enable effective support and navigation of healthcare services.

She stressed the need for transparency and accountability in decision-making and noted that while the ICB's role and purpose were positive and clear, there was less emphasis on building relationships and supporting integrated care. Sylvia called for clearer communication pathways into BOB ICB for Healthwatch and other organisations to fulfil their roles in supporting the patient voice.

She emphasised the importance of resourcing relationships at the place level and praised the significant progress made by the Oxfordshire Place-based Partnership in integrated working. Sylvia expressed concern that the proposed model's shift towards

centralisation and the potential loss of local place directors would undermine local working and the ability to tackle healthcare inequalities. She concluded by advocating for strong relationships to support health and care systems at the neighbourhood level and warned against the detrimental impact of centralising functions previously managed at the place level.

Contributions from Absent Speakers

Two contributions were read out from individuals who could not attend:

1. Laura Price

Laura Price, representing the joint Oxfordshire Voluntary, Community and Social Enterprise (VCSE) sector, expressed concerns about the proposed changes to the BOB ICB operating model. She highlighted that these changes would significantly impact the relationship that VCSE organisations in Oxfordshire had built with the ICB. Laura emphasised the importance of the role of the Director of Place for Oxfordshire, noting that this position had been crucial in fostering rapid progress in relationship building and collaboration. She cited examples of successful initiatives, such as the whole system approach to physical activity, which had reached 12,000 people and saved 8,100 GP appointments, and the Well Together programme, which had funded over 75 grassroots community groups.

She acknowledged the need for financial sustainability and the benefits of working across a wider geography but stressed that for local residents and community organisations, the term “BOB” was meaningless. Laura argued that without a local voice at a strategic level, it would be impossible for the VCSE sector to find a route into the system, and the ICB would struggle to unlock the potential of the sector to co-produce solutions to health service challenges. She urged the ICB not to dismantle the role of the place-based director, warning that it would undermine the progress made in Oxfordshire.

2. Doctor Simon Morris

Dr Simon Morris, representing Wallingford Primary Care Network (PCN), expressed concerns about the proposed changes to the ICB operating model. He highlighted the potential negative impact on primary care estate improvements, particularly for Wallingford Medical Practice, where he is a full-time GP and partner.

Dr Morris emphasised the dire state of the current premises, which were significantly undersized and inadequate to meet the growing demand due to local housing developments and an ageing population. He noted that the practice had already ceased some services due to space constraints and was operating out of converted storage rooms. He stressed the importance of the ongoing plans to relocate to a new building, which had made significant progress, including securing a valuable site from a local developer and support from various stakeholders.

He warned that the proposed ICB changes could stall these improvements, which would be harmful to primary care provision and negatively impact patient health and welfare. Dr Morris urged that any restructuring should not make it more difficult to

improve primary care estate, highlighting the critical need for investment in this area to ensure the sustainability and quality of services.

55/24 BUCKINGHAMSHIRE, OXFORDSHIRE, AND BERKSHIRE WEST INTEGRATED CARE BOARD PROPOSED NEW STRUCTURE AND OPERATING MODEL

(Agenda No. 5)

Matthew Tate (Chief Delivery Officer), and Hannah Iqbal (Chief Strategy and Partnership Officer), attended the meeting as representatives of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB).

The Chief Delivery Officer highlighted that the consultation process with staff was ongoing, and that partner engagement was being actively sought. He acknowledged the concerns raised by various stakeholders about the potential impact of the restructure on place-based partnerships and service delivery. He assured the attendees that the feedback received would be carefully considered and that the final proposals would reflect the input from both staff and partners.

The Chief Delivery Officer explained the context and necessity of the restructuring. He highlighted that the ICB was required to reduce its running costs by 30%, which prompted a review of their management structures. This review aimed to drive economies of scale and ensure the ICB could address strategic challenges more effectively.

The Chief Delivery Officer outlined that the initial set of structures proposed in April had received significant feedback, particularly concerning the clarity of the operating model and the potential transfer of staff to other organisations. This feedback, combined with the ICB's need to sign off a deficit position of £60 million, led to a revised set of proposals. These new proposals aimed to strengthen internal functions, such as finance and Continuing Healthcare (CHC), to better control and understand strategic issues.

The Chief Delivery Officer acknowledged the significant progress made by the place directors and the importance of maintaining strong relationships and collaborative working at the local level. He suggested that the new model could involve different leadership arrangements, with partners stepping into some of the roles previously held by ICB staff. He reiterated the commitment to supporting place-based partnerships and ensuring that the restructure would not undermine the progress made.

The Chief Strategy and Partnership Officer added context to the partnership development and collaboration aspects. She emphasised that the changes were not about altering service priorities or collaborative intent but were focused on management structures. She acknowledged the difficulty in balancing the consultation process with staff and the engagement with partners, given the sensitivity around potential redundancies.

The Executive Director of People in Oxfordshire County Council expressed his pride in the Oxfordshire contingent and his respect for the representatives from the BOB ICB. He provided a brief background of his career, highlighting his experience in the NHS and local government, emphasising the importance of collaborative work to achieve meaningful impacts on people's lives.

He discussed the BOB ICB's consultation document, agreeing with the importance of ICBs and their role as system leaders. The Executive Director stressed the need to balance system-level benefits with the individuality of place. He pointed out that Oxfordshire's integrated health and care system, supported by a significant pooled budget, was unique within the BOB footprint and required adequate resources to maintain its effectiveness. He expressed concerns about the proposals in the consultation document, questioning their alignment with the policy goals of integrated care systems.

He raised specific concerns about the engagement process, arguing that it was insufficient given the scale of the proposed changes. The Executive Director highlighted the integrated nature of Oxfordshire's commissioning arrangements and the potential risks to progress from the proposed changes. He emphasised the importance of the role of system conveners in fostering partnerships and innovation.
The Executive Director also addressed concerns about centralisation, arguing that local performance delivery was crucial, and that centralisation could undermine successful local initiatives, particularly in urgent care. He cited examples of effective local collaboration in reducing hospital discharge delays and improving patient outcomes.

The Director of Public Health at Oxfordshire County Council articulated the significant impact of local initiatives on the health and well-being outcomes of Oxfordshire residents. He emphasised the importance of understanding local populations to deliver tailored outcomes, highlighting the Community Board profiles work, which delved into the ten most deprived areas to identify their specific needs and assets. This approach revealed that while public health challenges were similar across communities, solutions needed to be customised to each community's unique context. He expressed concern over standardisation, arguing that localised approaches were crucial for effective public health interventions.

The Director of Public Health co-chaired the Health Inequality Forum for Oxfordshire Place, which brought together partners across organisational boundaries to address health inequalities. He cited the Move Together programme as an example of a successful initiative that improved physical activity in local communities and reduced GP appointments, demonstrating the importance of place-based initiatives in reducing demand on frontline services.

He warned against the potential negative impact of centralising services and reducing staff, which could undermine local initiatives that had shown significant improvements in health outcomes and cost savings. The Director also highlighted the role of the Health and Wellbeing Board, which had recently refreshed its strategy with input from all partners. He raised concerns about maintaining senior representation and effective delivery of the strategy across multiple local authorities under the new structure. He stressed the importance of the Joint Strategic Needs Assessment in

informing the health and wellbeing strategy and the need for continued collaboration across organisational boundaries.

He expressed concerns about infection prevention, particularly in light of the COVID inquiry report, which highlighted systemic unpreparedness for pandemics. He criticised the reduction of infection prevention staff at the local level, arguing that it contradicted the lessons learned from the pandemic. He emphasised the need for local capacity to manage outbreaks and emerging infections, such as measles and pertussis, which had seen increased prevalence due to reduced screening uptake post-pandemic.

The Committee began by questioning the lack of early engagement with partners and the short consultation period. They expressed concerns that the limited timeframe for consultation might not allow for comprehensive feedback from all stakeholders. The Chief Delivery Officer responded by acknowledging the tight timeline but emphasised that the ICB had made efforts to engage with key partners and gather input, and that they had received an extraordinary amount of feedback that suggested the timeframe was not inhibitive. He assured the Committee that the feedback received would be carefully considered in the final decision-making process.

The Chief Strategy and Partnership Officer added that feedback had been received from various partners, including Healthwatch, voluntary sector organisations, and primary care networks. Partners were notified of the proposed changes later than internal staff in order to allow staff to process the changes and potential redundancies.

The Committee expressed concerns about the short period for public and partner consultation, questioning whether the legal obligations for public involvement had been fully complied with. The Chief Strategy and Partnership Officer explained that the consultation was a management restructure, not a service change, and therefore different rules applied. They acknowledged the need for better partner engagement and admitted that there were lessons to be learned.

The Committee raised concerns about the potential impact on urgent care delivery in Oxfordshire, given the proposed changes to the resource supporting this area. They emphasised the importance of local knowledge and relationships in making improvements. The Chief Delivery Officer acknowledged the concerns and assured that the new model would support place-based change, and mentioned that the feedback might lead to changes in the proposed structures.

The Committee inquired about the alignment of the proposed restructuring with the national agenda on health and social care. They sought clarification on how the changes would support the broader goals of the NHS and the government's health policies. The Chief Delivery Officer explained that the restructuring was designed to enhance the ICB's strategic capabilities and ensure better alignment with national priorities. It was also highlighted that the changes aimed to improve efficiency and effectiveness in delivering health services while maintaining a strong focus on local needs.

The Committee raised a question regarding the substantial change toolkit, specifically addressing the lack of its completion by the ICB. The question highlighted that the toolkit had been sent to the ICB in July, shortly after the Committee learned about the proposed changes. In response, the Chief Strategy and Partnership Officer acknowledged that it was a mistake on their part not to have completed the toolkit. They were unaware that it had been sent and expressed willingness to rectify this oversight. The Chief Strategy and Partnership Officer committed to filling in the toolkit and completing it early the following week. They also reiterated the ICB's commitment to transparency and the importance of the substantial change toolkit in facilitating scrutiny by the Committee.

The Committee questioned the capacity of the new structure to support place-based partnerships, given the reduction in the number of place directors. They expressed concerns about the ability of a centralised approach to address local needs effectively. The representatives from BOB ICB explained that the new structure would involve a mix of dedicated support and centralised teams, with a focus on strategic insight and capability. They acknowledged the concerns and stated that the feedback would be considered to ensure the new model supports effective local delivery.

The Committee also raised concerns about the capacity to continue progress on primary care estates and safeguarding. They questioned whether the proposed centralisation would impact ongoing projects and the ability to address safeguarding issues effectively. The Chief Delivery Officer reassured the Committee that the ICB remained committed to these priorities and that the restructuring would not hinder progress. He emphasised that the changes were intended to streamline management structures and improve overall service delivery.

The Committee addressed issues related to infection control and antibiotic stewardship. They were particularly concerned about the potential impact of centralising public health functions on these critical areas. The Chief Delivery Officer acknowledged there were opportunities to operate and learn at scale, particularly in linking with emergency response models to address specific areas effectively. The Chief Nursing Officer at BOB ICB had directly discussed some of the highlighted risks with the Director of Public Health and had been working on ways to mitigate these risks.

The Committee also highlighted the importance of maintaining progress on the Wantage Community Hospital implementation plan. They sought assurances that the restructuring would not delay or disrupt the implementation of this plan. The Chief Delivery Officer confirmed that the ICB was fully committed to the Wantage Community Hospital project. He emphasised that the ICB would continue to prioritise local health infrastructure projects and ensure their successful completion.

The Committee inquired about the future relationship between the ICB and scrutiny, particularly in light of the proposed removal of the place directors who had been key points of contact. In response, the Chief Delivery Officer reiterated the commitment to ensuring effective place-based partnerships. They explained that while the place directors' roles were being restructured, there would still be dedicated senior posts focused on place-based functions. These roles would continue to be embedded in place-based partnership structures, health and wellbeing boards, and scrutiny

processes. The Chief Delivery Officer also mentioned the possibility of having executive sponsors to support place dynamics, ensuring that there was clear executive leadership involved in these areas. They highlighted the importance of strategic alignment across all scrutiny bodies.

The Committee **AGREED** to issue the following recommendations:

1. That the ICB proposed restructure constitutes a substantial change.

2. To **DELEGATE** to the Health Scrutiny Officer, in consultation and with the support of the Chair and the Executive Director for People & Transformation at Oxfordshire County Council, to write to the Secretary of State for Health and Social Care to request a call-in in relation to the ICB restructuring proposals unless:
    a. The ICB addresses the key asks made by the Oxfordshire Place-Based Partnership by 18th August 2024, and
    b. It is deemed that a local resolution has been reached.

56/24 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 6)

The Committee had received acceptances and responses to all the recommendations made to Oxford Health NHS Foundation Trust regarding the Trust's quality account, which was discussed during the meeting on 06 June 2024. The Health Scrutiny Officer reminded the Committee that these were not merely requests for additional information to be included in the quality account, but actual recommendations directed towards the Trust.

The Committee **NOTED** the responses to the recommendations.

57/24 CHAIR'S UPDATE

(Agenda No. 7)

The Committee Chair outlined the following points to update the Committee on developments since the previous meeting:

- A HOSC report containing recommendations from the Committee on Integrated Neighbourhood Teams in Oxfordshire, discussed in the June meeting, had been published in the agenda papers for this meeting.

- The Committee had a planned site visit to the John Radcliffe Hospital, focusing on patient safety, and received detailed and interesting insights into the Trust's steps and projects to improve patient safety.

- The Committee received a briefing from Oxford University Hospitals NHS Foundation Trust regarding the CQC inspection of maternity services at the Horton. The topic of maternity services throughout Oxfordshire was broadly discussed and would be revisited as part of the forward plan agreed at the June meeting.

- The HOSC working group examining the Oxford Community Health Hubs Project met with senior representatives of Oxford Health NHS Foundation Trust and discussed key progress made on the project, which was found to be extremely useful.

The Committee **NOTED** the Chair's Update.

58/24 FORWARD WORK PROGRAMME

(Agenda No. 8)

The Committee **AGREED** the forward work plan.

59/24 ACTIONS AND RECOMMENDATIONS TRACKER

(Agenda No. 9)

The Committee **NOTED** the progress made against agreed actions and recommendations.

..... in the Chair

Date of signing .....

OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Palliative/End of Life Care in Oxfordshire:

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 06 June 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on palliative care in Oxfordshire.

2. The Committee felt it crucial to receive an update on the developments around the RIPEL project as well as the state of palliative care services more broadly. The Committee also sought to assess the degree to which system partners were working collaboratively to deliver and improve palliative care.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of palliative or end of life care services being provided to patients, including in their own homes and localities. When commissioning this report on palliative care, some of the insights that the Committee sought to receive were as follows:

   - The geographical spread of palliative care services, and how these operate Countywide.
   - The resources, support, or budgets being allocated for palliative care services by the ICB.
   - The degree to which the RIPEL project has proven effective since the previous year, and whether sustainable sources of funding have been secured for its continuation.
   - The status and the future of palliative care to be delivered in Wantage (in light of the NHS's expressed commitments to providing palliative care services in the context of the public engagement exercise around the future of Wantage Community Hospital).

SUMMARY

4. The Committee would like to express thanks to Dr Victoria Bradley (Consultant in and Clinical Lead for Palliative Medicine Oxford University Hospitals NHS Foundation Trust); Kerri Packwood (Programme Manager for RIPEL at Oxford University Hospitals NHS Foundation Trust); Karen Fuller (Director of Adult Social Care); and Dan Leveson (BOB ICB Place Director for Oxfordshire); for

attending this meeting item on 06 June 2024 and for answering questions from the Committee.

5. The Clinical Lead for and Consultant in Palliative Medicine provided an update on the project's progress and achievements, and highlighted the significant improvements made in patient and family experiences due to the specialist services introduced over the past two years. These improvements were attributed to funding from Macmillan and the Sobell House Hospice charity, which had enabled much-needed advancements in palliative care. Despite challenging financial circumstances, the service had managed to save more resources within the system than it spent. She emphasised the profound impact of enabling patients to die at home, in accordance with their wishes, rather than in less preferred environments.

6. The Committee asked about the involvement of the community and stakeholders, and how deeply coproduction was embedded in the service design. The Clinical Lead acknowledged that while the service had always prided itself on being close to the community, there had been limited formal coproduction in the initial setup due to the speed required to implement changes. Moving forward, there was a strong emphasis on involving patients, families, and bereaved relatives in a more structured manner. This approach aimed to ensure that future service developments were closely aligned with the needs and preferences of those directly affected.

7. The Committee raised a question about the underutilisation of palliative care services by ethnic minority groups. The Clinical Lead explained that an Equality Diversity Inclusion Officer, funded by charity partners, was actively working to identify key groups and engage with them to understand and address barriers to service access. This included outreach efforts to culturally specific communities, such as the mosque in Banbury, to discuss culturally competent end-of-life care.

8. The Committee enquired about the justification for not extending the palliative care hub hours beyond the standard 9 AM to 5 PM. The Clinical Lead explained that while recognising that health crises occur outside regular working hours, pilot projects had shown minimal demand for extended hours. Embedding a specialist nurse within the Oxford Health single point of access from 5 PM to 8 PM resulted in very few additional calls, indicating that resources could be more effectively allocated elsewhere.

9. The Committee asked whether there was any additional support to pilot dedicated palliative transport services, and how confident the Trust was that they could access the resources for this. The Clinical Lead highlighted the significant distress caused by long waits for ambulance services, particularly for patients needing urgent transfers to hospices or their homes. To alleviate this, a pilot scheme funded by Sobell House was proposed to provide dedicated transportation options, aiming to improve patient and family experiences and assess the feasibility of long-term implementation.

10. The Committee asked about the relationship between palliative care services and care homes, and how contact was initiated. The Clinical Lead explained that the service maintained close ties with care homes, offering support through various means, including direct referrals and training for care home staff. The goal was to ensure that both patients and their families were aware of the available palliative care options and how to access them.

11. The Committee asked how confident the Trust were in securing ongoing and sustainable financial support for RIPEL from June 2025 onwards. It was responded that despite the project's demonstrated cost-effectiveness, securing continuous funding remained a challenge. Discussions with the ICB and other partners were ongoing to develop a sustainable business case for the project's continuation.

12. The Committee enquired how the Trust would increase support for carers and whether any specific areas of improvement had been identified. The Clinical Lead outlined ongoing research to better understand the needs of unpaid carers and the various support tools available. The aim was to ensure that carers were aware of the professional and community resources at their disposal, acknowledging the invaluable role they play in patient care.

13. The Committee asked about the status of the HOSC recommendations for improving palliative care services in Wantage, particularly regarding the provision of crisis palliative care beds. The Program Lead explained that the focus was on ensuring that community beds were generalist-led but specialist-supported, as demonstrated by the model implemented at Wallingford. Discussions were ongoing to determine the best approach for meeting the needs of the Wantage community.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are 3 key points/themes of observation that the Committee has in relation to palliative care in Oxfordshire. These 3 key points of observation relate to some of the themes of discussion during the meeting on 06 June, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

> ***Support for carers:*** The Committee is pleased that there is ongoing research to further understand the needs of unpaid carers and the various support tools that are available to them. It is vital that carers are well familiarised with the professional as well as the community resources available to them. Carers play a substantial contributing role in palliative care, and this should be acknowledged by the system. A key way in which the system can acknowledge the role of carers is through both making them well aware of what support there is available, and through increasing the actual support available to them. Carers are at the frontline of ensuring that palliative care patients are receiving the support that they require with their physical needs. Additionally, the system

should also acknowledge the powerful role that carers play in supporting the mental health and emotional wellbeing of patients. Often, palliative care patients can feel a sense of loneliness or potentially even abandonment. Having carers that are well supported and trained could help these patients feel reassured that they have not been forgotten and that their physical and mental needs are being catered for.

It is important to consider that carers may feel very adamant on providing the support that they do to patients, but that they may also lack the tools or skills to be able to do so. Having adequate support mechanisms in place can help to overcome this predicament and could boost the confidence and morale of carers, which can have a knock-on positive effect on the patients they care for.

The Committee therefore recommends that carers receive as much guidance as possible. This guidance can also take the form of specific training courses that could help inform carers as to how to best perform their duties as well as how to access any available support. It is also crucial that guidance for carers is available in as many languages as possible so as to cater for the ethnic diversity of carers.

Furthermore, the government's roadmap for adult social care data, as well as the NHS Long Term Plan, have both emphasised the importance of more data to help in identifying carers, as well as to understand the extent to which they are being supported effectively. By improving the recording and collection of data, the system could be in a better position to identify the unpaid carers who may be in the most need of support. This could also help to develop a stronger understanding of what the needs of these carers (and the needs of those they care for) may be, and could therefore enable the delivery of more targeted support.

Recommendation 1: *To ensure that carers receive the necessary guidance as well as support in being able to maximise the support they provide to palliative care patients.*

Sustainability of funding and resources: Upon scrutinising palliative care in an item in its June 2023 meeting, the Committee urged that sustainable sources of funding are secured for the continuation of the palliative care work provided in the context of the RIPEL project. One year on, and upon commissioning this year's palliative care report, the Committee was keen to understand how confident the system was in being able to secure ongoing and sustainable financial support for RIPEL from June 2025 onwards. Whilst the Committee is pleased with the proven cost-effectiveness of the project, it remains concerned regarding the challenges around securing continuous and sustainable funding for RIPEL. It is crucial that there is ongoing and in-depth collaboration between Oxford University Hospitals NHS Foundation Trust, the ICB and other key relevant partners to help develop a sustainable business case for the continuation of the project.

The imperative for sustainable funding and resource would also extend to palliative care services more broadly. The entire system should ideally work collaboratively to explore avenues for funding, as well as to help overcome challenges around workforce. The Committee appreciates that workforce shortages are not unique to Oxfordshire and that this constitutes a national challenge. However, demonstrable efforts should be made to ensure two things:

1. An identification of the level of workforce required to deliver palliative care services.

2. Clear steps to secure the required workforce and personnel required to provide palliative care services, including services in people's homes.

In NHS England's national framework for local action on palliative and end of life care, it is emphasised that whilst death cannot be defeated, systems should change the way we talk about dying, death and bereavement; and that there should be adequate preparation, planning, care, and support for those who are dying as well as for those who are close to them. If these objectives are to be met in Oxfordshire, then it is pivotal that the system identifies and secures the necessary resources to do so, and to ensure that such resources are as sustainable as possible.

Recommendation 2: *To secure sustainable sources of funding and resources for the RIPEL project, as well as Palliative Care Services more broadly.*

Improving transport services for palliative care patients: It is important that work is undertaken to improve transport services for palliative care patients. Such patients already experience tremendous physical, mental, and emotional difficulties, and it is therefore crucial that inconveniences caused by transportation are minimised inasmuch as possible. Long waits for transportation can cause significant distress for patients, particularly for patients who require urgent transfers to their homes or to hospices. The Committee urges that as much additional support as possible should be sought to pilot dedicated palliative transport services. The Committee is pleased to hear that a pilot scheme funded by Sobell House has been proposed to provide dedicated transportation options, with the aim of improving patient and family experiences. Nonetheless, assessments of the feasibility of a long-term implementation of such options should be made as urgently as possible.

Furthermore, as part of assessing and improving the quality of transport services in palliative care, the Committee urges that such services work closely with patients and their families to develop a robust feedback process. This can help transport services to review any potential areas of improvement. Additionally, transport services staff should receive as much training as possible in displaying empathy toward patients and their families, and in being able to physically handle patients in a manner that makes them feel as comfortable and as pain free as possible.

Recommendation 3: *To secure additional and sufficient resourcing and support for palliative transport services. It is recommended that transport services for palliative care patients are organised in a manner that avoids delay and distress for patients*.

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
    - Power to scrutinise health bodies and authorities in the local area
    - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
    - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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August 2024

Redesignation of the Urgent care centres on the Horton General Hospital (HGH) and John Radcliffe (JR) hospital sites.

Background

The Urgent Care Centres were set up a few years ago on both the JR and HGH to support the redirection of mobile patients who did not require to be seen in an Emergency Department. Many of these people are those with minor illness who need to be assessed by a clinician.

The two units were called Urgent Care Centres, this was based on the procurement rules at that time. If we had called them Urgent Treatment Centres we would have had to go out to tender and we had local Primary care units willing to run them. This matters, as both units take referrals from local GP practices who are struggling with on the day demand. Both units have been extremely successful at supporting the on the day demand for North and City of Oxford. South Oxfordshire has minor injury units and frailty units call EMU's.

Present situation

The two Urgent Care centres in Oxfordshire have been assessed for redesignation as Urgent Treatment Centres so their activity can be reported in the Oxfordshire 4hr standard. This is the process around the country and Oxfordshire is one of the last places to comply with this. This is designation only, it does not change the name of the units, their location, the types of patients that they see or their activity. The redesignation to an urgent treatment centre means that they can report their activity in the Oxford University Hospitals NHS Foundation Trust 4 hour standard.

The regional and National NHS England team have requested that the HOSC chair is made aware of this, to comply with full transparency.

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OXFORDSHIRE COUNTY COUNCIL

REPORT OF ENDORSEMENT FROM THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):
Warneford Park Hospital Redevelopment

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

The Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) has been closely involved in scrutinising and reviewing the Warneford Park Hospital Redevelopment Project. Oxford Health NHS Foundation Trust have approached the JHOSC with a view to brief the Committee on the proposals for the redevelopment, as well as to seek endorsement and support for the Trust's bid for government funding to redevelop the hospital.

The Committee has been involved in scrutiny of this proposal in four formats:

1. A briefing for the Chair, Vice-Chair, and Health Scrutiny Officer from the Trust and the Integrated Care Board on the proposal.

2. A written briefing submitted to the Committee by the Trust outlining the details of the proposal as well as the rationale behind redeveloping the Hospital.

3. A full Committee briefing on the redevelopment, with an opportunity for the Committee members to ask key questions in relation to the project.

4. A site visit by the Chair, Vice-Chair, Health Scrutiny Officer, and other Committee members to the Warneford Park Hospital Site.

These engagements with the Committee have provided useful insights into the following:

- The nature of the redevelopment proposal.
- The reasoning behind the proposals to redevelop Warneford Park Hospital.
- The imperative for mental health to receive further attention and funding/resource.
- That Oxford Health NHS Foundation Trust is formally applying for funding from government in order to embark on the redevelopment.

The Committee ***endorses*** and ***supports*** the Warneford Redevelopment Project, and the initiatives that have thus far been, and that will continue to be undertaken by the Trust, to apply for and secure government funding to embark on the redevelopment plans outlined to the Committee in the four scrutiny formats outlined above.

Below are some key points of observation and reflections that the JHOSC has on the proposals to redevelop the Warneford. These themes have been drawn from the interactions that the Committee have had with Oxford Health NHS Foundation Trust, as well as from broader reflections that the JHOSC have:

Patterns of mental ill-health: Mental ill-health has had significant impacts on the UK population. In the wake of the covid-19 pandemic, there has been a national increase in mental health decline. Yet in spite of the increasing prevalence of poor mental health, this area of health has not received appropriate levels of funding and resource when compared to physical health conditions. Serious Mental health is in urgent need of further investment for two reasons:

- To ensure further research into mental health is embarked upon in a manner that could not only improve the quality of clinical care for mental health patients, but also for the purposes of prevention.

- It is imperative that mental health inpatient services are able to benefit from increased funding and resource so as to improve the overall effectiveness of clinical care.

Mental health policy: The Committee is pleased to see that the Warneford proposal is in line with national and regional policies around mental health. For instance, improving mental health services as well as prevention is in line with the objectives of the Health and Wellbeing Strategy for Oxfordshire. It is also the case that from an NHS perspective, the proposal is also in line with NHS England's objective to drive improvement in inpatient mental health care, and would support the BOB Integrated Care Board's ambition to improve mental wellbeing outcomes for those living and working in Oxfordshire.

Constraints of the current hospital: The Committee understands that the current Warneford Park Hospital Site is not fit for purpose. Additionally, its listed status provides little opportunity to explore prospects for expanding/enhancing the current site. The fact that there are off-site wards can prove problematic in that it can produce risks to patients as well as undermine mutual support that could come with having an integrated site. Having visited the Warneford Park Hospital Site, the Committee recognises that the working spaces for staff can be overcrowded and at times rather limiting. This is problematic for two reasons:

1. The wellbeing of existing staff could be impaired by the limiting space and unfavourable working environment. In a mental health setting, it is pivotal that staffs' mental and emotional wellbeing is sufficiently catered for so as to provide a positive environment for patients also.

2. The negative aspects of the working space could also have a knock-on effect on staff recruitment and retention. The Trust would be in a better position to attract qualified clinical or administrative candidates if it is able to offer a positive working environment.

Reducing out of area placements: The Committee is aware that in some instances, patients are having to be transported to receive treatment for mental health in areas that are far from home. This is problematic in the sense that patients could be made to feel that they are far from home and from a familiar setting. Additionally, this could create challenges for the families and relatives

of patients to be able to visit their loved ones. Both of these factors could have a negative impact on patient's recovery. Therefore, the Committee feels that the redevelopment of the hospital could significantly reduce the prospects and occurrences of out of area placements.

Co-location of research and clinical care: The Committee understands that the Trust will jointly work with the University of Oxford for the purposes of creating a global brain health research facility on the site. This could certainly help with addressing the ever-increasing importance of merging science and clinical care; producing benefits not only for the purposes of research but also for patients themselves, who would potentially reap the benefits of world class research into mental health and psychology.

Warneford Hospital as a hub for community-based prevention of mental health crises: The Committee is in support of all work to support those at risk of a mental health crisis in the community, or for those who are leaving hospital. This is key to good practice and prevention, and the Committee is pleased that the Trust strategy as a whole includes a hub and spoke model with serious mental health hubs in community settings. This population-based approach is fully encouraged, and it is crucial that this benefits from further research.

Long-term economic benefits: The Committee believes that the redevelopment could produce significant economic benefits for the UK in the long run. The amount of funding that the Trust is seeking from government is small relative to the long-term economic benefits that could be generated through the research that could be produced from the brain centre on the site. This research could help improve knowledge and understanding of what the root causes of ill-mental health may be, as well as what the most effective forms of treatment could be for those suffering with ill-mental health.

CONSIDERATIONS AS TO SUBSTANTIAL VARIATIONS OF SERVICES:

A key consideration the Committee is required to have in regard to the proposal is whether there is a prospect of there being a substantial change or variation of services. The Committee is of the view that the Warneford redevelopment project *does not constitute a substantial change*: This decision has been made for two reasons:

1. The proposed redevelopment will not result in the removal or reduction of any mental health services that have been provided by the Trust today.

2. The use of the term substantial change can often have a negative connotation, and could imply that services are being amended or reduced to the point that it could have negative implications on patients and service users. However, in this instance, the Committee is of the view that this proposal could have a positive impact on improving mental health services for Oxfordshire.

KEY POINTS OF OBSERVATION:

Whilst the Committee is broadly supportive of this proposal, it has four key points of observation that the Trust should address as part of this redevelopment project:

1. To ensure that the patient is always retained at the heart of this project. This includes access during construction. It is crucial that patients as well as their loved ones are able to access the services on the site and outside space with as much ease as possible. Essentially, there should be minimal disruption to patients receiving services on the site throughout the course of the redevelopment.

2. It is crucial that the Trust is able to sustainably resource and deliver the services it is committed to providing on the site post-redevelopment.

3. The Committee is pleased that the design/proposal has been influenced by inpatients with lived experience, and would expect co-production to continue until the delivery of the new site.

4. *Risk factor:* In order to approve the bid for funding, government will understandably want reassurance that the funding it provides will be put to good use by the Trust, and that the Trust (in conjunction with the University of Oxford) is able to deliver the proposed project on schedule and with minimal disruption and risk.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: General Practice Provision in Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Julie Dandridge (Lead for Primary Care across Oxfordshire, BOB ICB)
- Daniel Leveson (BOB ICB Place Director, Oxfordshire)

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Monday 10th June 2024

Response to report:

Enter text here.

Response to recommendations:

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation; and for the ICB to provide evidence and clarity around any engagements adopted, to include evidence on key feedback themes and from which groups within Oxfordshire such themes were received from. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.	Partially accepted	The ICB has published a summary of feedback received. This feedback has not been collected on an Oxfordshire footprint. The summary feedback can be found 20240521-bob-icb-board-item-11-bob-icb-primary-care-strategy.pdf More details on the implementation of the strategy is now included in the Primary care strategy. This will be further developed over time.
2. To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.	Accepted	The ICS has a number of clinical networks including stroke, diabetes and respiratory that focus on prevention and improved pathways for these long term conditions. More details can be found in the Joint Forward Plan Joint Forward Plan | BOB ICB
3. To review ICB capacity with a view to increasing this to ensure adequacy, with a view that the ICB can work in a timely way with all District/City Councils across Oxfordshire on the securement and spending of health-infrastructure funding.	Rejected	The ICB is not in a position to increase its workforce capacity but welcomes the opportunity to work closely with all District/City Councils across Oxfordshire on the securement and spending of health infrastructure funding
4. That the ICB checks which practices are closing e-connect and telephone requests	Partially accepted	Practices that are temporarily unable to receive telephone requests for urgent appointments should inform the ICB. The

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

for urgent appointments and for what reasons, and that it is also checked as to whether/how the public have been communicated with around such closures. It is recommended that there is improved clarity and communication about the statistics concerning access to appointments.		main reason for this request is staff sickness. When informed the ICB advises practices to update their answer machine message and their website so informing patients. We do not currently have a method of monitoring when practices close of online consultations but are exploring what might be possible.
5. For there to be clarity and transparency around the use of any competency frameworks as well as impact and risk assessments around the role of non-GP qualified medical staff who are involved in triaging or providing medical treatment to patients. The Committee urges that the advocacy needs of patients are considered/provided for, and that patients are clearly informed about the role of the person who is treating them and the reasons as to why this is a good alternative to seeing their GP.	Accepted	There are some national sources of information for patients about the different roles in general practice. We will look to making these available on the ICB website.
6. That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.	Accepted	There are many legal agreements that need to be in place to progress the Great Western Park project. The ICB will update JHOSC when progress is made.

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Issue: Integrated Neighbourhood Teams in Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Lily O' Connor- Programme Director Urgent and Emergency Care for Oxfordshire, BOB ICB.
- Dan Leveson- BOB ICB Director of Place for Oxfordshire.
- Karen Fuller- Director for Adult Social Care, Oxfordshire CC.

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Thursday 8th August 2024

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. That there are clear governance and management processes around both the development as well as the activities of Integrated Neighbourhood Teams. It is recommended that there is clear transparency around this.	Partially accepted	We have a monthly Oxfordshire strategic group with senior representative from all stakeholders/providers, who oversee the following • Actual spend and predicted future funding required • Overview of the design, outputs and the development of outcomes of each INT • Agreement of the order of the phasing and overall development of INT's within Oxfordshire Each INT has the following • A Senior Responsible Officer (SRO) and deputy SRO • Weekly to monthly meetings depending on the needs of the INT • Join working with County council, Health Protection and the voluntary sector. • Co-production of the INT with the local stakeholders and population Focus for INT's • Reduce length of stay for those in hospital • Reduce the risk of hospital readmissions within 30 days of discharge • Enhance the efficiency of same-day responses for high-need patient referrals to ensure the best possible outcomes

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		• Proactively identify and manage patients with rising health and social care risks • Supporting holistic mental health support • Foster a supportive and healthy community environment • Focus on frailty, working with people to improve their quality of life and achieve greater independence • Reducing social isolation
2. To ensure ongoing coproduction with neighbourhoods and key stakeholders around the formation as well as the activities of Integrated Neighbourhood Teams. It is also recommended that an agreed definition of coproduction is outlined by system partners in this regard.	Partially accepted	We are following the County Council process for co-production. We have co-production on all areas where there are INT's. However, they are at different stages, City of Oxford mainly Barton is the most mature. I am attaching the process for co-production that we follow.
3. To develop a clear understanding of the health needs and population patterns for each locality, and to allocate resources for Integrated Neighbourhood Teams accordingly.	Partially accepted.	We have worked with public health, local councils and the information team in the OUHFT to create a data pack for each INT. This is to ensure that each INT understands their local population health and prioritise the areas that will make the most impact. Additionally, each INT as they develop recruit the posts/skill set required to meet this gap in health needs.

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Buckinghamshire, Oxfordshire and Berkshire West Joint Overview and Scrutiny Committee

Winter Plan, Oxfordshire

Introduction

1. This paper outlines the programme of work in Oxfordshire for the winter of 2024/2025
2. The papers cover:

- Southeast Regional winter plan
- Areas of achievement in Oxfordshire.
- Oxfordshire winter plan

Winter plan 2024/2025

3. **Key Operational Focus Areas:**

- **Supporting frail patients in the community**
  - delivering frailty transformation at scale – people are assessed in the right place to meet their needs
  - Maximising the number of people who can be assessed and treated in their own home, continue to increase in line with monthly trajectory for Hospital @ Home.
  - Adopt the ReSPECT model for personalised clinical care and to implement a consistent risk stratification approach for frail patients this winter.
- **Reducing Ambulance Handovers**
  - maximum handover time of 45 minutes - move to a mandated handover at 45 mins. Most handovers to take place within 15mins of arrival.
- **Capacity Management**
  - Reducing time spent in an emergency department and all assessments units across Oxfordshire, achieving at least 78% of the four-hour standard and 2% or less spending 12hrs or more in the department.
  - 95% of people discharged from the acute Trust directly to their own home
  - Review General & Acute core and escalation bed capacity plans to ensure sufficient beds are available throughout winter.
  - Review surge capacity across community services
  - Embedding the ReSPECT model for personalised clinical care
- **Mental Health**
  - Reducing inappropriate mental health placements
  - Reducing Length of stay across Mental Health inpatient beds

Challenges

4. Workforce and funding remain a challenge this winter.

5. In preparation for winter, we need to build on existing progress and develop the pathways further to create winter surge capacity.

Supporting frail people in the community - Hospital at Home

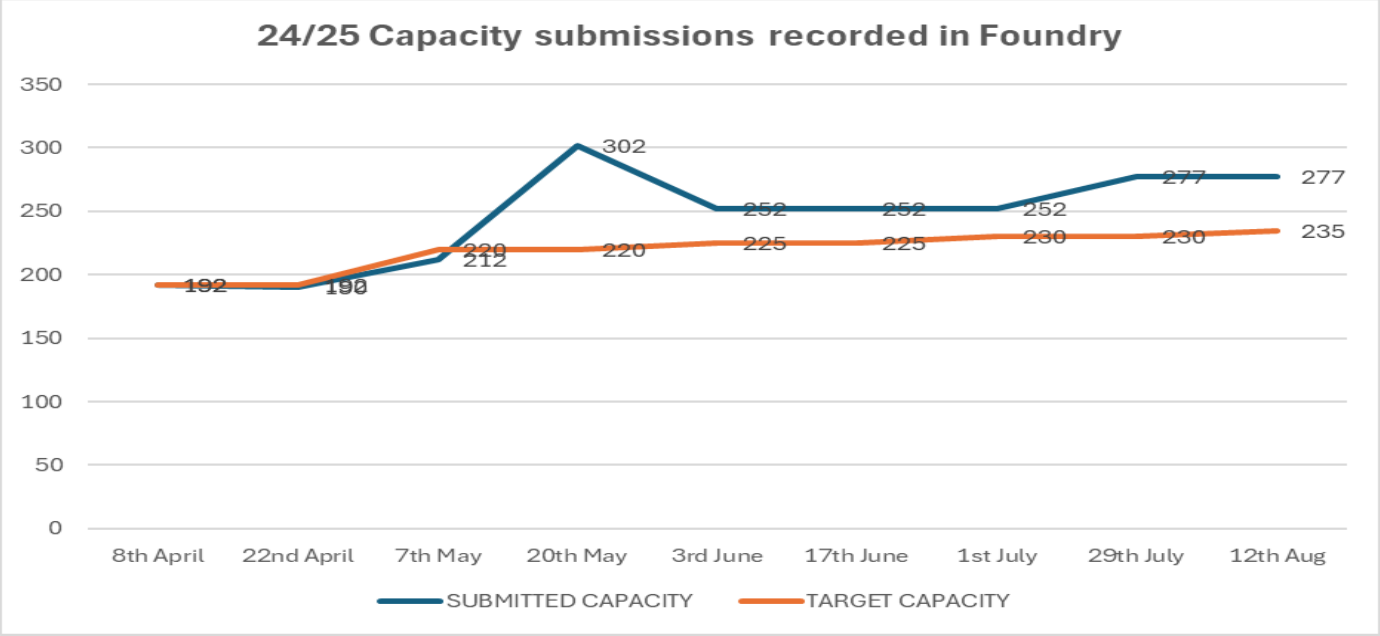
6. December 2023, Oxfordshire merged the two Hospital @ Home teams into one team covering north, city and south Oxfordshire. This has resulted in an integrated team with single oversight of all people being cared for in the H@H service across Oxfordshire.

7. Figure1.1 and 1.2 below shows that the service is above target since May 2024.

Figure 1.1 **The number of patients the service(s) can see at any one time**

	24/25 Capacity submissions recorded in Foundry								
Date	**8th April**	**22nd April**	**7th May**	**20th May**	**3rd June**	**17th June**	**1st July**	**29th July**	**12th Aug**
Children's VW	12	12	12	12	12	12	12	12	12
PMLH@H	30	18	40	40	40	40	40	40	40
Oxon Acute VW*	150	160	160	250	200	200	200	225	225
SUBMITTED CAPACITY	**192**	**190**	**212**	**302**	**252**	**252**	**252**	277	**277**
TARGET CAPACITY	*192*	*192*	*220*	*220*	*225*	*225*	*230*	*230*	*235*
Difference (N)	0	-2	-8	82	27	27	22	47	42
Difference (%)	100%	99%	96%	137%	112%	112%	110%	120%	118%

8. Figure 1.2 The number of people cared for in Hospital @ Home services per months against trajectory.

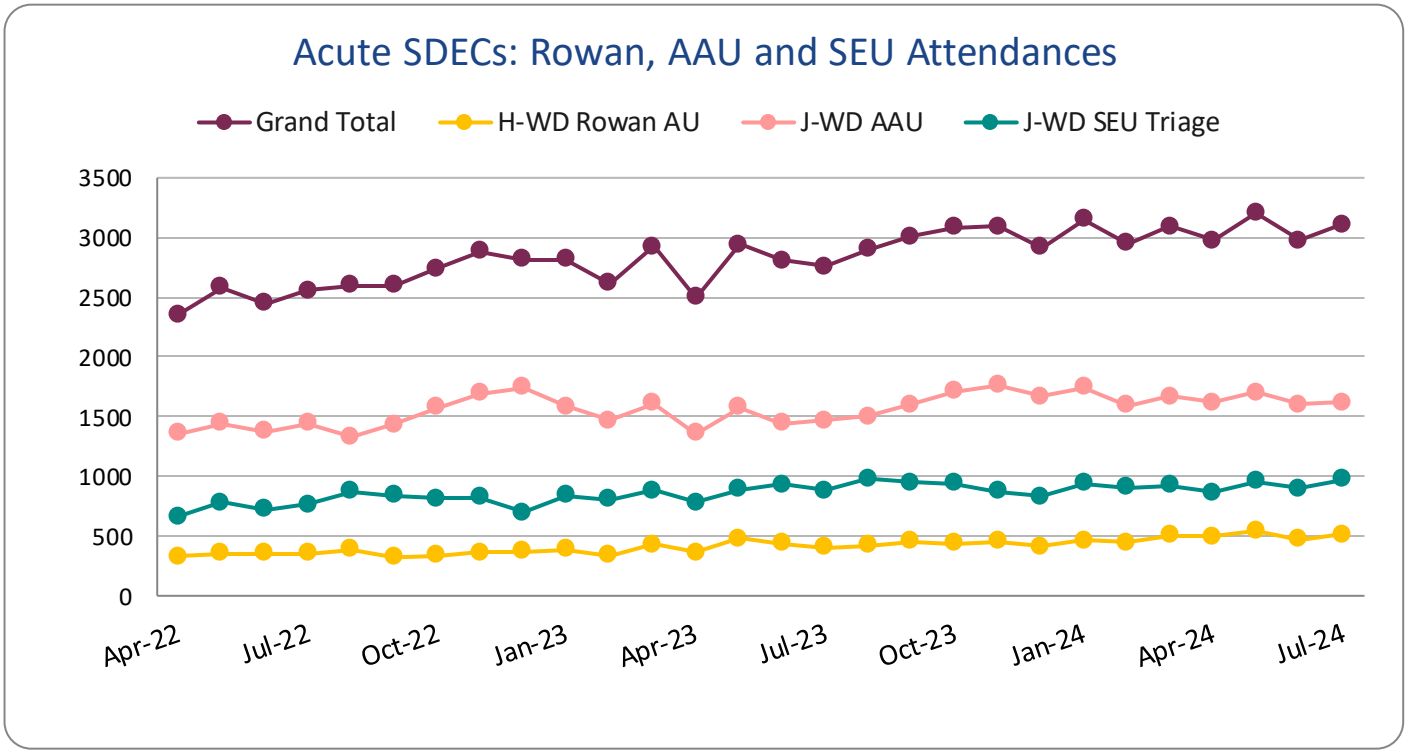


9. Over 2024/25, the Hospital @ Home team will move to extending their working hours from 20:00 to 22:00hrs across the whole county 7 days a week. This will create additional visiting capacity over the winter months.

10. The Same Day Emergency Care Units in the community and hospital setting support the referrals from healthcare professionals across Oxfordshire and the Hospital @ Home teams to see people who require further assessment and diagnostics. This avoids people requiring an Emergency Department attendance or admission to hospital.

11. Figure 1.3 on the next page, illustrates the increase in activity across the acute Same Day Emergency Services (SDEC) in the John Radcliffe and Horton General Hospitals. This creates capacity for people.

Figure 1.3 Increase in activity in Same Day Emergency Services (SDEC)



Supporting frail people in the community – Discharge to Assess

12. 2023/2024, Oxfordshire Social Care has continued to develop Discharge to Assess both supporting people returning directly home from hospital (figure 1.4) but also supporting people who require reablement to maintain them staying in their own home (Figure 1.5). Figure 1.6 illustrates how many people are returning to independence following reablement.
13. Figure 1.4 Outcomes for Discharge to Assess

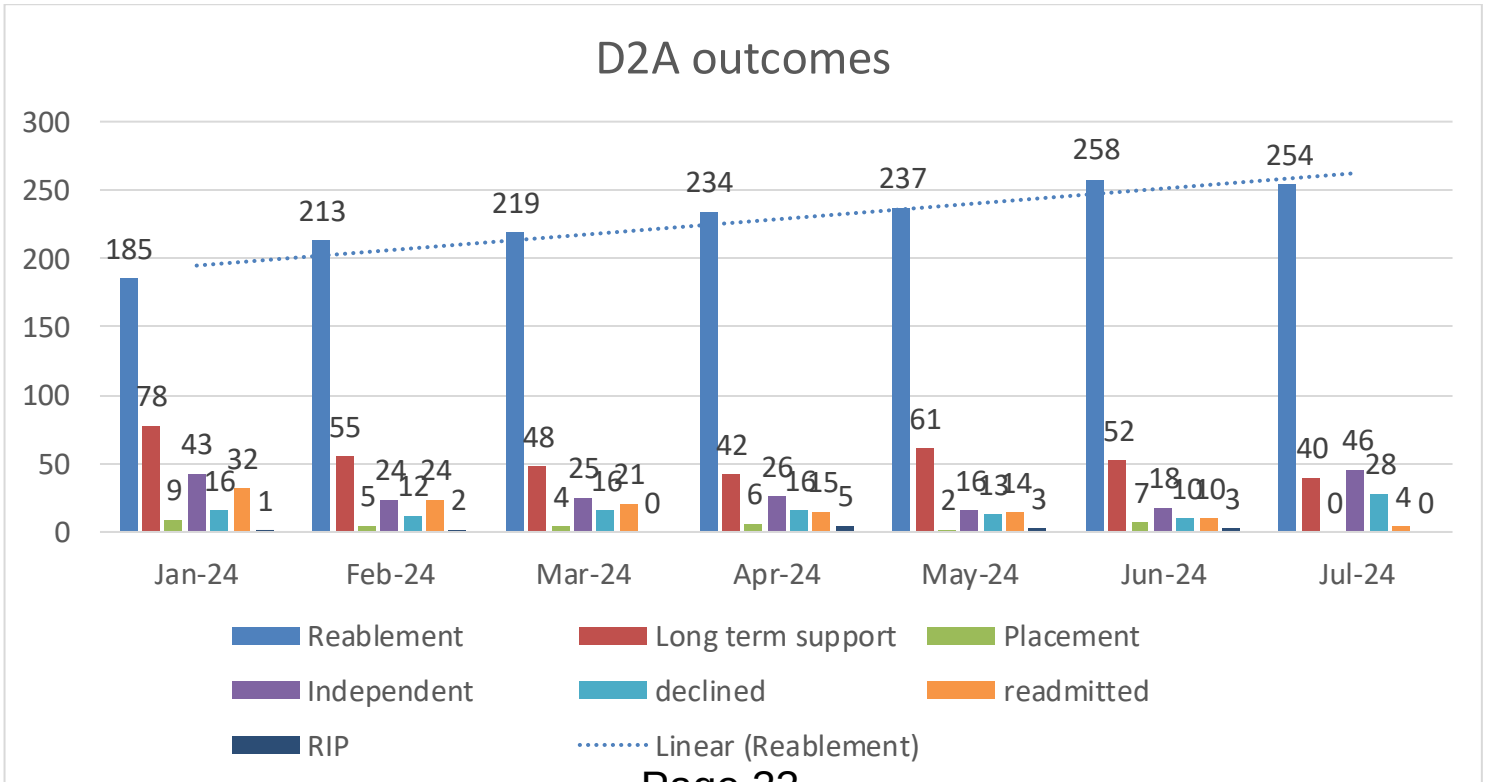


Figure 1.5 Increase in the number of people per month who have been maintained within their own home.

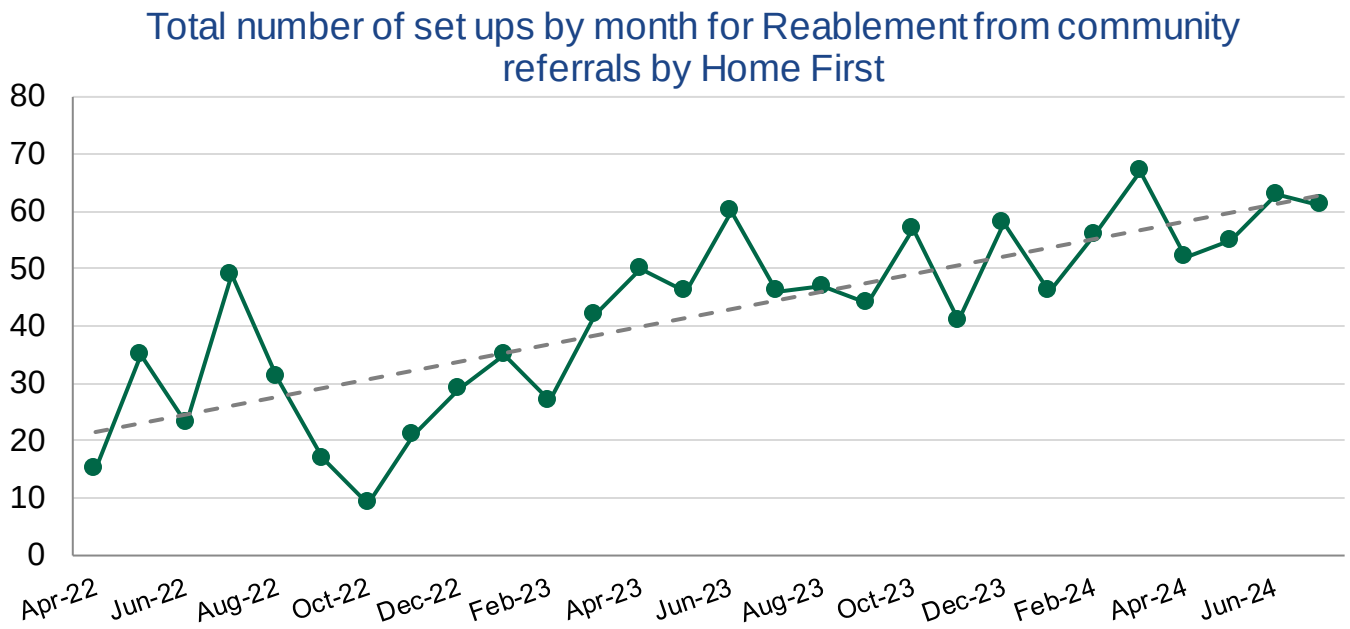
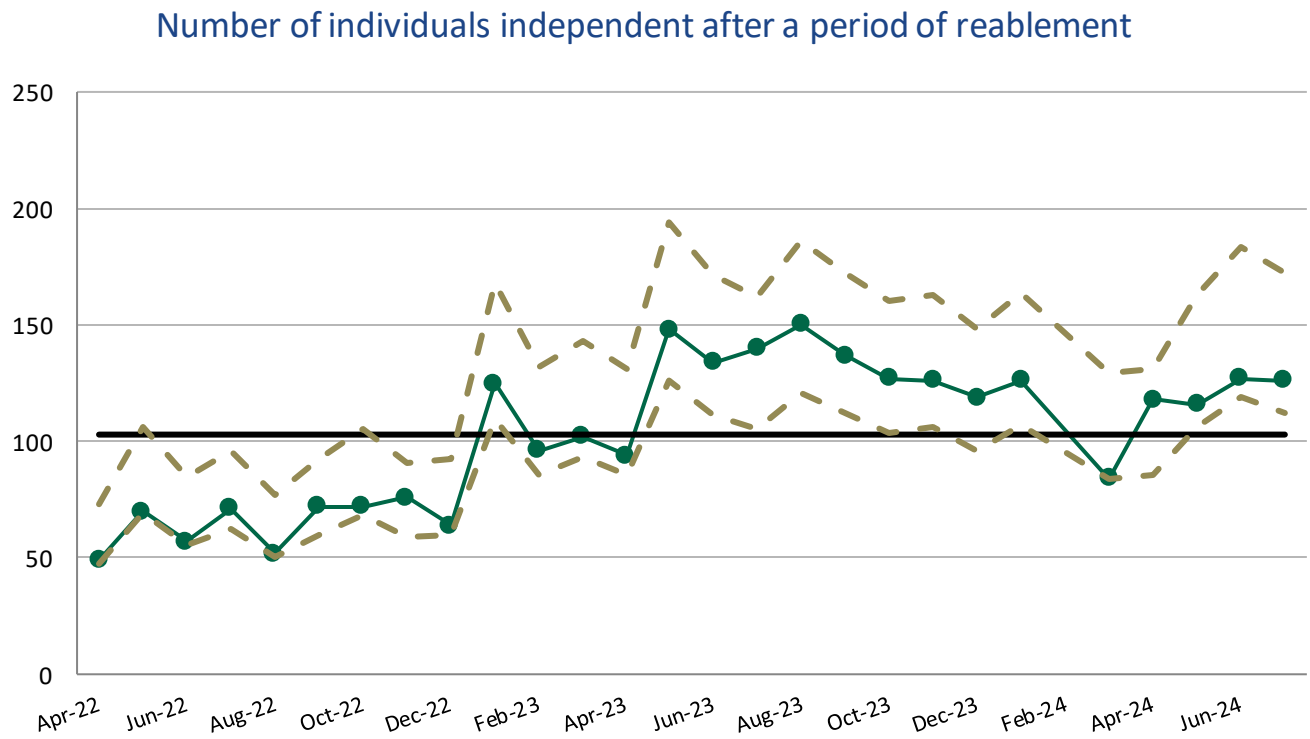


Figure 1.6 Increase in the number of people per month who are independent after reablement



14. Discharge to assess also supports people who have high needs such as those recovering from delirium and who need 24/7 care for a short time. This short-term intensive support with D2A, has meant that more people can now be supported in their own home with a quicker recover, instead of transferring to a step-down bed.

15. The Discharge to Assess team are reviewing how addition surge capacity can be delivered during the winter months, when there is an increase in the number of people requiring larger reablement packages of care.

Winter Plan

Supporting frail people in the community

16. Develop Single Point of Access (SPA) to support all health care professionals to refer people who can be assessed and cared for in their own home.

17. Expand capacity within Hospital @ Home teams to provide consistent cover until 22:00hrs 7 days a week.

18. Hospital @ Home working closely with Integrated Neighbourhood teams with a view to discharge people earlier to them but to support remotely.

19. Integrating Urgent Community Response with the overnight visiting service to delivery service that provides more home visiting capacity in the evening and overnight.

Supporting frail people in the community – Integrated Neighbourhood teams (INTs)

20. Oxfordshire has integrated Neighbourhood teams across Banbury, Oxford City, Bicester, Wantage and Witney. During the winter months these will continue to be developed to address the following.

21. To reduce health inequalities by reducing morbidity and mortality in areas of concern, stroke, heart failure and respiratory disease.

22. Continue to develop an integrated approach across Primary Care, Community and acute services for those with the highest need and based on the local population needs.

23. Local population health data has dictated some INTs need to focus on people with Mental Health, alcohol and substance misuse or the needs of children.

24. Coordinated care mainly for those who meet the frailty criteria – especially those just discharged from hospital where additional assessment and support will maintain them safely in their own home.

Supporting frail people in the community – ReSPECT

25. The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

26. ReSPECT and decision-making conversations happen between a person, their families, and their health and care professionals. These conversations help create an understanding of what is important to the person.

27. Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

28. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

29. Implementation will start within the community and then the acute Trust.

Reducing Ambulance Handover delays

30. Focus on referring people from the ambulance stack in the control room directly to Single Point of Access (SPA) to avoid an ambulance being deployed where another team can access and treat the patient.

31. Ambulance crews to refer appropriate patients to SPA where they can discuss the person with a clinician to see if Urgent Community Response or Hospital @ Home can carry out further assessment s or treatment.

32. Reducing ambulance handovers, the majority of which to be achieved within 15 mins.

33. Maximum handover time of 45 minutes: prepare to move to a mandated handover at 45 mins

34. Improve process for signing off ambulance handovers in real time to improve data quality

Increasing capacity - Acute Care

35. Improving streaming, direction and initial assessment of people as they arrive in the Emergency Department.

36. Continue to focus on reducing the length of time people spend in the Emergency Department, 2% or less with a length of stay 12hrs and over.

37. Achieving at least 78% of the 4hr standard.

38. Further development of the children's Emergency pathways to improve flow and quality of care.

Transfer of Care HUB

39. Continue to reduce the number of days people are away from their own home and increase the number of people returning directly home from the acute Trust to 95%.

40. Expand cover from 6 days a week to 7.

41. Focus on reducing Length of Stay across all Oxfordshire bed bases.
    - Improve communication with people and their carers pre and post hospital discharge
    - Digital integration to improve information sharing
    - Working closely with Integrated teams to ensure all those who can be supported at home do so at the earliest opportunity.

Discharge flow

42. Referring people who require support to return home at the earliest opportunity.
43. Improving communication with people and their carers prior to discharge and within the first 48hrs post discharge.
44. Intense approach to reduce length of stay across all Oxfordshire step down beds.
45. Improve approach and timely access to step down care across community hospital and short stay HUB beds

46. Review the impact of discharge to assess on Oxfordshire residents.
47. Social Care reviewing plans to deliver surge capacity for the expected increase in double handed care over January to March 2025.
48. Hospital @ Home and Urgent Community Response reviewing how to create additional capacity to support Health Care professional referrals for people who require assessment in their own home.

Mental Health – Reducing Length of stay

49. Embed new BCF schemes agreed for 24/25 (additional embedded housing workers).
50. Continue to realise value from 23/24 BCF / ADF schemes (step-down housing/embedded housing workers, discharge liaison support into care homes; inpatient personality disorder intervention/discharge team; one-off flexible use fund).
51. Design and implement national requirements for 'purpose of admission' and '72-hour assessment' within inpatient care with the aim of further LOS improvements and decreased delays.
52. Implement revised national MH OPEL triggers and actions.
53. Improved integration of Mental Health into the TOC Hub to assist with discharge pathways and admission avoidance to older adult MH inpatient care.
54. Introduction of enhanced MDT / senior oversight process for adults with LOS over 60 days and older adults with LOS over 90 days.
55. Inappropriate out of area placements- trajectory to reduce to 2 people at any one time in out of area inappropriate placements.

Future work and next steps

56. The progress across the various Urgent and Emergency Care pathways will continue to be sustained and developed further over the winter.

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Integrated Improvement Programme Oxfordshire winter 24/25

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Lily O' Connor
Programme Director of Urgent and Emergency Care Oxfordshire

Requirements for winter 2024/2025

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Supporting frail patients in the community**
  - delivering frailty transformation at scale – people are assessed in the right place to meet their needs
  - Maximising the number of people who can be assessed and treated in their own home, continue to increase in line with monthly trajectory for Hospital @ Home.
  - Adopt the ReSPECT model for personalised clinical care and to implement a consistent risk stratification approach for frail patients this winter.
- **Reducing Ambulance Handovers**
  - maximum handover time of 45 minutes - move to a mandated handover at 45 mins. Most handovers to take place within 15mins of arrival.

Capacity Management

  - Reducing time spent in an emergency department and all assessments units across Oxfordshire, achieving at least 78% of the four-hour standard and 2% or less spending 12hrs or more in the department.
  - 95% of people discharged from the acute Trust directly to their own home
  - Review General & Acute core and escalation bed capacity plans to ensure sufficient beds are available throughout winter.
  - Review surge capacity across community services
- **Mental Health**
  - Reducing inappropriate mental health placements
  - Reducing Length of stay across Mental Health inpatient beds

Achievements in 2023/24

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Out of hospital Care**
- Integrated one Oxfordshire Hospital at Home Service, increasing capacity to assess and treat more people in their own home, slide 4 and 5.
- Increase in the number of people seen in Same Day Emergency Care (SDEC) Units Slide, slide 6.
- Integrated Neighbourhood teams in Oxford City and Banbury- focus on areas of deprivation to improve earlier detection of deterioration and improve quality of life
- Further improvements to MH crisis support within the community and to NHS 111 which have resulted in people not needing to be seen in an emergency department
- Increase in the number of people receiving mental health crisis care in their own homes avoiding a hospital conveyance and potential admission.
- Reduction in the number of people following a fall been attending an Emergency Department

- **In hospital care**
- Increased bed capacity within OUHFT over the winter months
- Development of additional assessment space collocated to the JR ED
- Implementation of plan to increase senior clinical decision makers in the overnight period in JR ED.
- Improved performance of the 4hr Emergency Department standard, achieved 78% in March 2024.
- Both Urgent Care Centres working 7 days a week

Hospital @ Home – compliance against trajectory

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

24/25 Capacity Trajectories

Capacity = target number of beds i.e. number of patients the service(s) can see at any one time

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Oxfordshire	192	220	225	230	235	240	245	250	255	260	265	272

24/25 Capacity submissions recorded in Foundry

Date	8th April	22nd April	7th May	20th May	3rd June	17th June	1st July	29th July	12th Aug
Children's VW	12	12	12	12	12	12	12	12	12
PMEH@H	30	18	40	40	40	40	40	40	40
Oxon Acute VW*	150	160	160	250	200	200	200	225	225
SUBMITTED CAPACITY	**192**	**190**	**212**	**302**	**252**	**252**	**252**	277	**277**
TARGET CAPACITY	***192***	***192***	***220***	***220***	***225***	***225***	***230***	***230***	***235***
Difference (N)	0	-2	-8	82	27	27	22	47	42
Difference (%)	100%	99%	96%	137%	112%	112%	110%	120%	118%

NB: 20th May submission includes Hospice Outreach for the first time, but their submission was inaccurate.

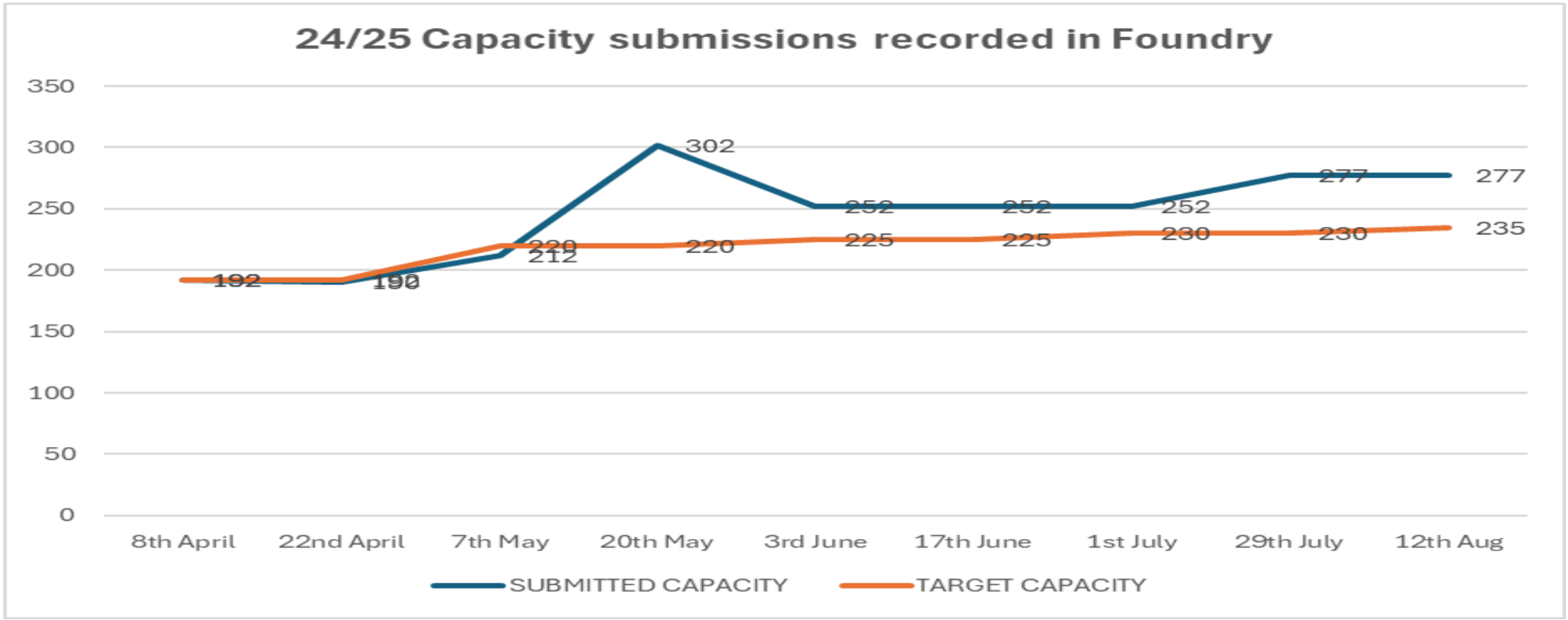
***Oxon Acute VW date includes:**

- Central, North & South H@H
- Sue Ryder
- Home Hospice
- CARe Team
- COPAT
- Covid Care @ Home
- Hospice Outreach (as of 20th May)
- Stroke ESD

Increase in the number of people who are seen in SDEC and Hospital at Home

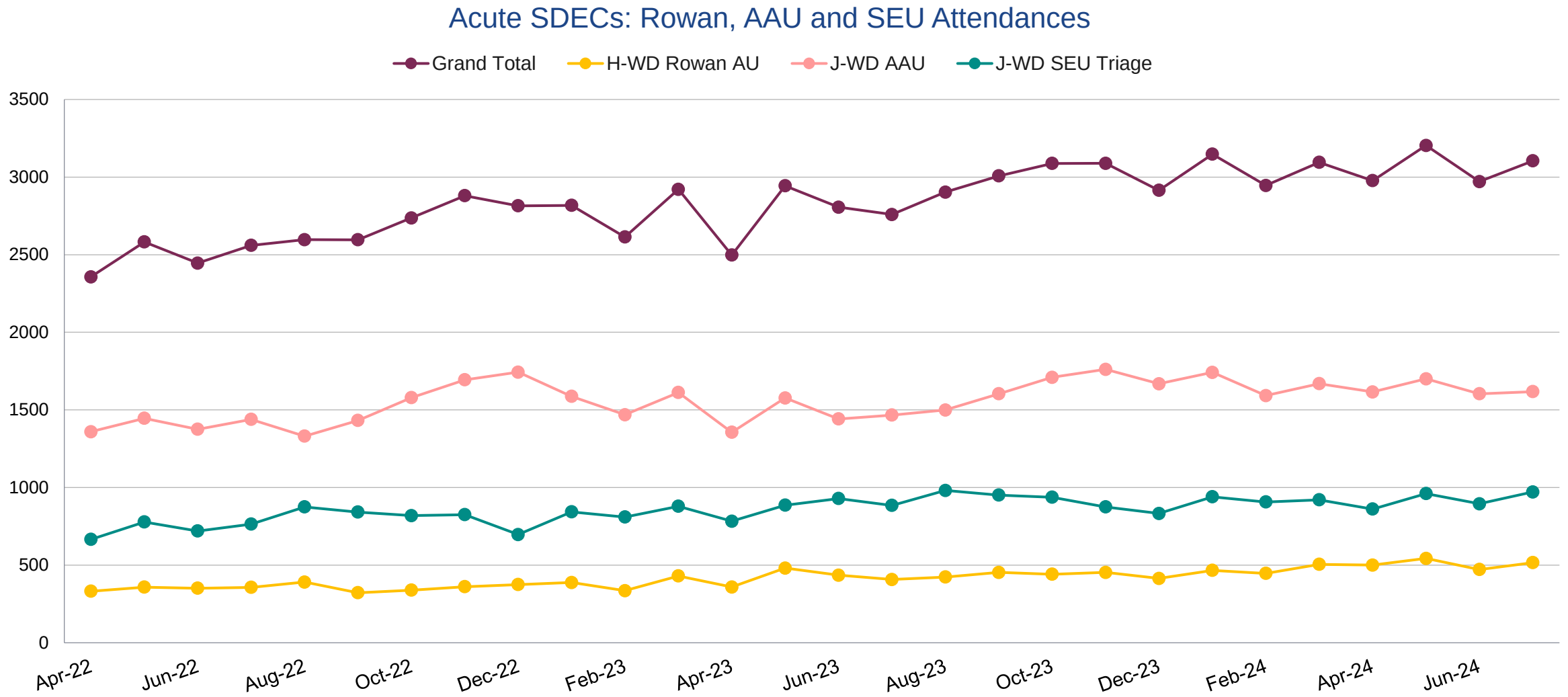
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Number seen in Hospital at Home against trajectory



Increase in activity across Same Day Emergency Care services (SDEC)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System



Achievements in 2023/24

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Discharge**
- There is a reduction in the number of bed days lost to people who to their own are waiting to return home and a reduction in the number of days people are away from home.

➢ **Reablement outcomes to independence have increased** to above 70% again with an additional 13% of people having a reduction in support totalling 83%.

➢ **D2A Outcomes remain good** – most people are moving into reablement pathway, reduction in number of readmissions.

➢ Trusted Assessor Pilot with providers has been successful and continues to grow.

➢ Reduction in hours from start of reablement to end of reablement remains good at 52%

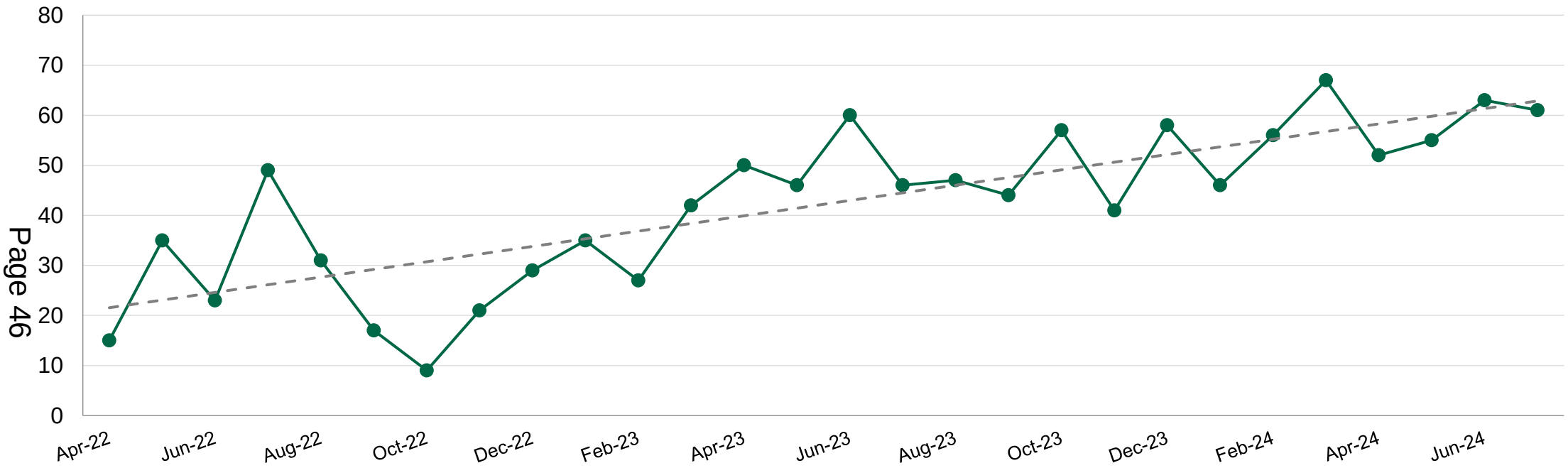
- Effective weekend discharge teams have increase weekend discharges mainly on a Saturday.

- Expansion of Transfer of Care HUB to include all Oxfordshire patients in out of county beds, providing us with an overview of reducing their length of stay

Activity level for Reablement (D2A), related to Admission Avoidance

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

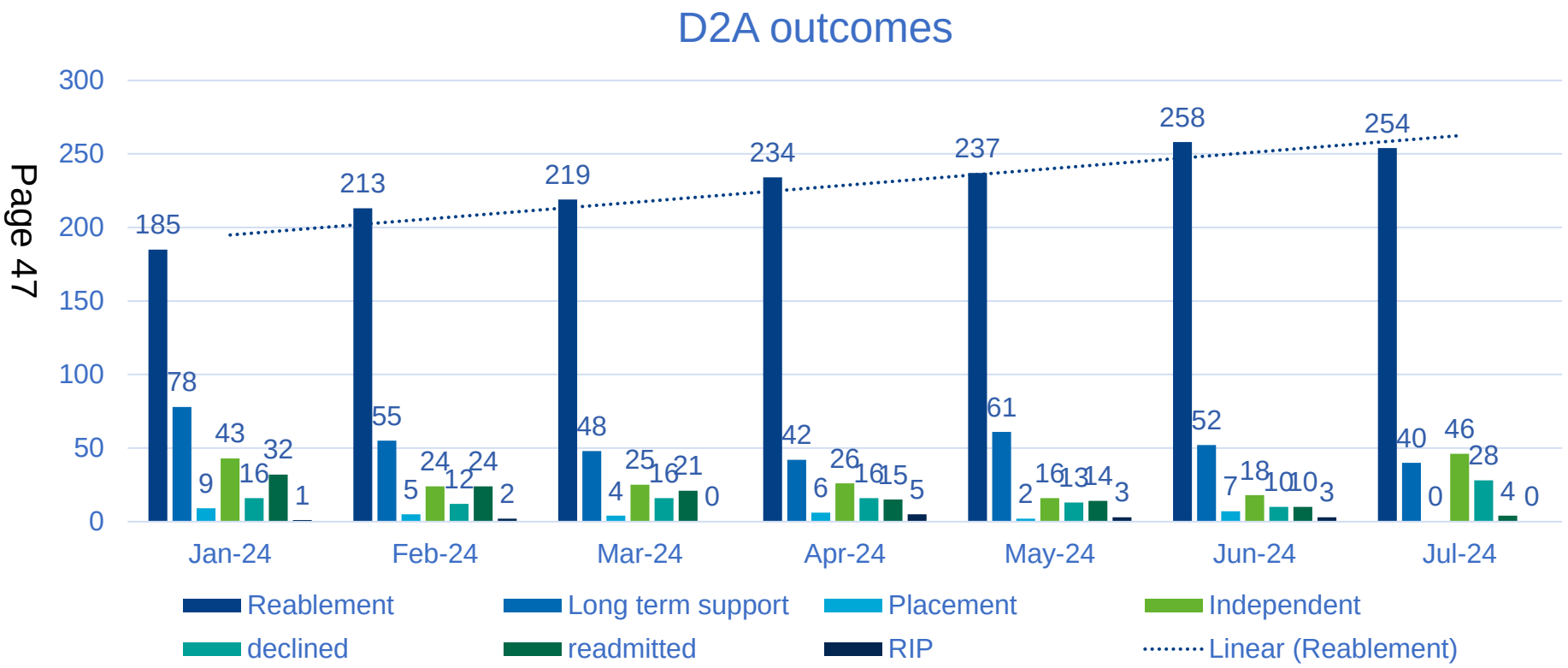
Total number of set ups by month for Reablement from community referrals by Home First



Key: Set Ups ——— Trend Line - - - -

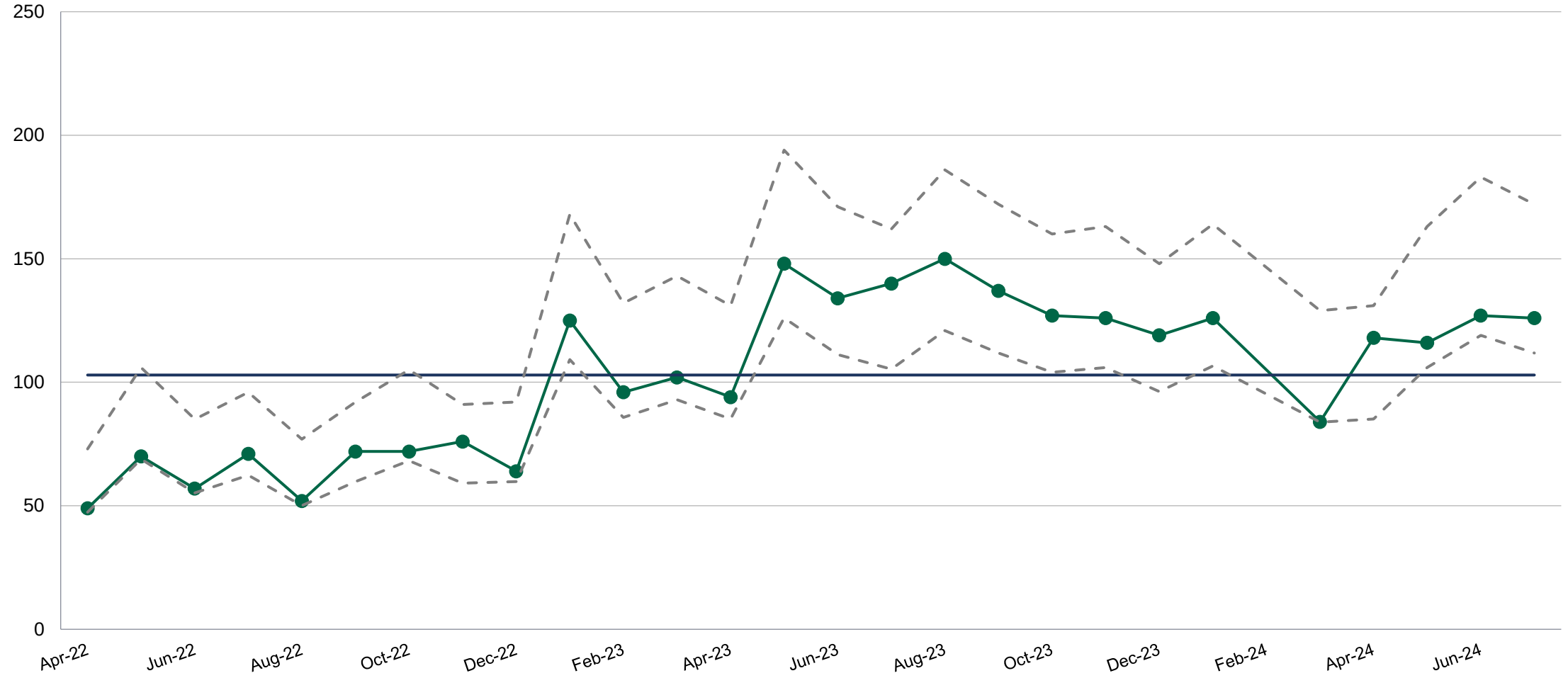
D2A Outcomes

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System



Number of individuals independent after a period of reablement

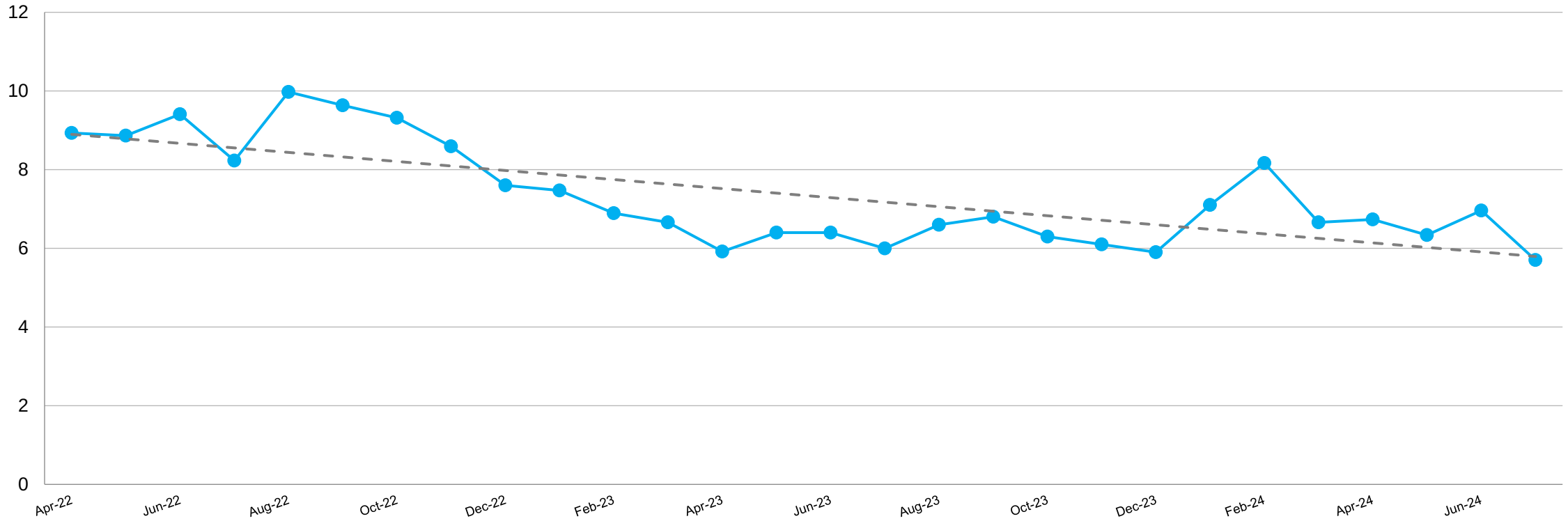
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System



Reduction in the number of days people are delayed waiting to return home.

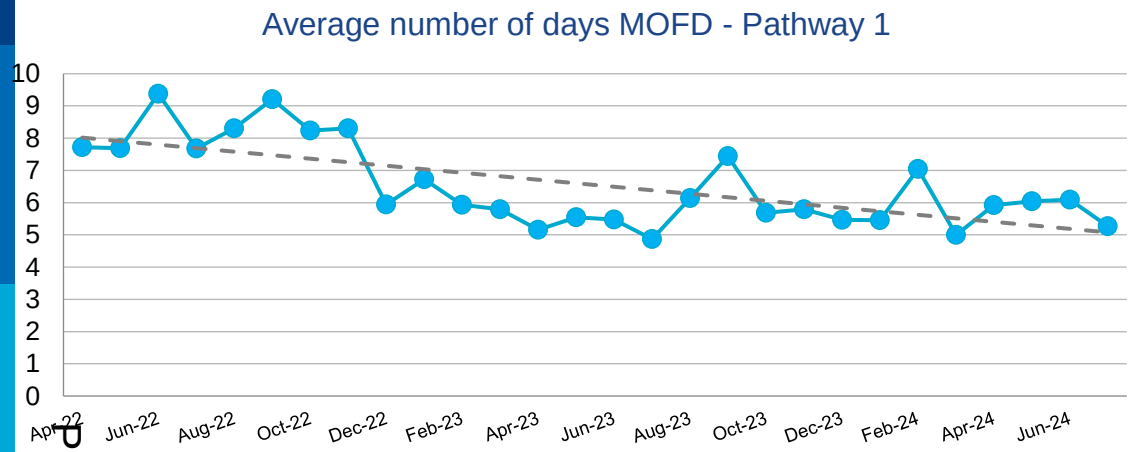
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

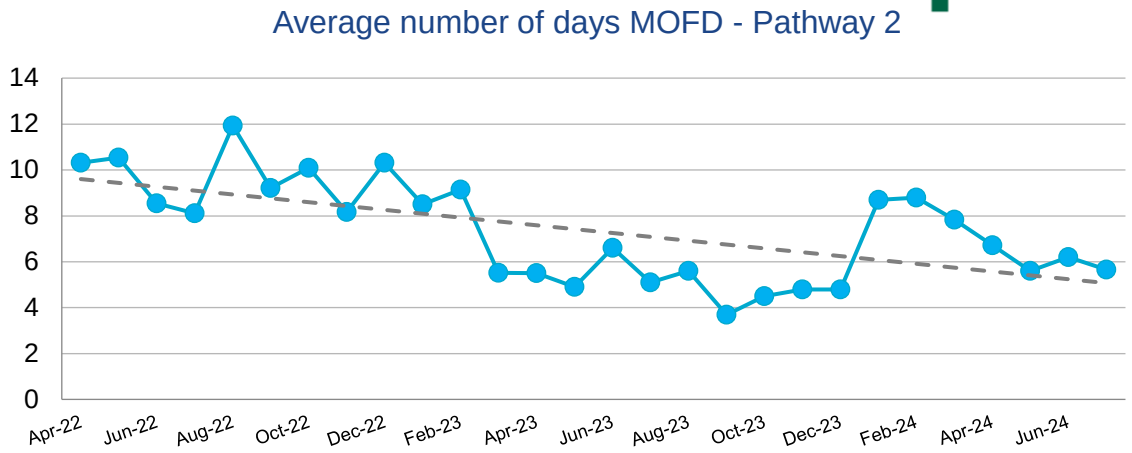
Average days away from home for MOFD patients in acute inpatient wards

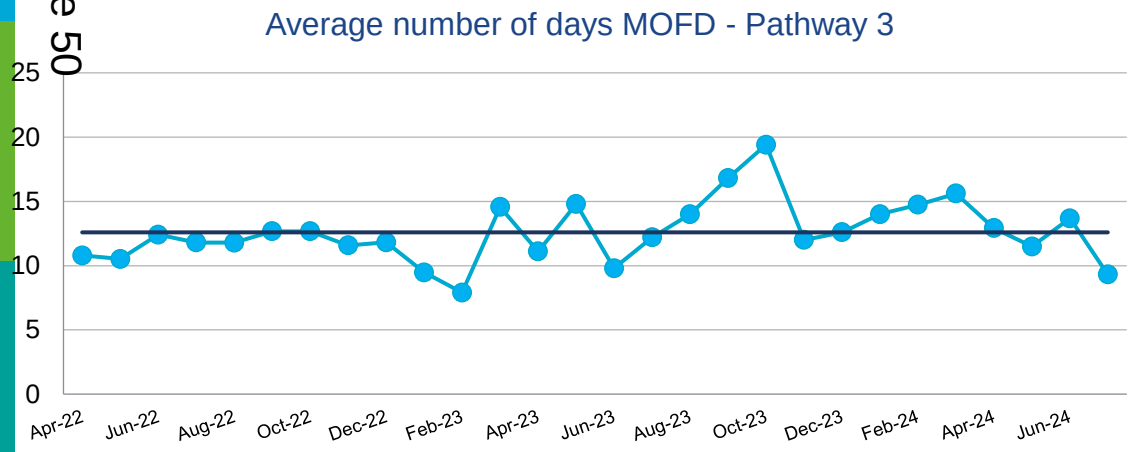


Days away from home for delayed discharges for OUHFT inpatients

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System







Key: Avg. number of days MOFD — Trend Line - - - - Mean ——

Achievements in 2023/24

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Mental Health**
- Crisis team expansion from City to North and West Oxfordshire providing home treatments from those leaving inpatient MH beds.
- Out of hospital Care team and access to step down and the housing officers have provided support for the homeless pathway from MH beds.
- Overall length of stay is continued to reduce, and the number of days delayed had reduced.
- Additional MH support to Care homes supported people requiring placements reducing their delay
- Reduction in inappropriate Mental Health Placements
- Reduction in the total number of people delayed and the number of days delayed for those in MH inpatient beds

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Winter plan 2024/2025

Supporting frail patients in the community

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Expand capacity to meet increasing demand over the winter period.**
- Develop Single Point of Access (SPA) to support all health care professionals to refer people who can be assessed and cared for in their own home.
- Expand capacity within Hospital @ Home teams to provide consistent cover until 22:00hrs 7 days a week.
- Hospital @ Home working closely with Integrated Neighbourhood teams with a view to discharge people earlier to them but to support remotely.
- Integrating Urgent Community Response with the overnight visiting service to delivery service that provides more home visiting capacity in the evening and overnight.

Supporting frail patients in the community- Integrated Neighbourhood teams

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Oxfordshire has integrated Neighbourhood teams across Banbury, Oxford City, Bicester, Wantage and Witney. During the winter months these will continue to be developed to address the following.

- To reduce health inequalities by reducing morbidity and mortality in areas of concern, stroke, heart failure and respiratory disease.

- Continue to develop an integrated approach across Primary Care, Community and acute services for those with the highest need and based on the local population needs.

- Local population health data has dictated some INTs need to focus on people with Mental Health, alcohol and substance misuse or the needs of children.

- Coordinated care mainly for those who meet the frailty criteria – especially those just discharged from hospital where additional assessment and support will maintain them safely in their own home.

- Develop and report on metrics for INTs to assess clinical and cost effectiveness.

Supporting frail patients in the community-ReSPECT

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.
- ReSPECT and decision-making conversations happen between a person, their families, and their health and care professionals. These conversations help create an understanding of what is important to the person.
- Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.
- The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.
- Implementation will start within the community setting and then the acute Trust.

Reducing Ambulance Handovers

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Focus on referring people from the ambulance stack in the control room directly to Single Point of Access (SPA) to avoid an ambulance being deployed where another team can access and treat the patient.
- Ambulance crews to refer appropriate patients to SPA where they can discuss the person with a clinician to see if Urgent Community Response or Hospital @ Home can carry out further assessment s or treatment.
- Reducing ambulance handovers, the majority of which to be achieved within 15/30 mins.
- Maximum handover time of 45 minutes: prepare to move to a mandated handover at 45 mins
- Improve process for signing off ambulance handovers in real time to improve data quality

Increasing capacity – improving flow

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- **Acute Care**
- Improving streaming, direction and initial assessment of people as they arrive in the Emergency Department
- Continue to focus on reducing the length of time people spend in the Emergency Department
- Further development of the children's Emergency pathways
- Continue to reduce the number of days people are away from their own home

- **Transfer of Care HUB**
- Achieve 95% of people in acute care returning to their own home
- Expand to working from 6 days to 7 days a week
- Focus on reducing Length of Stay across all Oxfordshire bed bases.
- Improve communication with people and their carers pre and post hospital discharge
- Digital integration to improve information sharing
- Working closely with Integrated teams to ensure all those who can be supported at home do so at the earliest opportunity.

Increasing surge capacity – Improving flow

- **Discharge flow**

- Referring people who require support to return home at the earliest opportunity.
- Improving communication with people and their carers prior to discharge and within the first 48hrs post discharge.
- Intense approach to reduce length of stay across all Oxfordshire step down beds.
- Improve approach and timely access to step down care across community hospital and short stay HUB beds
- Review the impact of discharge to assess on Oxfordshire residents.
- Social Care reviewing plans to deliver surge capacity for the expected increase in double handed care over January to March 2025.
- Hospital @ Home and Urgent Community Response reviewing how to create additional capacity to support Health Care professional referrals for people who require assessment in their own home.

Mental Health – reducing Length of stay

- Embed new BCF schemes agreed for 24/25 (additional embedded housing workers)
- Continue to realise value from 23/24 BCF / ADF schemes (step-down housing/embedded housing workers, discharge liaison support into care homes; inpatient personality disorder intervention/discharge team; one-off flexible use fund)
- Design and implement national requirements for ‘purpose of admission’ and ’72 hour assessment’ within inpatient care with the aim of further LOS improvements and decreased delays
- Implement revised national MH OPEL triggers and actions
- Improved integration of Mental Health into the TOC Hub to assist with discharge pathways and admission avoidance to older adult MH inpatient care
- Introduction of enhanced MDT / senior oversight process for adults with LOS over 60 days and older adults with LOS over 90 days .
- Reducing Inappropriate out of area placements- trajectory to reduce to 2 people at any one time in out of area inappropriate placements.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Thank you

Questions?

Meeting	Health and Social Care Overview and Scrutiny Committee (HOSC)
Date of Meeting	Thursday 12 September 2024
Title	Adult and Older Adult Mental Health in Oxfordshire
Date of Report	30 August 2024
Version	1
Author(s)	Oxford Health NHS Foundation Trust (OHFT) Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Oxfordshire County Council (OCC) Oxfordshire Mental Health Partnership (OMHP)

Introduction

1 This briefing paper provides an overview of adult and older adult mental health provision in Oxfordshire in response to the following points raised by the Oxfordshire Scrutiny Officer:

- The degree to which there is an Adult and Older Adult Mental Health service for Oxfordshire, and how this operates.
- Current trends and patterns of Adult and Older Adult Mental Health amongst Oxfordshire residents; including any data relating to this.
- The nature of commissioning for such services, and any examples of such Adult and Older Adult Mental Health Services being commissioned
- The degree to which there is overall effective partnership working within the Oxfordshire system for the purposes of Adult/Older Adult Mental Health.
- The extent to which there is an adequacy of resource, including funding and workforce, for this.
- How you plan to continue to develop and to improve Adult/Older Adult Mental Health Services moving forward.
- The support being provided to tackle suicide.
- Whether there are any high-risk groups that have been identified, and the kind of support that such vulnerable groups can expect to receive.
- Whether any Mental Health Needs Assessments have been conducted.

The paper does not read as a question-and-answer document, rather some sections have been grouped together where overlapping and/or similar themes and content are covered.

2 This paper mainly relates to commissioned secondary care mental health provision in Oxfordshire. It must be noted that a great deal of mental health care and support is provided outside of these commissioned arrangements, for example, within Primary Care.

3 It is important to note that this briefing paper does not relate to Neurodivergent diagnostic provision, which includes conditions such as Attention Deficit Hyperactive Disorder (ADHD) and Autism Spectrum Disorder (ASD).

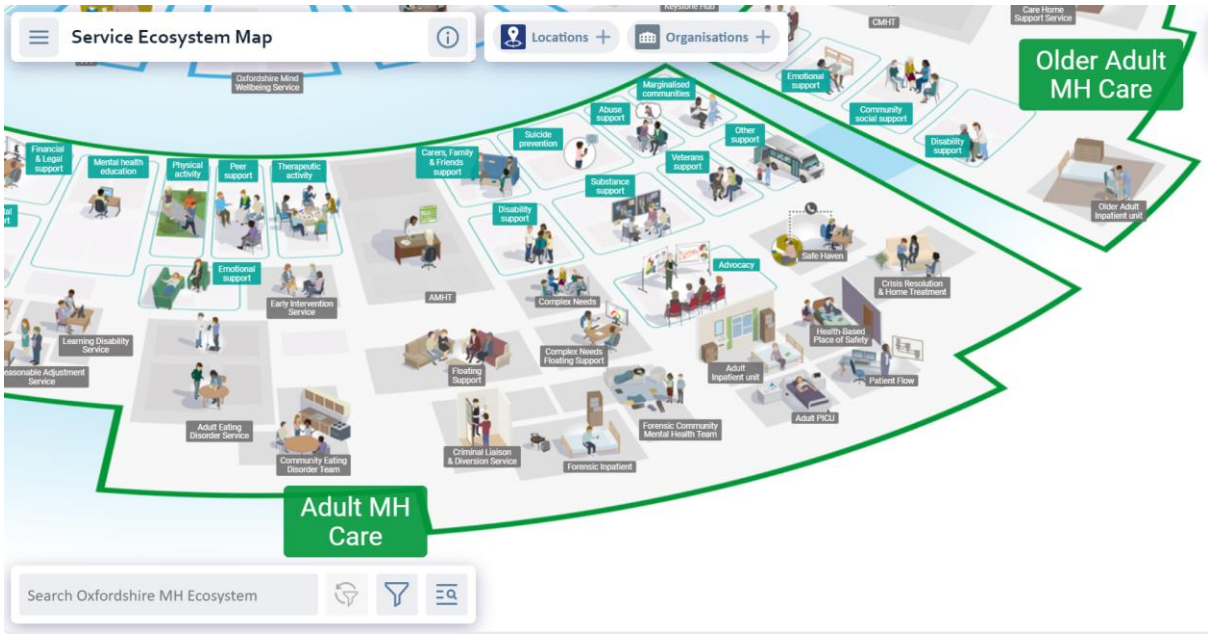
Summary of commissioned adult and older adult mental health provision in Oxfordshire

4 The commissioning of mental health provision for adults and older adults in Oxfordshire is the responsibility of the Health, Education and Social Care (HESC) Joint Commissioning Team that sits within OCC but also discharges responsibilities on behalf of BOB ICB. The "Live Well" function within HESC holds 3 significant contracts that cover the scope of the vast majority of provision:

- The "Outcomes Based Contract" (OBC) between BOB ICB / OCC and the Oxfordshire Mental Health Partnership via OHFT covers those aged 18 – 64 with moderate to severe mental health needs, with an annual value of approximately £76 million.
- The "Mental Health Contract" between BOB ICB / OCC and OHFT covers provision associated with Community Eating Disorders, Older Adults (aged 65+) and Liaison Psychiatry, with an annual value of approximately £20 million.
- The "Improved Access to Psychological Therapies" (IAPT), or "Talking Therapies for Anxiety and Depression" contract between BOB ICB / OCC and OHFT covers talking therapies provision for those with common mental health problems, aged 16+ in Oxfordshire, with an annual value of approximately £14 million.

5 In 2024, efforts were made to map out the entirety of mental health provision in Oxfordshire. The purpose of this was to develop insights and observations from a wide range of stakeholders to enable improvements in future years. It also provided an intuitive graphic that helps explain how mental health provision works in Oxfordshire. Below are two stills of the product[1] which can be explored further through an online platform. As of now, the platform is not openly available but there is an opportunity to review this in the near future to develop a resource that is openly available to residents and practitioners alike.

[1] Oxfordshire MH Ecosystem - Service Ecosystem Map



Outcomes Based Contract

6 The OBC has been in place since 2015 and has grown over time. It is delivered by the OMHP (further detail in section 23) and incorporates a wide range of individual services and teams that work together to provide holistic care and support. These include:

- Adult Mental Health Teams (AMHTs) – multi disciplinary teams that support residents with moderate to severe mental health needs. There are 3 teams that cover Oxfordshire; North, City and South, each with multiple bases. AMHTs also provide care in the community and in people's homes. AMHTs also have workers from VCSE organisations so they are better equipped to work with a wider range or residents and their needs.
- Early Intervention in Psychosis (EIP) – specialist service that works intensively with people aged 14 – 35 as they experience their first episode of psychosis. The EIP team is recovery focussed and aims to support people to reduce individual risks and issues associated with their mental illness. Part of this offer is the At Risk Mental State (ARMS) team which supports people who begin to have unusual experiences relating to their mental health, such as hearing voices or feeling extremely paranoid.
- Perinatal Mental Health Service – specialist team that works with people from pre-conception, up to 24 months after birth. The Perinatal service works collaboratively with maternity services and health visitors, providing holistic support to some very vulnerable individuals and families.
- Complex Needs Service – therapeutic community for people with personality disorder and the associated challenges.
- Individual Placement and Support (IPS) – specialist interventions to support people with Serious Mental Illness (SMI) to enter or return to paid employment. In Oxfordshire this is delivered by Restore.
- Keystone Mental Health and Wellbeing Hubs – a recent addition to provision in Oxfordshire, community assets that support individuals close to their home in a holistic and non-stigmatising fashion. The Keystone Hubs have been designed to meet the needs of people that may have previously fallen between thresholds of primary care and secondary care. Also intended to reduce referrals to AMHTs so they can complete intensive treatment plans with those that need them most.

- Acute inpatient wards – there are two male and two female acute inpatient wards in Oxfordshire. Inpatient care is required when they require interventions and support that cannot be delivered without bedded care. Inpatient beds must also be available for those that are detained under the mental health act (MHA).
- Psychiatric Intensive Care Unit (PICU) – there is one male PICU in Oxfordshire. PICU beds are accessed by some of the most unwell and complex individuals and often require highly intensive support and interventions.
- Supported accommodation – there is a wide range of supported accommodation options available to Oxfordshire resident with mental health needs. Response and Oxfordshire Mind provide approximately 300 units across 80 properties as part of the OBC, ranging from specialist recovery provision, to intensive 24 hour supported accommodation.
- Recovery college – educational courses and workshops that aim to help people to take steps towards recovery from mental health issues, or to support someone in their own recovery journey, delivered by Restore.
- Specialist floating support and housing expertise – regular, intensive support for individuals with complex mental health and wider social needs, delivered by Elmore and Connection Support.
- Mental health helpline – urgent and emergency support available via 111 and 999. The helpline is open access to anyone in Oxfordshire and has OHFT clinicians embedded within the South-Central Ambulance Service (SCAS) Clinical Co-ordination. The helpline also supports a diversion from ambulance dispatch and Accident and Emergency (A&E) attendances where appropriate.
- Police 'Street' Triage – mental health clinicians supporting Police Officers on twilight shifts to aid information sharing and joint decision making, with a view to effectively managing application of Section 136 of the Mental Health Act (MHA).
- Hospital based places of safety – safe spaces for police to bring people that are detained under the MHA. There are three in Oxfordshire and a further two in Buckinghamshire that operate under a single point of access.
- Adult Crisis Resolution and Home Treatment Team (CRHTT) – community-based team that supports admission avoidance and timely discharge from inpatient care. Currently only operating in Oxford City and partially through North Oxfordshire, plans are in place to deliver full county coverage.
- Safe Havens, sometimes referred to as crisis cafes – one site in Banbury and another in Oxford. Safe Havens are non-clinical services operated by Oxfordshire Mind, they offer listening support for people at risk of, or those experiencing mental health crisis. Support is available through a combination of one to one and small groups, as well as over the phone or face to face.

Mental Health Contract

7 The Mental Health Contract covers further adult and older adult provision that does not currently sit within the OBC, this includes:

- Older Adult Community Mental Health Teams (CMHTs) – similar to AMHTs, this community-based provision offers multi-disciplinary assessment and treatment for moderate to severe mental health conditions.
- Memory Clinics – work closely with Older Adult CMHTs, providing diagnosis of dementia, as well as treatment and support for people newly diagnosed with dementia. There are also strong links with many VCSEs to support resident and their families, including (but not limited to) Age UK Oxfordshire.
- Older Adult Inpatient Wards – there are two wards for people aged 65 + in Oxfordshire, providing care and support for people that cannot be nursed safely

in the community. There is a multi-disciplinary approach to patient care and support and advice is also available to families and carers.

- Adult Community Eating Disorders - specialist assessment and treatment for adult patients with eating disorders. The multidisciplinary team offer individually tailored treatment packages that address both the physical and psychological aspects of an eating disorder. OHFT also deliver Adult inpatient care for eating disorders in Oxford and Marlborough (Wiltshire) Swindon, although these units are not locally commissioned i.e. NHS England commission them directly through the Healthy Outcomes for People with Eating Disorders (HOPE) Provider Collaborative to support people from a wider footprint.
- Emergency Department Psychiatric Service (EDPS) – liaison psychiatry team that is collocated with John Radcliffe (JR) and Horton Hospital Emergency Departments. The team assess people (all age) that come to emergency departments with psychiatric needs. EDPS also offer in-reach support to some wards alongside the Oxfordshire Psychological Medicine Service (OPMS) within Oxford University Hospitals (OUH).

Talking Therapies, previously known as Improving Access to Psychological Therapies (IAPT)

8 Talking Therapies offer a variety of psychologically informed interventions for common mental health problems in line with National Institute for Health and Care Excellence (NICE) guidance recommendations. Most people self-refer to Talking Therapies but Primary Care colleagues can also make referrals to the service. Talking Therapies deliver one to one support, as well as courses and groups. Treatment options are available online and in person, and support individuals with a range of needs, including those relating to employment and physical health.

Summary of mental health and wellbeing need in Oxfordshire

Joint Strategic Needs Assessment

9 The Oxfordshire Joint Strategic Needs Assessment (JSNA) includes a comprehensive overview of population need. The JSNA is broken down into several digital products, one key product is the extract for mental health and wellbeing.

10 Census data within the Oxfordshire JSNA tells us that the Oxfordshire population has risen by 71,500[2] (10.9%) from 2011 to 2021. This included considerable increases to those of working age in their 30's (15%) and 50's (27%), as well as those aged over 65 (25%). Population increases were experienced by all districts within Oxfordshire, but the greatest increases were in Cherwell (19,100 or 13.5%) and Vale of the White Horse (17,900 or 14.8%).

11 The gap in life expectancy for males living in affluent areas is 10.9 years longer than in some of the most deprived areas, for females the gap is 11.5 years[3]. Abingdon, Banbury and Oxford have between them 17 wards that sit within the 20% most deprived in the country based on the Index of Multiple Deprivation (IMD[4]).

12 Prevalence of depression in Oxfordshire is recorded by General Practitioners (GPs) and published as part of the Quality and Outcomes Framework (QOF), in 2022/23 there were 86,169 adult residents (13.17%[5]) recorded with depression, this is similar

[2] https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA2023_Population.pdf
[3]https://public.tableau.com/views/OxfordshireLocalAreaInequalitiesDashboard/Overview?embed=y%3Adisplay_count&%3AshowVizHome=no
[4] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[5]https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA2023_MentalWellbeingEXTRACT_FINAL.pdf

to the England average (13.25%). There was a 0.63% increase from 2021/22 – 2022/23[6], forming part of an overall increase to the prevalence rate by 2% since 2017/18. Levels of anxiety reported in the general population i.e. those who are not living in care homes or supported living services, have decreased in line with the England trend and are now below the England average for the first time since 2013/14[7].

13 Of all 10 – 19-year old's in Oxfordshire, 11% (9,584 of 88,000) were referred to OHFT mental health services. This is against a backdrop of the rate of probable mental disorders among 17- 19-year-olds increasing from 1 in 6 in 2020 and 2021, to one in four in 2022[8]. It reasonable to suspect that this increase will result in a continuing trend of more residents requiring and seeking support in coming years.

14 For the years 2018, 2019 and 2020, Oxfordshire had one of the lowest rates of death from drug misuse when compared with statistical neighbours and was also below the national average[9].

15 Oxfordshire has detentions under s136 of the Mental Health Act into places of safety which are 20% below the national average. However, 75%[10] of admissions to adult acute psychiatric beds in Oxfordshire take place under the MHA, compared to a national average of 50%.

16 Homelessness and rough sleeping is difficult represent and quantify, but it has a significant impact on a range of health and social care provision in Oxfordshire. It is estimated that approximately 1,000 homeless adults sleep rough or in supported accommodation over the course of one year[11].

Service User, Resident and Professional insights

17 As part of the transformation programme to re-procure mental health provision in Oxfordshire, engagement and information gathering exercises have taken place. Surveys[12], reviews and group / individual sessions with people that access mental health services and practitioners that work in assessment, treatment and community support provision (both NHS and non-NHS) are currently being analysed. Early indications have highlighted areas to be considered for improvement, these include:

- More timely access to assessments and interventions, as well as support for whilst waiting, this is relevant to a wide range of provision.

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[6]https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2022-23#resources

[7]https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2021tomarch2022

[8]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1134596/State_of_the_nation_2022_-_children_and_young_people_s_wellbeing.pdf

[9] https://fingertips.phe.org.uk/profile/mortality-profile/data#page/1/gid/1938133058/ati/15/iid/92432/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

[10] Draft NHS Benchmarking report for mental health services in England 2023/24

[11] https://insight.oxfordshire.gov.uk/cms/system/files/documents/2019_Homelessness_HNA.pdf

[12] Please take a moment to share your perspectives through our survey, accessible via this link: https://letstalk.oxfordshire.gov.uk/mental-health-survey Carers: https://forms.office.com/e/Umh8iCJ5P8 - closing date 2nd Sept
Veterans: Veterans - Making mental health care better in Oxfordshire – we want to hear from you… (office.com) – Closing 9th August

- Flexibility of how individuals access and engage with services, this includes a wider range of opening days/times, as well as the us of technology as appropriate.
- Holistic approaches and interventions for co-occurring needs, such as neurodiversity, physical health concerns. This should also include comprehensive training for NHS and VCSE organisations
- A need for person centred approaches and planning, support people to understand the choices they have by equipping them with knowledge of provision and support available to them
- Continuity of care and support and to enable rapport and trust to be developed with practitioners.
- Better join up across organisational boundaries and age thresholds.
- Greater emphasis on living a fulfilling life through the 'building blocks of health', namely support with building and maintaining social connections, as well as support to secure stable housing, ranging from readily available social housing to long term supported accommodation.
- Ensure equity of provision outside Oxford city, including health and care provision and community assets and support.
- Embedding of, and integration of the Keystone Hubs within communities and the health and social care landscape.

Suicide Prevention

18 Oxfordshire data shows that the suicide rate per 100,000 population was 9.6% 2020-2022 compared to 10.3% in England. This represents 184 deaths over a 3-year period, the male rate remains 3 times higher. In the County in 2022 and 2023 males aged 35-44 years had the highest number of deaths followed by 25-34 years. In females, the highest age range was 45-54 years. Most deaths occur in the home. Contributory risk factors include relationship breakdown, bereavement, serious illness/long term condition, depression and anxiety. Nationally, 27% of all deaths by suicide are from people in contact with mental health services. Additional local analysis explored suicide alongside deprivation, self-harm, unemployment, substance misuse and alcohol. This shows that the highest proportion of suicides were from residents living in the least deprived areas of Oxfordshire. There was also no identified correlation between unemployment, substance misuse or alcohol.

19 People who have been bereaved by suicide are at a higher risk of suicide and this is an important element of suicide prevention work. In Oxfordshire there are two organisations who provide help and support: Amparo[13] and SeeSaw[14]. There is a role within Thames Valley Police that liaises with families, and they will explore with them the help available. They will also provide the Help is at Hand[15] guide.

20 In September 2023 there was a new National Suicide Prevention Strategy[16] published. This is a 5-year cross sector strategy setting out ways to prevent suicides for everyone as well as supporting groups where there are higher suicide rates. The national suicide rate has not fallen since 2018. Oxfordshire's Suicide and Self-harm Prevention Strategy[17] 2020 -2024 focused on the following action areas:

- Realtime surveillance and analysis
- Identifying high risk groups and behaviours
- Supporting after suicide and self-harm including living experience

[13] Get help now. Free and confidential,for as long as you need it. (amparo.org.uk)
[14] Supporting children and young people bereaved by suicide | SeeSaw
[15] You are not alone: Help is at Hand for anyone bereaved by suicide - GOV.UK (www.gov.uk)
[16] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)
[17] Item 10.4 - OxfordshireSSHPreventionStrategy.pdf

- Promote resilience and wellbeing

21 Public Health are leading a process to updated the Suicide Prevention Strategy. In July 2024, a workshop was delivered to facilitate coproduction and collaboration. Insight will be used to inform the updated strategy and action plan. The strategy will be published in 2025.

22 The Oxfordshire Suicide Prevention Multi-Agency Group (MAG) is an established network made up of professionals from over 20 organisations to deliver actions identified within the strategy for suicide prevention. During the last year the following progress has been made:

- Upskilled and supported frontline workers and volunteers in organisations such as Homeless Oxfordshire, Archway, Enrych, HealthWatch across all districts through delivering a mental health and suicide prevention training delivered by Oxfordshire MIND
- Use Real-Time Suicide Surveillance System (RTSS), for in-depth monitoring of Oxfordshire suicides using intelligence from Thames Valley Polics, Coroners and Public Health. This information is used to target specific interventions and support communities.
- Worked in partnership with Thames Valley Police to implement a 'Target Hardening' project to make high risk locations safer which has resulted in design changes to bridges and railway stations. There has also been training for staff in railways on suicide prevention in Oxfordshire
- Oxfordshire County Council have implemented Ripple[18] an innovative interception tool that provides support when harmful content is viewed online
- Oxford Health and Oxford University Hospitals have various initiatives such as supporting reduction initiatives within hospital estates, training the workforce to approach vulnerable people, initiatives for male suicide, LGBTQ+ and autism programmes
- Delivered geotargeting campaigns for wellbeing in specific geographical locations
- Both University of Oxford and Oxford Brookes University are progressing with membership of the University Mental Health Charter Programme[19]
- Samaritans deliver outreach programmes locally such as Feet on the Street and Listeners in (HMP Bullingdon) as well as ad hoc talks and outreach events across the county. Support for organisations following suicides or near misses e.g. Fire & Rescue, Network Rail Locations
- Oxfordshire's Men's Health Partnership have delivered a range of outreach events in partnership with 15 local organisations. In November 2023 they launched #30Chatsin30Days social media campaign.

Partnerships and Collaborative Working

Oxfordshire Mental Health Partnership (OMHP)

23 Mental Health provision in Oxfordshire has benefitted from partnership arrangements and collaboration for many years now. As outlined in section 6, the OMHP has delivered mental health services via the OBC for adult residents since 2015. This innovative arrangement not only enables a more diverse range of needs to be met in one place but has also been praised for having "pioneered the model of outcomes-based commissioning in mental health"[20].

[18] Home - Ripple Suicide Prevention (ripplesuicideprevention.com)
[19] University Mental Health Charter - Student Minds Hub
[20] Centre for Mental Health, Review of Oxfordshire Mental Health Outcomes-Based Commissioning Contract, July 2019

24 The OBC that is delivered by the OMHP was originally put in place as a 5 +2-year contract. The 2-year extension was executed in 2021 and extended once more through a single tender waiver for a further 2 years in 2023. The annual value of the OBC has increased from approximately £45 million in 2015, to almost £70 million in 2024. This speaks to the extent at which Oxfordshire is committed to partnership working between commissioners and providers as the means for improving services, rather than using competition between providers as the vehicle for change. A transformation programme is currently underway to further develop these arrangements to better meet the needs of our whole population, more details in section 45.

25 Members organisations of the OMHP are detailed in the table below:

Name	Summary
Provider Organisations	
Connection Support	VCSE organisation solving homelessness and achieving independence.
Elmore	VCSE organisation supporting people with multiple complex needs.
OHFT	NHS provider of mental health and community health services.
Oxfordshire Mind	VCSE organisation providing wide range of mental health support.
Response	VCSE organisation providing specialist support and accommodation.
Restore	VCSE organisation supporting people with recovery and training/employment.
Commissioning Organisations	
BOB ICB	Statutory body responsible for commissioning healthcare provision.
Oxfordshire County Council	Upper Tier local authority responsible for social care and education.

26. Alongside individual services and teams delivered by each organisation, the OMHP has established embedded workers across many teams. These workers bring multiple organisations, skillsets and perspectives together in one place. Examples include Oxfordshire Mind, Elmore and Connection Support workers forming part of the OHFT adult mental health teams. The partnership enables mutual benefit for statutory and VCSE organisations, embracing the 'value added' aspect of each sector, such as peer-support from volunteers and people with lived experience as well as the ability to access funding opportunities to increase sustainability.

27 OHFT continues to take on the role as a system leader to improve how organisations work together to support people with ill mental health. Key partnership work includes developing a shared definition of adult mental health needs to support referrals in Oxfordshire, establishing an agreed set of NHS resources for patients to report on their outcomes following mental health support (Patient Reported Outcome Measures, PROMs), a shared understanding of the mental health pathway and a 'service-user led' passport which helps people to have their story read and understood as they move between services.

28 Since their inception, the OMHP and OBC have evolved to respond to national strategies, plans and priorities such as the Five Year Forward View and the Long Term Plan (LTP). This transformation has resulted in some services that look radically different to how they were in 2015, as well as some services that are brand new. One (of many) significant development is the implementation of the Community Mental Health Framework (CMHF). The expectation of CMHF was to improve support for people with a Severe Mental Illness (SMI) who previously may have fall into the gap between Primary Care and Secondary Care provision. In Oxfordshire this has been done through the introduction of the Keystone Mental Health and Wellbeing Hubs across the county. The Keystone Hubs are situated in high footfall areas such as high

streets, making them easily accessible for the population they cover. The idea being that any member of the public can walk in and seek advice on how to access support for mental health or issues which impact on mental health. 5 hubs have opened in Oxfordshire over the last 3 years, they are situated in Banbury, Kidlington, Cowley, Abingdon and Wantage. The Keystone Mental health teams (KMHTs) are employed by OHFT, and they work alongside VCSE organisations to support accessing Hub provision for service users without the requirement for a referral from Primary Care. VCSE partners are utilising space within the Keystone Hubs to deliver services and the Department of Work and pensions (DWP) is also looking to develop clinics from the Hubs.

BOB Mental Health Provider Collaborative

29 The BOB Mental Health Provider Collaborative (PC) emerged in 2023 as part of NHS England's Provider Collaborative Innovator scheme. It was 1 of only 9 selected across the country to benefit from hands on support improve quality and efficiency of patient care. The PC will lead on the transformation of mental health services on a large scale. It will connect with and support the efforts of our Place-Based Partnerships and will strengthen joint efforts between OHFT and BHFT to ensure resources are utilised efficiently, unwarranted variations are identified and addressed, and pathways are redesigned to improve lives, with a particular focus on reducing health inequalities. The BOB Mental Health Provider Collaborative encompasses all non-specialised, all-age mental health services.

30 Together with system partners, the PC has developed a Transformation Programme comprising 4 priority areas that were identified through a series of workshops and surveys, and are aligned to system priorities:

- Area 1: Mental Health Crisis & Urgent Care (Community)
  The scope of projects (under development) includes Right Care, Right Person (Section 136), Alternatives to Inpatient Care and Secure Transport

- Area 2: 3-Year Adult Inpatient Transformation
  The scope of projects (under development) includes Culture of Care and Adult Inpatient Programme Workstreams which are currently in development.

- Area 3: Localising Mental Health Care
  The scope of projects (under development) includes New Models of Service Delivery (Joint Area 2), Local Rehab Provision (Joint Area 2), Female PICU (Joint Area 2) and Care Close to Home (Returning OAPS & 117 Residential)

- Area 4: Co-Production

To deliver this programme, the governance structure has been updated based on stakeholder engagement to further strengthen relationships with existing system structures.

Oxfordshire Prevention Concordat for Better Mental Health

31 The Oxfordshire Prevention Concordat for Better Mental Health was established in 2018, it is convened by Public Health. The group consists of 17 organisations and has made demonstratable progress in this time. A Mental Wellbeing Needs Assessment was completed to inform priorities, the Oxfordshire Communications Group was established and delivered 9 joint mental health and wellbeing campaigns, and the Oxfordshire Men's Health Partnership successfully developed and launched their 30 Chats in 30 Days Campaign.

32 The group has recently updated the Oxfordshire Mental Health Prevention Framework[21] 2024-2027. The framework recognises the need to address the wider social determinants of health, tailor approaches to address the needs of local communities and prioritise the key life stages where people are more at risk of poor mental health. This will be achieved through four key areas:

- Collaboration and co-production
- Insight and Evaluation
- Confident Workforce
- Resilient Communities.

National research[22] tell us that living in a community where there are assets such as green space, play areas, community buildings and strong social networks can promote feelings of togetherness and support for mental wellbeing.

Resources

Financial resource

33 BOB ICB continues to meet the minimum Mental Health Investment Standard (MHIS), the LTP reinforced a commitment to MHIS to ensure "local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to ICBs (previously CCGs)"[23]. This means that despite the broader financial challenges faced by the NHS, investment into mental health services is protected, this is a very welcome position. Prior to the formation of BOB ICB, OCCG also met MHIS requirements.

34 Although MHIS ensures that funding increases on an annual basis, it does not tackle the variation in how much each CCG or ICB had invested as a starting point. Following a review of mental health investment and activity, in 2020 an agreement was reached between OHFT and OCCG to increase investment in mental health services by approximately £12 million on a recurrent basis, this was on top of and additional to the minimum MHIS. The review of investment and activity was support by the NHS Benchmarking Network, it concluded that Oxfordshire:

- Invested in CAMHS and IAPT services in line with statistical neighbours.
- Invested in adult and older adult mental health services lower than its' statistical neighbours, meaning that the model of care was more geared towards tackling greater levels of acuity, rather than preventing ill health and intervening at the earliest possible opportunity for a greater number of residents.

35 The £12 million agreement was enacted over the course of three years. It was used to address findings in the review, and therefore directed towards adult and older adult provision, it enabled:

- OHFT (and OMHP VCSE organisations) to offset (some) cost pressures that had materialised due to historical investment lower than that of statistical neighbours.
- A levelling up of mental health services to ensure that they are in line with national expectations.
- The transformation of mental health services as per the LTP, further supported by funding increases in line with the MHIS and national Service Development Funding (SDF) allocations.

[21] Mental Health Framework (oxfordshire.gov.uk)
[22] 2. Mental health: environmental factors - GOV.UK (www.gov.uk)
[23] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

36 When the LTP was launched in 2019/20, it was supported by indicative activity, workforce and funding trajectories. This provided visibility and transparency amongst providers, commissioners and assurance bodies meaning that multiyear plans[24] could be put into place to deliver the transformation of mental health services. The table below is an extract[25] that sets out the BOB ICB "fair shares" of funding that has been available across England from 2019/20 – 2023/24.

Service area	2019/20	2020/21	2021/22	2022/23	2023/24
BOB					
CYP Baseline Increases	£981,395	£2,245,889	£3,082,920	£4,655,382	£6,410,055
CYP SDF		£90,483	£1,574,183	£2,448,000	£3,999,171
Perinatal Baseline Increases	£2,056,652	£3,796,661	£4,704,359	£5,878,484	£6,034,112
Perinatal SDF	£337,714	£0	£0	£0	£0
IAPT Baseline Increases	£2,752,011	£3,433,446	£5,438,672	£7,448,183	£11,035,083
IAP SDF	£0	£0	£0	£0	£0
Community Baseline Increases	£2,417,750	£6,808,474	£7,186,129	£8,437,500	£13,687,106
Community SDF			£2,825,308	£6,942,000	£8,527,067
Crisis and alternatives Baseline Increases	£473,177	£2,877,934	£4,280,136	£4,666,771	£5,254,197
Crisis and alternatives SDF	£1,380,784	£1,774,444	£732,052	£988,000	£1,275,859
Therapeutic inpatient Baseline Increases		£210,940	£350,060	£706,543	£1,249,144
Therapeutic inpatient SDF	£0	£0	£0	£0	£0
Oxfordshire					
CYP Baseline Increases	£392,558	£898,356	£1,233,168	£1,862,153	£2,564,022
CYP SDF	£0	£36,193	£629,673	£979,200	£1,599,668
Perinatal Baseline Increases	£822,661	£1,518,664	£1,881,744	£2,351,394	£2,413,645
Perinatal SDF	£135,086	£0	£0	£0	£0
IAPT Baseline Increases	£1,100,804	£1,373,378	£2,175,469	£2,979,273	£4,414,033
IAP SDF	£0	£0	£0	£0	£0
Community Baseline Increases	£967,100	£2,723,390	£2,874,451	£3,375,000	£5,474,843
Community SDF	£0	£0	£1,130,123	£2,776,800	£3,410,827
Crisis and alternatives Baseline Increases	£189,271	£1,151,174	£1,712,055	£1,866,708	£2,101,679
Crisis and alternatives SDF	£552,314	£709,777	£292,821	£395,200	£510,344
Therapeutic inpatient Baseline Increases	£0	£84,376	£140,024	£282,617	£499,657
Therapeutic inpatient SDF	£0	£0	£0	£0	£0

a. All values are indicative.
b. Baseline increases are displayed as cumulative recurrent growth from the 2018/19 position.
c. Within Oxfordshire, some discretionary movement has taken place for baseline increases between categories, e.g. from IAPT to Community, these have been agreed by system leaders.
d. SDF values are non-recurrent with the expectation that any recurrent requirements are addressed through the allocation of baseline funding in subsequent years.
e. Oxfordshire values are based on 40% of the overall BOB allocation.
f. Although funding typically goes to NHS mental health providers, it is not an entitlement or a guarantee. An increasing amount of this (value TBC) has gone to VCSE organisations, either directly, or via arrangements put in place by OHFT.

37 Service planning and commissioning in Oxfordshire has evolved into a much more collaborative and inclusive process, whereby it is done alongside providers to maximise benefit from subject matter experts. This includes the allocation of financial resource in annual planning rounds. Each year priorities are brought forward and considered for new investment from baseline increases and/or SDF if available and

[24] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
[25] Extract from NHS LTP Analytical Tool – January 2023 v11.6.xlsx

appropriate. Alongside "new" priorities or projects, attention must also be given to commitments from previous years that have increasing requirements, as well as other pressures that arise such as those associated with prescribing and Section 117 aftercare.

38 For 2024/25, new investment priorities are detailed below:

- The next step of a county wide rollout of the Crisis Resolution and Home Treatment Team (CRHTT), building on the provision that is in place in Oxford City. Approx. £3,400,000
- Ongoing developments within the Brain Health Centre to provide timely and reliable dementia diagnosis. Approx. £110,000.
- Improvements to inpatient provision, to enhance a recovery focussed model with dedicated resource to deliver psychologically informed therapeutic interventions. To increase safety and quality on wards through digital observations, with a view to reducing incidents on wards such as self-harm and restrictive practice. Approx. £620k.

39 Planed spend on mental health in Oxfordshire is summarised in the table below. This relates to recurrent baseline expenditure only. SDF for 2024/25 is currently being disaggregated across Buckinghamshire Oxfordshire and Berkshire West. It should also be noted that the values below are indicative, as some spend may fit within several categories, but to avoid double counting, has only been captured in one. "Community B Supported Housing Services" shows as a negative value, this is due to an accounting adjustment that takes place throughout they year.

Cost Centre Description	Planed Spend 2024/25
NON-CONTRACTED ACTIVITY	£963,000
CYP MENTAL HEALTH (EXC LD)	£9,076,100
PERINATAL MENTAL HEALTH	£1,198,300
EIP TEAM (14 - 65YRS)	£886,800
IAPT	£10,610,000
A&E WARD LIAISON MH ADULT	£707,000
ADULT COMMUNITY CRISIS	£1,677,700
AMBULANCE RESPONSE SERVICES	£95,900
COMMUNITY A NOT BED-BASED NOT PLACEMENTS	£66,017,400
COMMUNITY B SUPPORTED HOUSING SERVICES	-£6,984,300
MENTAL HEALTH ACT	£5,941,400
SMI PHYSICAL HEALTH CHECKS	£180,100
LOCAL NHS ACUTE MH & REHAB IP SERVICES ADULT	£29,053,300
LD AND AUTISM	£14,937,200
ADHD	£435,800
TOTAL	**£134,795,700**

Non-financial resource

40 Additional investment into mental health services has been well received, but this scale of investment has meant that it has been challenging to convert new funding into practitioners. In mental health the vast majority of spend is on staff, although there is digital advancements and resources are becoming more common, most of the care is delivered by people. There have been longstanding challenges with recruitment of qualified staff across clinical services, particularly qualified nurses and occupational

therapists (OTs). OHFTH has been proactive in sourcing temporary staff through its' internal bank and agencies to cover the vacancies. Although controls and price caps are in place, these mitigations remain more costly than the preferred substantive roles.,

41 A comprehensive range of initiatives to retain existing staff as well as recruit to new roles are underway. Incentives have been put into place for some roles and services that are particularly difficult to recruit to. Human Resources (HR) and recruitment experts are extending reach across Oxfordshire and beyond through the use of social media, recruitment days within Oxford and attending recruitment fayres across the country, linking with educational institutions and directly to students.

42 OHFT has focused on developing its own staff by employing nursing associate trainees. Once these trainees qualify as registered nurse associates, they can pursue further training to become qualified nurses. Teams are now integrating these staff members into their skillmix and supporting their career development. Additionally, OHFT is reviewing skill mixes within teams and considering alternative roles for band 5 and 6 nurses and occupational therapists (OTs) to optimize budget use. By promoting participation of staff surveys and exit interviews, OHFT has been able to gather a wide range of feedback and act upon it. Efforts have resulted in some improved (reduced) vacancy rates within services, for example, across the Oxfordshire AMHTs, the vacancy rate is 23%, a 10% reduction when compared to 12 months ago.

43 Oxfordshire has a thriving VCSE sector and has been keen to embrace all benefits of it, including the ability to act and recruit to posts at pace. Much progress has been made to support VCSE employed practitioners, to work alongside clinical counterparts in NHS organisations. This cross pollination has had mutual benefit to the workforce, but also to residents. Resident now have access to a more diverse range of practitioners and interventions, meaning that they can have their needs met in a way which is most appropriate and preferable to them.

44 There are economic benefits to investing more in VCSE organisations, particularly local organisations that also bring social value[26]. However, costs are now often comparable to those outside of the VCSE sector, in part due to the introduction of the Oxfordshire Living Wage. This has brought about affordability challenges for VCSEs that have introduced the Oxfordshire Living Wage without having increased income. Despite these challenges, the true appeal and benefit of having VCSE partners is the fact they extend the reach and range of support and interventions available to a greater proportion of our population.

The future for adult and older adult mental health in Oxfordshire

45 The end of the OBC in March 2025 brings about an opportunity in Oxfordshire to further improve provision in Oxfordshire. A large programme of work is underway to review adult and older adult mental health contracts in Oxfordshire, with a view to strengthening the offer available to Oxfordshire residents by setting an aspirational direction of travel for provision over the next ten years.

46 The Provider Selection Regime (PSR) has recently been introduced (April 2024) by regulations under the Health and Care Act 2022 as a set of rules for the procurement of health and social care provision, it has been designed to[27]:

- introduce a flexible and proportionate process for deciding who should provide health care services

[26] https://www.nicva.org/resource/how-social-value-can-work-for-vcse-organisations
[27] https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/

- provide a framework that allows collaboration to flourish across systems
- ensure that all decisions are made in the best interest of patients and service users.

This also comes at a time when commissioners are making a conscious effort to give providers greater flexibility and sustainability by having fewer contracts in place, each having a longer duration.

47 Oxfordshire is now presented with an opportunity to consolidate and strengthen several existing contracts and service models, into one comprehensive and all-encompassing offer for residents aged 18 and over. This will mean that residents will have more choice and control based on what support is best for them, bringing together over £100 million of resource per annum, over a 10-year period. BOB ICB and OCC intend to follow the PSR to award the head contract to OHFT, and to support them to be a true integrator and value generator. In turn, OHFT, alongside BOB ICB and OCC will apply the PSR to activities and interventions that fit best with VCSE partners, this is expected to increase further throughout the life of the head contract.

48 As has been the case with the OBC, the new contract will be targeted towards the strengths and needs of Oxfordshire but will also be sufficiently agile to respond to national strategies, priorities and opportunities.

49 Planning and delivering positive change at this scale requires a great deal of skills and expertise from all involved, but particularly from our senior leaders. To better equip some of our most senior leaders in Oxfordshire, a select cohort has embarked upon a leadership development programme. The purpose of this is to further enhance our system capabilities, as well as the critical working relationships and trust across organisations and sectors.

Closing statement

50 The efforts outlined in this briefing reinforce a strong commitment to the ongoing delivery and improvement of mental health services in Oxfordshire. This comes from senior leaders across provider and commissioning organisations, spanning health, social care and the VCSE sector. It is evident that collaboration and partnership working in Oxfordshire is a key feature of the way that care and support is delivered, and is perhaps one of the greatest assets within the county. This provides a strong foundation for the future transformation of mental health services for Oxfordshire residents.

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healthwatch Oxfordshire

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview Scrutiny Committee

September 2024

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1. Healthwatch Oxfordshire reports to external bodies

For all external bodies we attend our reports can be found online at: https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/

We attend **Oxfordshire Place Based Partnership** meetings under Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). We work together with the five Healthwatch groups at place across BOB ICB to give insight into committees at BOB ICB wide level, including BOB ICB Quality Committee, BOB ICB Health Overview Scrutiny Committee and BOB Integrated Care Partnership (BOB ICP).

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting - June 2024:

Healthwatch Oxfordshire reports published to date:

All the following reports published since the last meeting can be seen here: https://healthwatchoxfordshire.co.uk/reports All reports are available in **easy read**, and word format. (Note: Election purdah guidance from Healthwatch England delayed publication of some reports until July). Since the last meeting we published the following reports based on focused insight gathering:

- **Eye Care – people's experience of eye care services in Oxfordshire (Sept 2024)** including views on primary and secondary care - appointments, information and communication, referral to a specialist service, quality of care, and support to manage an eye condition - with 141 respondents. People were generally positive about their experiences of appointments at eye care services: 68% responded 'good' or 'very good 'for 'availability of appointments', 64% for 'waiting time for an appointment', and 73% for 'convenience of appointment time'. People were slightly less positive about their experiences of travelling to appointments, costs of care, and referrals. We heard that availability of appointments at the Oxford Eye Hospital (Oxford University Hospitals NHS Trust - OUH) was generally good, although people also experienced cancelled appointments, difficulty with transport and attending early appointments, busy waiting areas, and long waits to be seen. Some were frustrated at not being able to receive outpatient eye care at their local health facility.

  Patients rated aspects of service quality highly, citing excellent experiences of care at the Oxford Eye Hospital. Most staff were viewed as considerate, kind

and caring, with some providing outstanding care. However, crowded outpatient waiting areas, delayed appointments, and a perception of inadequate staffing left some people dissatisfied and concerned about patient safety.

We heard that communicating with the Oxford Eye Hospital was often difficult, especially about appointments and hospital arrangements. Appointment letters were sometimes poorly written, confusing, or contained incorrect information, others were not patient-friendly or were not adapted to people with additional needs. Feedback on how well eye care professionals explained eye tests and medical procedures was generally positive for both private and NHS providers.

The report was shared with OUH and BOB ICB for response, OUH developed an action plan in response to the recommendations, BOB ICB had not responded to the report at the time of publication.

- **Supporting oral health in children under 10 (July 2024)**

  In September 2023, Buckinghamshire, Oxfordshire and West Berkshire Integrated Care Board (BOB ICB) funded Healthwatch Bucks, Healthwatch Oxfordshire and Healthwatch Reading to undertake a community-based research project to understand some of the challenges that parents and caregivers face when looking after the **oral health of children under 10 years old**. The project was supported through the Core20PLUS5 Connectors initiative, a national NHS programme working to reduce health inequalities. The three Healthwatch teams each recruited and trained five 'Community Connectors' who interviewed parents and caregivers in their community about their children's oral health. Together the three Healthwatch organisations heard from 215 parents and caregivers. Families who contributed their views included parents and caregivers of children with and without special educational needs and disabilities (SEND).

  We published a series of reports – one joint report to BOB ICB and a report aimed at the Oxfordshire system. Responses and report can be seen here: https://healthwatchoxfordshire.co.uk/our-work/research-reports/

- **Community Participatory Action Research** (CPAR2) **(July 2024)** The final report https://healthwatchoxfordshire.co.uk/reports and accompanying film https://youtu.be/5_P3MMGUirI of work by community researchers from Oxford

Community Action was published in July- highlighting views of people using community food services in OX4 and the **impact of cost of living**. This was presented to key stakeholders and system leaders at the CPAR 2 South-East showcase event on 6th June in London. An event to share the findings will be held in October. Healthwatch Oxfordshire was the host organisation for the community researchers, providing on the ground support and mentoring for their research over the year.

- **Patient Participation Groups (PPG's) in Oxfordshire –** (July 2024)
  In January and February 2024, we carried out a survey to hear from people involved with PPGs in Oxfordshire. We wanted to hear about how PPGs are running, what is going well, what challenges PPGs are facing and what support they need.

  We wanted to help identify where that support can be provided and by whom. We heard from 78 people representing 35 Patient Participation Groups and GP practices across Oxfordshire. PPGs can support communication between practices and patients, but they do this best when they are supported by effective communication from the health system and supported to connect with other PPGs.

- **Enter and View Visits**

Since the last meeting we made one Enter and View visit to the OUH Discharge Lounge.

We published the following reports (https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/) on Enter and View visits to the following services:

- Health Visitor Service at Bluebell Centre, Didcot (July 2024)
- The Surgical Emergency Unit at John Radcliffe Hospital (July 2024)

All published Enter and View reports are available here:
https://healthwatchoxfordshire.co.uk/our-work/enter-and-view
and information https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/01/Enter-and-View-easy-read-information.pdf

Our current work:

- We have a live survey on **Women's Health** services here: https://www.smartsurvey.co.uk/s/womenshealthservices/
- We closed our survey to hear from the public on **experience of leaving Hospital (discharge)** in the last twelve months https://healthwatchoxfordshire.co.uk/news/leaving-hospital/ a report on our findings will come to HOSC in November (see below for some initial findings).
- We continue ongoing outreach to groups and events across the county, including hospital stands, community groups and events e.g. play days, community events, and have been focusing on hearing about hospital discharge, men and women's health, as well as general listening.
- We published formal letters and responses here: https://healthwatchoxfordshire.co.uk/news-and-events/correspondence/ including: Comment on Quality Accounts (Oxford University Hospitals NHS Trust -OUH, South Central Ambulance, Oxford Health and Sue Ryder), and a letter to BOB ICB in response to proposals for a revised operating model.
- We attended a meeting in June to discuss the Children's Trust Board which has not met for over a year – we would like HOSC to note we would like to see a clear pathway for re-establishment of a functioning Board and its essential focus on children and young people.
- We have received a report from Keep the Horton General outlining women's experiences of birth and note the ongoing discussions. We have sought assurance from OUH and commissioners (BOB ICB) that they are responding to the issues raised within this report.

Healthwatch Oxfordshire Annual Impact Report 2023-4

On 2nd July we held an online event showcasing our work during 2023-24. The full report, Easy Read summary and video of the event presentation can be found here: https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2023-24/

3. Key issues we are hearing from the public:

We hear from members of the public via phone, email, online feedback on services (https://healthwatchoxfordshire.co.uk/services), and when out and about. This enables us to pick up and raise with health and care providers and commissioners

on emerging and current themes. Below are some examples of comments from the public on different issues.

Some of the themes we have been hearing include GP appointments, NHS dentistry, problems accessing interpreting support, access to podiatry care.

Relating to this HOSC meeting agenda feedback includes:

- **Discharge from hospital** – our full report will be shared with HOSC ahead of its November meeting. Preliminary findings from 149 members of the public and 88 health and care professionals include:
    - People were mostly happy to get home from hospital. They valued having in-depth and thorough conversations with health and social care professionals about getting home and managing their recovery.
    - There are some challenges around communication about discharge– for example, we heard that patients and their families are not always kept up to date about what is happening, and some were confused about what to expect and what they were entitled to in terms of care and support after getting home. Some people felt that they needed more information about follow-up medical care and who to contact if problems arose.
    - There are also some challenges around home care provision – such as lack of continuity in carers, wide time windows for care visits, and communication problems with carers and care providers.
    - We heard that unpaid carers value being involved and listened to in decision-making. They told us about the impact that looking after someone after discharge has had on their lives and wellbeing. Most of the unpaid carers we heard from said they had not been offered support.
    - Health and care professionals told us that the new Discharge to Assess (D2A) pathway is helping to move people out of acute hospitals more quickly, and the use of multidisciplinary and multiagency teams has improved communication and increased referral quality – but there are still some gaps in communication between services.
- **Medicines**

Some indication from the public about issues with medications, capacity demand on pharmacy, including long queues and waits, prescriptions missing, poor stock supply

– including for common medications, and ADHD meds, and longer waits for medication:

- *"Getting meds from chemist or lack of them. I am Diabetic and used to get a weekly injection and the chemist cannot get them so have not had for months now" (Signposting call, June 2024)*
- *"The staff are really lovely face to face and get everything sorted out if you attend but if you are relying on them for regular deliveries of correct medication, please be very careful. Medication is rarely without errors in some form. They do dosset boxes weeks in advance so if you have changes made it can be weeks before things get corrected again"*
- *"The pharmacy is totally inadequate for the amount of people using it. This results in very long waits. They quite often do not have the medication you need and have to wait days for it to arrive. This has resulted on numerous occasions of going elsewhere"*
- *"Pharmacy is no longer able to meet the demands of the 10,000 or so people living in area. They struggle to get pharmacists and sometimes have to close for the day due to not having a dispenser. Repeat prescriptions are not dealt with promptly. The shop is small and cramped with poor stock levels, and regularly has a queue of customers"*
- *"We have used the pharmacy for several years, but this year they stopped supplying one medication (name) that my wife took, and on one or two occasions we even had trouble accessing statins of the correct dosage. In the case of the [medication], we tried several other pharmacies without success, finally managed to get it elsewhere" (Feedback centre review)*
- *"lack of stock of common prescription medication" (Feedback centre review)*

- **Adult Mental Health**
  - Some feedback on access to community mental health services: common themes are that it can be difficult to get support – for example referrals are rejected or calls are not returned, and perception that you have to be at acute risk before getting support – and that the care

available does not meet people's needs. We heard several experiences of people being referred back and forth between different services.

- *"It's really hard to get any sort of treatment unless you hit crisis point. Help, when it is provided, is inconsistent and short term."*
- *"My son has ADHD and autism and is now in transition to adult services and support - but no support and I don't know where to go - he keeps getting passed from a to b to c"*
- "*The Crisis team are great, but clearly lack resources, they do their best within the constraints they have, but the ADMH Team - It is likely the same problem, they lack resources and so prioritise who they feel will benefit most"*

We also heard positive reviews of support including Warneford Hospital. We also attended a My Life My Choice Health Voices Group to hear about mental health support for people with a learning disability – and challenges for support for people with autism.

Connect Health MSK services

We have started to hear more mixed feedback from the public about Connect Health including challenges with communication, getting appointments, and longer waiting times for MSK services:

- *"I had a referral from the GP. I was able to get an appointment after six months, in December. I had to wait for another appointment. We phoned in February and were told to call at the end of May. In mid-May I received a letter saying that I had been removed from the waiting list. It is difficult to accept and impossible to understand at all. It's stressful! They knew I was waiting for a date and did nothing to help me".*

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NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of meeting: 12 September 2024	**Paper no:**

Title of paper: Medicine Shortages

Paper is for:	**Discussion**	✓	**Agreement**		**Information**	✓

Purpose of paper:
To inform committee members of issues faced as a result of medicines shortages and some of the steps taken to mitigate the effect on patients.

Recommendations

Members of HOSC are invited to note the contents of this paper.

Authors:	Julie Dandridge. Head of Primary Care Infrastructure Head of Pharmacy, Optometry and Dentistry, Claire Critchley Medicines Optimisation Lead NHS Buckinghamshire, Oxfordshire and Berkshire West ICB

Date of paper: 28 August 2024

Medicine Shortages

1. Background and the national context of medicine shortages

1.1 Medicines shortages affect healthcare systems worldwide. They can be caused by several complex and interacting factors and can occur at short notice and change rapidly, making forward planning difficult. In recent years, there has been an increase in shortages due to global issues: for example, COVID-19 caused a significant reduction in manufacturing capacity, the UK's exit from the European Union affected the distribution supply chain and recent global conflict has caused further instability.

1.2 The proportion and type of medicines affected by supply shortages can vary but it generally impacts only a small percentage of the total medicines available.

1.3 Community Pharmacy England conducted a survey with pharmacy teams across England which highlighted how critical the situation has become: 97% of pharmacy teams reported patients being inconvenienced as a result of medicine supply issues and 79% reported that patient health is at risk due to these issues.

2. Reasons for medicine shortages

2.1 Shortages can be due to various factors as described above and often cannot be attributed to one reason. Reasons may include:

- manufacturing issues
- changes in NHS contract or pricing strategies
- distribution issues
- withdrawal or discontinuation
- demand fluctuations
- stockpiling or panic buying.

Response to the shortage of one medicine can lead to shortage of the replacement medication.

3. The impact of medicine shortages

3.1 Medicine supply issues affect all areas of healthcare. In the last 3 years, Oxford University Hospitals NHS Foundation Trust has been affected by 369 supply shortages of which an average of 60 (range 45 to 80) are active at any one time. Many of these shortages will affect patients accessing prescriptions in the community. The HealthWatch research found that 42% of patients have experienced problems getting their medicine with almost a quarter of patients experiencing their medication being out of stock in the past 12 months.

3.2 Patients are often significantly impacted by medicine shortages; for example, prescription switches to an alternative medication may not suit the patient as well as their previous, regular medicine, and experience anxiety worrying about shortages

affecting their treatment, and they may spend time trying to access a medicine which is in short supply.

3.3 Community Pharmacy England report that medicine supply issues not only disrupt the timely dispensing of medications but also impose significant strain on community pharmacies operationally and financially. Supply issues also increase burden on General Practice as pharmacy teams frequently need to contact GPs for alternative prescriptions when items are unavailable.

3.4 The effects of a medicine shortage on patients and clinicians can range from a low impact, where a cost-neutral suitable substitute medicine can easily be substituted, to a critical situation involving potentially life-saving medication where harm to the patient is likely if an alternative is not readily available. Response will vary depending upon the medicines involved, the duration and extent of the issue and the suitability of alternatives.

3.5 Supply disruptions affect medicines across a range of therapeutic areas with recent examples including treatment for diabetes (e.g. semaglutide, Insulin Humulin S®), epilepsy (e.g. carbamazepine), pancreatic enzyme replacement therapies (PERT) (e.g. Creon® capsules) and Hormone Replacement Therapy (HRT).

4. National Mitigations

4.1 The Department of Health and Social Care (DHSC) Medicines Supply Team is responsible for supporting management of supply issues nationally and they publish regular updates for primary and secondary care which can be found on the Specialist Pharmacy Service (SPS) website. This tool was launched in 2022 in response to increasing shortages and includes some of the known supply issues, potential impact and recommended actions.

4.2 MIMS has also launched an on-line drug shortages tracker which clinicians can access to find out information on current shortages and recently resolved issues. The tracker also suggests possible alternatives where appropriate. Users need to register and log in to view but registration is free for GPs and nurses.

4.3 The Commercial Medicines Unit (CMU) on behalf of NHS England is responsible for negotiating the regional contracts of thousands of medicines each year. Manufacturers are required to inform them if they anticipate any potential supply issues with their contracted products. CMU are informed of anticipated shortages, timeframes and reasons for delay and this information is shared with the NHS Trusts monthly.

4.4 Following an impact assessment, shortages deemed higher risk or those that are expected to have the most impact are communicated specifically, in the form of a Medicine Supply Notification (MSN) or National Patient Safety Alert (NatPSA). Serious Shortage Protocols (SSPs) are sometimes put in place to enable community pharmacists to supply patients with specific alternative medicines; these are available to view on the NHS Business Service Authority's dedicated SSP web page, along with supporting guidance.

4.5 Issues will vary from region to region and, in general, there is not one individual source that can provide the panacea to aid supply management so various information sources must be used. Although these tools are useful, the advice and recommendations can quickly become outdated, and recommendations must be interpreted before they can be implemented.

5 Local mitigations

5.1 The ICB Medicines Optimisation Team provides advice to local practices and community pharmacies on medicine shortage and communicates current shortages and suitable alternatives via its regular newsletter and website, both of which are available to all primary care clinicians. The team is also able to add certain information to ScriptSwitch which is a software tool used by prescribers to provide real-time information and recommendations at the point of prescribing.

5.2 Community Pharmacies often have links with other pharmacies and are able to share stock information enabling individuals to be redirected where a medicine is out of stock. However, it should be noted that most pharmacies use similar wholesalers meaning a medicines in short supply would impact a number of pharmacies.

5.3 Since 2023, the OUH Pharmacy Department has had a dedicated medicines supply shortages practitioner to identify and manage potential supply issues in the Trust by working with clinical areas and procurement teams and implementing various strategies to mitigate the impact of the supply shortage. The successful management of these shortages has been aided by having a supply shortages database on the Trust intranet where everyone can be kept up to date.

5.4 The ICB Medicines Optimisation Team works together with local system partners to help manage supplies for our patients when there are significant issues. Recent examples include ADHD drugs, where the ICB worked with Oxford Health to try to ensure supplies were available wherever possible and with the current PERT shortage, where the team is working with OUH and OH to try to establish local back up stock for the BOB population. In some cases, the Area Prescribing Committee (APC) is required to discuss and approve guidance on what to do in the event of a medicine shortage.

6. Summary

6.1 Medicines supply problems can affect many patients across England and have become a daily occurrence.

6.2 The management of these medicines shortages requires a coordinated and proactive approach involving multiple stakeholders. By implementing the above robust strategies and maintaining effective communication, the NHS aims to mitigate the impact of shortages and ensure that patients continue to receive the necessary treatments.

6.3 Whilst the coordination of these supply disruptions at national levels have helped create a more uniform approach across the NHS, interpretation in the local context is an important prerequisite before they can be implemented at a local level. Ongoing coordination of supply problems across Oxfordshire will help to further reduce potential harm from shortages, particularly for medicines prescribed in both hospital and primary care.

7. Reference sources and further reading

- Community Pharmacy England; Pharmacy Pressures Survey 2024
- A Guide to Managing Medicines Supply and Shortages - NHS England

- A Guide to Managing Medicines Supply and Shortages
- Medicines shortages: regulatory processes to manage supply disruptions
- Healthwatch Briefing

August 2024

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Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Select Meeting: Thursday 12 September 2024

Health Oversight and Scrutiny Committee

Title:	**Management of Medicines Supply Shortages**

Status:	**For Information**
History:	**FINAL**

Board Lead:	**Chief Medical Officer**
Author:	**Bhulesh Vadher, Director of Pharmacy and Medicines Management, OUH**
Confidential:	**No**
Key Purpose:	Assurance, Policy

Executive Summary

1. Medicines shortages are a significant global issue, exacerbated by factors like manufacturing issues, changes in NHS contracts, distribution problems, product withdrawals, demand fluctuations, and stockpiling, and can lead to patient harm and increased financial pressures on healthcare systems. The effects range from low impact, where substitutes are available, to critical situations involving life-saving medications, potentially causing treatment delays, errors, and suboptimal care. The Department of Health and Social Care (DHSC) and the Commercial Medicines Unit (CMU) manage supply issues nationally, while local responses involve alternative sourcing, stock management, rationing, collaboration, and communication.
2. In the last 3 years, OUHFT has been affected by 369 supply shortages of which an average of 60 (range 45 to 80) are active at any one time. Examples of current and recent shortages include Creon® capsules, Insulin Humulin S® vials, and Pabrinex® IV injection, semaglutide Ozempic® Injection; each require specific strategies to manage the shortages effectively.
3. OUH Pharmacy Department has a dedicated medicines supply shortages practitioner to identify and manage potential supply issues by working with clinical areas and procurement teams, implementing various strategies to mitigate the impact of the supply shortage on the Trust. The successful management of these shortages have been aided by having a supply shortages database on the Trust intranet where everyone can be kept up to date on each supply disruption. There is a Medicines Shortage Bulletin published regularly to advise prescribers about the agreed alternatives to be used during shortages. The practitioner leads on the local implementation of any national initiatives from DHSC, NHS England and other national bodies. In addition to this, the practitioner chairs a weekly supply shortage meeting where clinicians and other staff affected by shortages can attend to discuss alternatives and monitor progress on any other strategies put in place to manage supply shortages. Future measures to further reduce potential harm from shortages should include investment in the Trust's EPR system so that decision support at the point of prescribing can be utilised enabling increased agility when responding to shortages. Improved coordination of supply problems across the ICB is desirable, particularly for medicines prescribed in both hospital and primary care.

Recommendations

4. This is a briefing paper submitted jointly from OUH and BOB ICB for information and assurance. HOSC are asked to note the content of this paper and support the current arrangements for managing supply problems in OUHFT.

5. HOSC are asked to note the improvements proposed to further reduce potential harm from shortages including:
    a. Investment in the Trust's EPR system so that decision support at the point of prescribing can be utilized enabling increased agility when responding to shortages.
    b. Improved coordination of supply problems across the ICB, particularly for medicines prescribed in both hospital and primary care this is actively being worked on with the ICB and wider SE Region.

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Management of Medicines Supply Shortages

1. Introduction

1.1. Medicines shortages affect healthcare systems worldwide. They can be caused by several complex and interacting factors, and can occur at short notice and change rapidly, making forward planning difficult. In recent years, there has been an increase in shortages due to global issues such as COVID-19 caused a significant reduction in manufacturing capacity, the UK's exit from the European Union affected the distribution supply chain and, recent global conflict has caused further instability.

1.2. The proportion of medicines affected by supply shortages can vary, but it generally impacts a small percentage of the total medicines available. For example, in the UK, disruptions typically affect a very small proportion of medicines in the NHS, and most shortages can be managed without interrupting people's supplies. However, the degree of disruption in normal healthcare provision from a single supply shortage can be extensive and range from inability to provide optimal care to, in certain situations, having to cancel or postpone clinical procedure.

1.3. Supply issues attract regular media coverage. Recent supply issues that have gained coverage include medicines for treating ADHD, diabetes, cystic fibrosis and epilepsy.

1.4. Shortages can arise from various factors and often cannot be attributed to one reason, sometimes a shortage has resulted from the accumulation of several factors. Response to the shortage of one medicine can lead to shortage of the replacement medication. Reasons may include:

1.4.1. Manufacturing issues- these include-difficulty obtaining raw materials or API (Active Pharmaceutical Ingredient), medicine recalls or batch failures, and capacity issues. Problems in production processes quality control failures, and regulatory interventions can disrupt supply.

1.4.2. Changes in NHS contract or pricing strategies.

1.4.3. Distribution issues - Importing/exporting bans or restrictions, wholesaler ordering process delays.

1.4.4. Withdrawal or discontinuation – competitors may withdraw/discontinue products causing strain on other medicines in class.

1.4.5. Demand Fluctuations: sudden changes in prescribing practices due to change in guidance or practice, pandemics or switching products as result of shortages elsewhere can lead to shortages.

1.4.6. Stockpiling or panic buying - This often happens because of a rumoured shortage or shortage with similar products. This is actively discouraged within NHS Trusts.

2. Impact of Medicines Supply Shortages

The effects of a shortage on patients and clinicians could range from a low impact, where a cost-neutral suitable substitute medicine can easily be substituted, to a critical situation, involving potentially life-saving medication where harm to the patient is likely if an alternative is not readily available. Response will vary depending upon medicines involved, duration and extent of the issue, and the suitability of alternatives. Therefore, a wide range of risks is possible.

2.1. Risk of patient harm due to unavailability of essential medicines:

2.1.1. Lack of available treatment or alternative, leading to potential treatment failure or deterioration in condition due to delays.

2.1.2. Errors due to unfamiliarity with alternative treatment options (prescribing, administration or advice)

2.1.3. Medications delayed or suboptimal treatment options

2.1.4. Decision support rules and safety alerts built into EPR may not be available for alternative agents.

2.1.5. Continuation of care in community may be affected, and patients may be referred into secondary care who were previously cared for in primary care and stabilised on treatment.

2.2. Financial pressures:

2.2.1. Alternatives may be significantly more expensive leading to cost pressures

2.2.2. The Trust may have to cover the cost for importing unlicensed alternatives

2.3. Risk of redirection of clinical resources:

2.3.1. Clinical resources may be redirected from direct clinical care to support the practicalities of reviewing and introducing alternative products.

2.3.2. Alternatives may require additional monitoring or clinic visits.

2.3.3. Increased training and counselling may be required to understand any changes made.

2.3.4. Increased workload for clinicians and Pharmacy services.

3. National tool and resources to support the local response

3.1. The Department of Health and Social Care (DHSC) Medicines Supply Team are responsible for supporting management of supply issues nationally and many shortages are now listed on the Specialist Pharmacy Service (SPS) Medicine supply tool online. This tool was launched in 2022 in response to increasing shortages and includes some of the known supply issues, potential impact and recommended actions.

3.2. The Commercial Medicines Unit (CMU) on behalf of NHS England are responsible for negotiating the regional contracts of thousands of medicines each year. Manufacturers are required to inform them if they anticipate any potential supply issues with their contracted products. CMU are informed of anticipated shortages, timeframes and reasons for delay and this information is shared with the NHS Trusts monthly.

3.3. Shortages deemed higher risk or those that are expected to have the most impact are communicated specifically, in the form of a Medicine Supply Notification (MSN) or National Patient Safety Alert (NatPSA).

3.4. Other information sources that may identify a shortage include wholesalers, clinicians, purchasing colleagues working across the NHS, primary care representatives, professional clinical groups, order failures or from patients themselves.

3.5. In general, there is not one individual source that can provide the panacea to aid supply management, and various information sources must be used. Issues will vary from Trust to Trust and region to region. Although these tools are useful, the advice and recommendations can quickly become outdated, and recommendations have to be reinterpreted before they can be implemented within the context of the local Trusts. Contradictions between the measures put in place in hospitals and what is being advised in primary care may sometimes create confusion. For example, in some situations, patients are encouraged to visit the hospital for a supply of medicines in short supply (example national shortage of GLP-1 receptor agonists including semaglutide for type 2 diabetes). This could confound the hospitals strategy to restrict limited stock for the most critically ill patients. Better coordination between hospital and primary care is required.

4. OUH experience and processes for mitigation

4.1. In the last 3 years, OUHFT has been affected by 369 supply shortages of which an average of 60 (range 45 to 80) are active at any one time. Further details about these supply problems are provided in Figures 1 to 4 below.

4.2. Since 2020, the pharmacy department have operationalised a medicines supply shortages practitioner working as part of the Medicines Effectiveness Team. The role of the practitioner is to support identifying and managing any potential supply issues. They lead the OUH Pharmacy response by liaising with clinical areas, taking appropriate actions in advance and ensuring transition to a suitable alternative is effective and communicated in a timely manner.

4.3. Once an issue has been identified, the required action will vary depending on the potential impact on the Trust, these may include:

4.3.1. Ensure all potential information regarding the shortage is gathered– reason(s) for the shortage, anticipated resupply date and potential impact to the Trust

4.3.2. Checking availability of different strengths, manufacturers, suppliers to source a direct alternative.

4.3.3. Working with procurement colleagues within the region to support each other and help share knowledge.

4.3.4. Managing current supplies – putting in place potential short-term restrictions, remove from clinical areas stock lists.

4.3.5. Identifying and sourcing unlicensed imports or UK specials to help support demand – ensuring all required paperwork is prepared and completed in preparation.

4.3.6. With the support of clinical teams ensure appropriate communication or guidance is in place to aid colleagues who may be affected by the shortage.

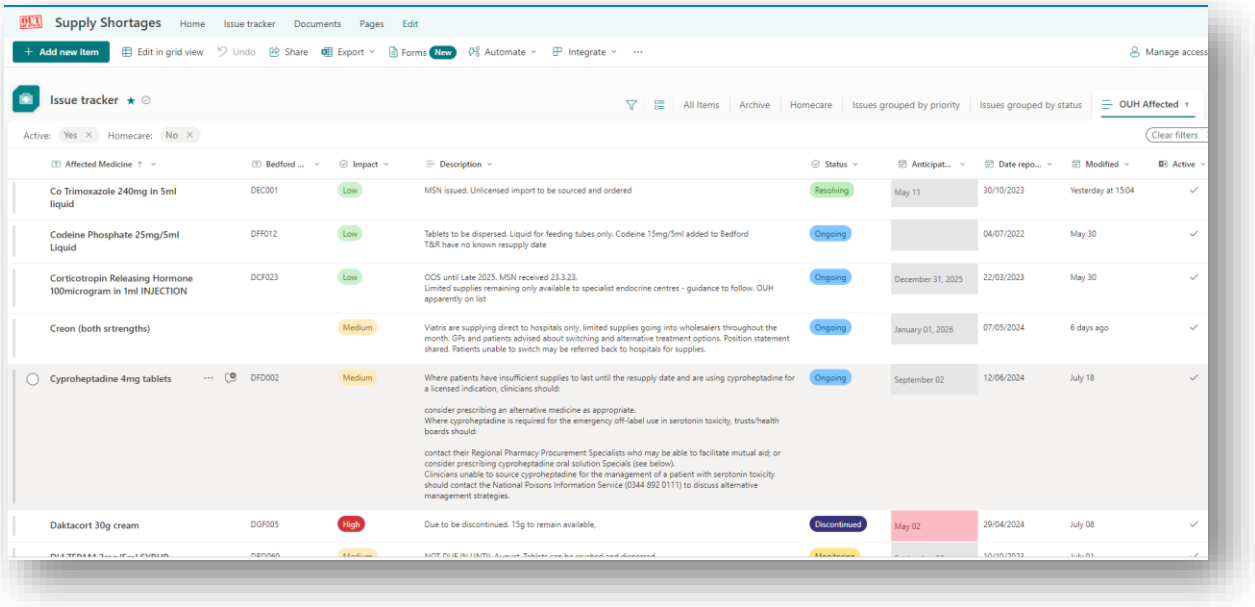
4.3.7. Responding to an MSN (Medicines Safety Notice) or NatPSA (National Patient Safety Alert), ensuring any action points recommended by these are adhered to and recorded via Ulysses (the Trust incident reporting system).

4.4. Ongoing work throughout the month includes weekly procurement meetings with colleagues across the region, weekly OUH pharmacy meetings with clinical and procurements leads to discuss potential issues arising, monthly shortage summaries sent to all pharmacy colleagues and maintaining an internal medicine supply shortage database. In addition, a

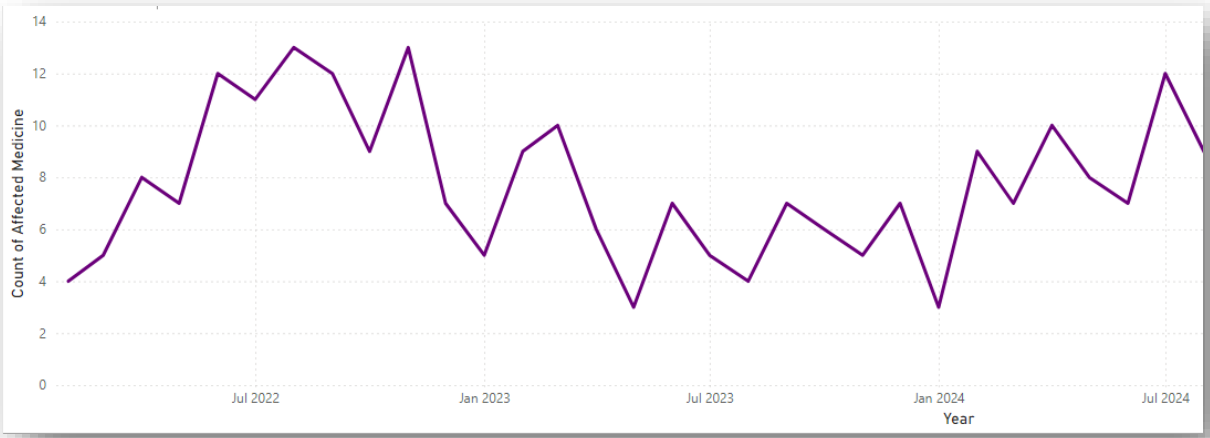
supply shortage update is presented at the Trust's monthly Medicines Management and Therapeutics Committee (MMTC) meeting.

4.5. The Medicines Supply Shortage database is updated by the medicines supply shortage practitioner with the support of procurement colleagues. As of 07/08/24, OUH Pharmacy is currently monitoring and managing 61 active supply shortages, and a further 25 are being managed within Homecare services.

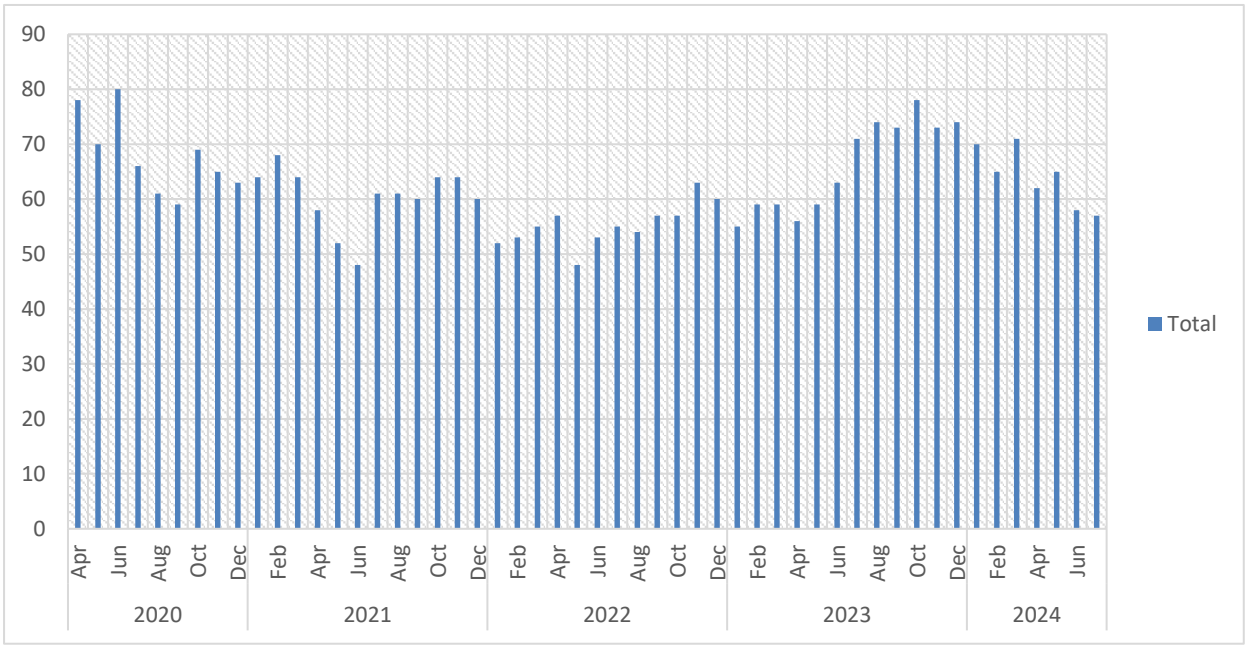
5. Figure 1. Medicines Supply shortage database available to Trust colleagues



6. **Figure 2. Graph show that there are between 4 and 12 new shortages added to the database each week.**



7. **Figure 3. Graph show that we have an average of 60 (range 45 to 80) active supply shortage at any one point in time.**



8. Figure 4. Status of all shortages added to databse since 2021.

Status	Count of Issue tracker
Resolved	225
Discontinued	28
Ongoing	27
Need Update	25
Long Term	21
Monitoring	15
New	14
Resolving	11
Short Term	3

9. Examples of some of the current & recent shortages impacting OUH

Example 1: Creon® capsules

Supply shortage ongoing until at least 2026. This is due to unavailability of the API and an increase in demand. Indicated for the treatment of pancreatic exocrine insufficiency such as in cystic fibrosis, pancreatic cancer and pancreatitis. There is no clinical alternative.
Limited supplies are available in the community setting; GPs are being advised to switch patients where appropriate. Those that cannot switch are referred to secondary care for review to determine ongoing supplies. These teams are looking at alternative options as to how best to provide for these patients.

Example 2: Insulin Humulin S® vials

Went out of stock between May and June 2024. The preparation is also used to manufacture a variable dose insulin syringe special from Portsmouth specials manufacturing unit. To support Portsmouth manufacturing, the action was to send out all remaining Humulin S vials to Portsmouth to support the manufacturing process and ensure they could continue to manufacture the variable dose syringes. Routine use was switched to Actrapid® vials.

Example 3: Pabrinex® IV injection

Became out of stock for an unspecified length of time. Is used for treatment of Wernicke's encephalopathy, alcohol dependence and refeeding syndrome. Collaboration between clinical colleagues across the Trust ensured a suitable alternative (Unlicensed Thiamine) was sourced and all communication, electronic

prescribing and decision support pathways (Power Plans) were prepared and ready in advance of the shortage.

10. Conclusion

The management of medicines shortages in the NHS requires a coordinated and proactive approach involving multiple stakeholders. By implementing robust strategies and maintaining effective communication, the NHS aims to mitigate the impact of shortages and ensure that patients continue to receive the necessary treatments. Whilst the coordination of these supply disruptions at national levels have helped create a more uniform approach across the NHS, interpretation in the local context is an important prerequisite before they can be implemented at a local Trust level. Having a dedicated senior pharmacy technician working as medicines supply practitioner has helped OUHFT to put effective systems in place. Having a named officer to manage supply problems is a standard that could be adopted for all acute healthcare providers as it avoids moving clinical staff away from patient-facing duties to manage supply disruptions.

Some suggested improvements to further reduce potential harm from shortages include:

Investment in the Trust's EPR system so that decision support at the point of prescribing can be utilized with more agility to respond to shortages.

Improved coordination of supply problems across the ICB, particularly for medicines prescribed in both hospital and primary care: this is actively been worked on with the ICB and wider SE Region.

11. References

[1]: A Guide to Managing Medicines Supply and Shortages - NHS England [2]: A Guide to Managing Medicines Supply and Shortages [3]: Medicines shortages: regulatory processes to manage supply disruptions

Statement on Medicine Shortages from Dr Leyla Hannbeck (Chief Executive of the Independent Pharmacies Association)

The Independent Pharmacies Association (IPA), as the voice of independently owned pharmacies, has since several years post pandemic raised concerns about the medicines supply issues. It was the IPA that indeed brought this issue to the attention of the national media since 2021 and called for this topic to be on the radar. We have regularly and consistently discussed the medicines shortages challenges with the officials at the DHSC and with politicians asking for a more transparent approach and urging the decision makers to act before we get a serious patient safety incident.

Medicines supply issues take on average 2-3hrs per day of community pharmacy teams' time and on many occasions have led to abuse and violence against pharmacy teams. We also regularly see destressed patients who cannot get hold of their medicines who need to travel from one pharmacy to another in the hope of getting hold of their regular medicine.

There are various reasons causing medicines shortages, these include global shortages of raw material, costs to produce medicines and a lengthening of the average time that it takes to produce medicines – Brexit, time taken to process regulatory applications and the VPAS system have all had a role to play. We are also concerned that there is no transparency regarding the supply of medicines and we have repeatedly called for the DHSC to bring healthcare professionals on the frontline and wholesalers and suppliers and patient groups together to discuss these challenges with the view to find solutions. Unfortunately this has not yet happened.

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Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Thursday 12 September 2024

Health Oversight and Scrutiny Committee meeting

Title:	**HOSC Epilepsy Paper**

Status:	**For Information**
History:	**Final Version**

Board Lead:	**Chief Medical Officer**
Author:	**Dr Rustam Rea, Deputy Chief Medical Officer/Director of Patient Safety and Effectiveness** **Heidi Beddall, Deputy Chief Nursing Officer / Director of Quality, NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board**
Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. The paper summarises the current service provision by OUH for people with epilepsy in Oxfordshire
2. It outlines the pressures on the service and the increasing demand over the last few years
3. It explains the recent legal requirements for prescribing Sodium Valproate to women of child bearing age and the impact that this has had on both patients and staff
4. It highlights the need to comply with these regulations in a safe way and outlines the progress made towards this so far
5. It outlines the requirements regarding the prescription of Topiramate in both primary and secondary care
6. It describes the plans for ongoing improvement of the service and the need for further investment to provide safe and effective epilepsy services across Oxfordshire.

Recommendations

7. This is a briefing paper submitted jointly from OUH and BOB ICB for information and assurance regarding the current and proposed provision of epilepsy services in Oxfordshire with particular reference to the recent changes in regulations for prescription of Sodium Valproate and Topiramate.

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1. Purpose

1.1. This paper provides responses to the questions sent by HOSC on Tuesday 13 August requesting responses for a meeting on Thursday 12 September 2024 to discuss Epilepsy services in Oxfordshire. This meeting was postponed from June 2024.

1.2. The responses have been collated from colleagues at both OUH and the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB).

1.3. A short presentation will accompany this paper at the meeting on the 12 September.

2. Background

2.1. Epilepsy is a disorder of the brain characterised by repeated seizures due to uncontrolled bursts of electrical activity. There are many causes of epilepsy including congenital abnormalities, genetic disorders, trauma, tumours, stroke, neurodegenerative diseases, immune and inflammatory disorders, and metabolic disorders. Almost 1% of the population has epilepsy, so it is one of the commonest serious chronic neurological conditions. 30-40% of patients have ongoing seizures despite trying different anti-seizure medications. Patients with seizures and epilepsy often present to the Emergency Department and often require urgent advice and review.

2.2. Epilepsy has a risk of causing severe injury and increases the risk of early death, including a risk of sudden unexpected death in epilepsy (SUDEP). Epilepsy is among the top ten causes of premature death in the UK. It is an important cause of maternal death in pregnancy. Around 50% of epilepsy related mortality is considered preventable. Epilepsy is also associated with an increase in psychological and psychiatric difficulties, and has an impact on driving, education, employment, relationships, pregnancy, and fertility.

3. Oxfordshire OUH catchment, local population. Whether there are any high-risk groups that have been identified.

3.1. The John Radcliffe and Horton Hospitals serve a population of 762,500, so almost 7265 people in the Oxford catchment area have epilepsy. The John Radcliffe Hospital is also a tertiary referral centre for people with complex epilepsy and for people being assessed for epilepsy surgery, so also

receives many additional referrals from outside of Oxford (total catchment area of 2.5 million people).

3.2. Epilepsy particularly affects vulnerable groups including people with learning disability, people with mental health difficulties, children, pregnant women, older people, and people who are homeless or socioeconomically deprived.

4. Oxfordshire Epilepsy Workforce: Adult Oxford Epilepsy Team including full-time equivalent neurologists and specialist (a comment about comparison with other tertiary centres and with similar western European countries would be helpful). What are trends on demands on clinical time and where are these pressures coming from.

4.1. The Adult Oxford Epilepsy Team is a small but very cohesive unit comprising the equivalent of two whole time Consultant Neurologists specialising in Epilepsy, the equivalent of 2.6 whole time Epilepsy Specialist Nurses, one Learning Disability Epilepsy Specialist Nurse (who also has an honorary contract with the Community Learning Disability Service), and one administrative assistant (not currently filled).

4.2. The Team assesses and manages people with suspected first seizures, people with established epilepsy, and people with suspected epilepsy. Oxford is a tertiary Epilepsy centre, so we also manage patients with complex epilepsy from other centres. We are also an Epilepsy Surgery Centre, so fully evaluate patients for epilepsy surgery and vagus nerve stimulation (VNS). We also provide care and advice for inpatients with seizures and epilepsy.

4.3. NICE recommends 9 epilepsy specialist nurses per 500,000 people. Oxford has 3.6 epilepsy specialist nurse for 762,500 people. In comparison, Sheffield is a tertiary epilepsy centre with a similar population catchment area and has the equivalent of 11 epilepsy specialist nurses and at 5 neurologists specialising in epilepsy.

4.4. England has one consultant neurologist per 50,000 people, compared to one neurologist per 25,000 people in France and Germany.

5. Trends of increasing demand

5.1. The increasing clinical demand on this small unit has resulted in significant waiting times to see new and follow-up patients, both for the local population and for tertiary referrals, and a marked increase in workload for the existing staff. As epilepsy treatment becomes more specialised with

new drugs and regulations, primary care physicians are referring increasing numbers of patients into specialist care. For example:

Referrals to the Epilepsy Specialist Nurses have tripled from 104 in 2021 to 323 in 2023, with a 25% increase in patients seen in clinic (1,566 in 2020 to 2,040 in 2023).

Requests for written advice and guidance from General Practitioners requiring response letters from the Epilepsy consultants have increased more than ten-fold from 104 in 2020 to 1,259 in 2023.

The increasing number of patients with vagus nerve stimulators has required the introduction of additional satellite clinics (at the Horton Hospital and in Brackley) to support the expansion in VNS Services.

In Buckinghamshire, there is also the Epilepsy Society Chalfont Centre which provides care to on-site residents who live with epilepsy (https://epilepsysociety.org.uk/what-we-do/our-chalfont-centre). They work in association with UCL in London

6. Are there any community-based based epilepsy services in Oxfordshire? Are there any GPs with a specialist interest in epilepsy across Oxfordshire? the ICB? Is there any training about epilepsy for GPs and community-based professionals? Is there any community-based epilepsy service?

6.1. There are no GPs in Oxfordshire with a special interest in epilepsy known to the team at the John Radcliffe Hospital. There are no GPs within BOB with a specialist interest in epilepsy.

6.2. One community neurology nurse who covers North Oxfordshire supports some patients with epilepsy, but they also support patients with other chronic neurological conditions. Our Lead Learning Disability Epilepsy Specialist Nurse (Lead LD ESN) has an honorary contract with Oxford Health's Learning Disability Service and works closely with the Community Learning Disability Nurses (CLDN's) in Oxfordshire. Part of the Lead LD ESN's role is, in collaboration with Oxford Health, to develop a 'seamless' service for people with a LD and epilepsy – 'A pathway', across both organisations and in doing so, support CLDNs to provide a robust, safe and reliable community-based service for people with a learning disability and epilepsy. Systems and processes take a considerable time to navigate and improve. The Lead LD ESN is also involved in providing epilepsy-related educational updates to CLDN's.

6.3. The Learning Disability Epilepsy Specialist Nurse can visit some patients at home, predominantly patients with Vagal Nerve Stimulation (VNS) devices and arranges 'ad hoc' clinics at the Horton General Hospital.

6.4. Our Epilepsy Specialist Nurses see patients at the monthly VNS satellite clinic in Brackley and can see some patients at the Horton General Hospital.

7. Waiting times: data on waiting times and any trends against recommended NICE good practice including first seizure clinic; follow-up appointments; new tertiary patient; Waiting time for the ketogenic diet for children with severe epilepsy; epilepsy learning disability service.

7.1. We are currently unable to meet some national guidelines. For example:

- Waiting time to be seen in first seizure clinic: 9 months (NICE guidelines: within 2 weeks).
- Waiting time to be seen as a new tertiary patient: almost 12 months (NICE guidelines: within 4 weeks)
- Waiting time to be seen in follow-up: 9-12 months.

7.2. Our current waiting list for ketogenic dietary therapy for children with epilepsy is 3 years. This is significantly higher than other UK centres. The national average is 4-5 months, and highest at other UK centres is 8 months (figures provided by a Ketogenic Dietitians Research Network survey, 2021). As 80% of our patients come off the diet after 2 years, current staffing allows us to take on 17 new patients per year. However, our current referral rate is approximately 36 patients per year, and so the waiting list continues to rise. Nationally, KD referrals are rising annually: 754 patients were following KD in the UK and Ireland in 2017, compared to 101 in 2014; referrals were 45% higher in 2019 compared to 2017 (Whitley et al, 2020). A charity (Daisy Garland) funded a dietetic assistant (DA) post for a fixed period which has now finished.

7.3. There is currently a business case for further Dietitians to provide KD input. The preferred option includes funding for 1.0 WTE dietetic Assistant (band 3), 1 WTE band 7 Dietitian, and 1 WTE band 7 dietitian (temporary 2 year fixed). This is in the process of being finalised and submitted.

7.4. As it will take time for the business case to be approved followed by recruitment and training, year 1 figures reflect only having the DA in post. From year 2, there will be a permanent caseload ability of 80 and an additional 30 people who can start a KD for 2 years. We will therefore have a rolling caseload of 32 patients weaning each year, and the

additional 30 will wean after 2 years. Referrals will continue at 36/year and the waiting list will increase by 4/yr.

Year	Number of Patients on Waiting list	Waiting list duration
1	72	2.3 Yrs
2	24	0.8 Yrs
3	28	0.9Yrs

7.5. This business case will be dependent on additional funding for epilepsy services to provide the increasing number of treatments for an increasing population of people with epilepsy.

8. The new regulation on Valproate and Topiramate. What is the impact on patients of the accelerated Valproate regulation, in particular the OUH Trust response to the statements made in the public petition item on the June HOSC meeting by Dr Judy Shakespeare and Kristi (members of the public who presented at the June HOSC).

8.1. The MHRA has issued new guidance mandating enhanced oversight and review of sodium valproate prescribing for girls and women of childbearing potential, effective January 2024. These are legal requirements as they have been applied to the licence of the medicine. This is because valproate exposure during pregnancy can lead to severe consequences for the unborn child, including physical birth defects (10%) and neurodevelopmental disorders (30-40%). However, valproate is a potent antiseizure medication and the best agent for certain common epilepsy types. Changing valproate to another agent risks loss of seizure control, impacting on quality-of-life and driving, and increasing the risk of injury and mortality.

8.2. All women of childbearing potential already taking valproate must now have a second independent specialist opinion (at least 238 girls and women in Oxfordshire alone who all now require a new patient appointment) to continue valproate. The Oxford Epilepsy Team also manage many patients from Northampton, Kettering, Berkshire, Buckinghamshire, and further afield, so the number of women who will require this second opinion in Oxford will be significantly higher.

8.3. An assessment of the prevalence of Valproate primary care prescriptions was undertaken across BOB: selected data is included in the table below:

	Bucks	Oxon	Berks West	BOB Total

Total number of patients prescribed Valproate	1329	1609	1223	4161
Females under 55	160	238	173	571
Females 55 and over	292	326	214	832
Males	889	1045	835	2769

This table excludes an additional 179 patients who are from non-EMIS practices in BOB for whom we don't have precise data.

8.4. A second independent specialist opinion is now also required before any patient of reproductive age (males and females) can be newly commenced on valproate.

8.5. The MHRA has some concern that valproate may affect fertility in men, and small animal studies suggest a possible toxic effect on the testes, although the relevance in human is unknown. This must now be discussed with all men already taking valproate, adding to already short clinic consultation times. It is very possible that the MHRA will issue a similar mandate that all males taking valproate (> 1000 boys and men in Oxfordshire alone) will also require a second independent specialist opinion to continue valproate.

8.6. The impact of the MHRA valproate regulations on patients is significant. Women and girls of childbearing potential, regardless of their personal circumstances, are recommended to use a highly effective long-term contraceptive agent to continue or commence on valproate i.e. the implant, Depo injection or the contraceptive coil, from menarche up to the age of 55 years. The risk of poor seizure control in people (particularly children, in whom at least 27% are seizure-free on valproate) is understandably of great concern to patients and their families, who rightly worry about the potential impact on driving and employment, as well as the risk to their lives from uncontrolled seizures.

8.7. People with epilepsy are already experiencing great concerns because of shortages of anti-seizure medications, so access to the right medicine at the right time is even more important. Unlike progressive neurological conditions, lack of access can trigger breakthrough seizures that can be immediately life-threatening. Many women who are understandably concerned that an effective drug may be withdrawn feel that the MHRA regulations do not incorporate sufficient patient involvement with the decision-making regarding valproate or the patient's right to choice (an opinion tabled at the HOSC meeting on 6th June 2024 by Kristi McDonald).

8.8. The discussions with our patients regarding valproate must therefore be even more comprehensive, sensitive, and collaborative.

9. What is the impact on the workforce in terms of increased workload and in terms of their wellbeing and clinical ethics?

9.1. The impact of the MHRA valproate regulations on staff is significant. The impact of these new requirements on an already overstretched epilepsy team are enormous. Team members are already working many additional hours per week. A second independent specialist opinion for 238 women in Oxford alone is the equivalent of an additional 238 hours of consultant time. This is an underestimate of the number of patients the Oxford team will be seeing because the department also sees people from outside of the BOB ICS. In addition, the more detailed discussions with patients that are now required take a significant amount of additional time in the clinic and required longer and more detailed clinic letters. It is likely that similar requirements will be mandated for male patients, but even if this does not occur imminently, all male patients on valproate now need additional explanation both verbally and in writing, contributing significantly to consultation times.

9.2. The ongoing oversight and audit of the new regulations as well as the mandatory attendance at frequent local and national meetings contribute to the additional workload.

9.3. These requirements cannot be fulfilled or sustained without either additional staffing or cancellation of large numbers of outpatient clinics, for which patients have already waited almost 12 months.

9.4. This additional workload has a significant impact on the morale and work life balance of the epilepsy team.

10. In June the MHRA also announced that the Prevent programme will apply to Topiramate. What data outcomes are required locally for reporting nationally? Is any other data collected locally on outcomes of patients with epilepsy?

10.1. On 21st June 2024, the MHRA announced that the Prevent programme will now also apply to the anti-seizure medication Topiramate, as topiramate has been shown to also be associated with a higher risk of congenital malformations, low birth weight, and intellectual disability. Topiramate is however a very effective anti-seizure medication for certain common epilepsy syndromes.

10.2. Women and girls taking topiramate are now required to use a contraceptive agent, ideally highly effective long-term contraception, from the age of menarche to the age of 55 years. Patients on topiramate now

also require detailed discussion about further detailed discussion about the risks of topiramate to the unborn baby, and the need to use an effective contraceptive agent. The MHRA topiramate risk acknowledgement form now needs to be completed annually. This is a significant amount of additional work. A second independent specialist opinion is not yet required, but it may be in the future. The exact number of women taking topiramate in our catchment area is currently being ascertained.

10.3. An assessment of the prevalence of current topiramate primary care prescriptions was undertaken across BOB: selected data is included in the table below:

EMIS Web practices	Buckinghamshire		Oxfordshire		Berkshire West	
ALL patients (male & female)	610		880		653	
	Number of patients	**% of female pts**	**Number of patients**	**% of female pts**	**Number of patients**	**% of female pts**
Females ≥ 8 to < 56 yrs	295		425		319	
Migraine - coded	216	73%	333	78%	227	71%
Epilepsy - coded	51	17%	65	15%	60	19%
Mental health (unlicensed)	4	1%	7	2%	4	2%
Neuropathic pain (unlicensed)	4	1%	9	2%	4	7%
Other/Unknown Indication	20	7%	11	3%	24	8%

This table excludes an additional 68 female patients (aged 12-54 years) prescribed topiramate between April – June 2024 who are from non-EMIS practices in BOB for whom we don't have precise data.

10.4. Separate MHRA risk awareness forms are provided for epilepsy and migraine indications. Where the patient is on topiramate for epilepsy the discussion and annual review form must be completed between the specialist and patient/carer, for migraine this is under the remit of primary care. No independent second clinical signatures are currently required for the topiramate pregnancy prevention programme forms.

11. Wantage: OUH has partnered with the Oxfordshire wide system to consider specialist clinics to bring to Wantage Community Hospital. The outcome of co-production and engagement is that epilepsy was included in the long list this year that was shared with the public in July. Please update the Committee on what steps have been taken to progress this proposal?

11.1. Consultant-led neurology clinics currently run at the JR, the Horton, and are also embedded in psychiatry at the Warneford Hospital. This joint service with psychiatry is unique in England and has been very successful. Our SpRs also rotate to run clinics at Swindon, Northampton, Milton Keynes, Reading and Queen's Square (London). We currently do not have the personnel resources to run additional clinics in Wantage Community Hospital but will continue to review this depending on resources. Work is ongoing to define the services that may be able to operate out of Wantage Community Hospital.

12. Patient Safety: Who is leading and at what levels of governance locally has consideration and assurance been given of the patient safety of people with epilepsy and their families including the adequacy of resource, funding, workforce and training for the Oxfordshire epilepsy service in the light of population-health needs and the added work and nature of the MHRA regulations on Valproate and Topiramate, and the context of medicines shortages.

12.1. The system approach has been led by the Quality Team at BOB ICB and has brought together health providers across the ICS including OUH. Following publication of the MHRA alert in November 2023, the BOB ICB patient safety lead established a working group to undertake a gap analysis and develop an improvement plan. This group feeds into the South East regional sodium valproate group who have been escalating the safety and capacity concerns from BOB ICB to the regional system quality group since January 2024.

12.2. In February 2024 the implementation of the MHRA alert was added to the ICB risk register. The risk is: *As a result of the changes to the regulatory requirements of Valproate from MHRA and the resulting national patient safety alert there could be harm to patients and impact on services*. The risk is scored as 20 (25 is the highest a risk can score) and through mitigations the inherent risk scores 15. This risk is highlighted to the South East regional system quality group each month as part of ICB escalations.

12.3. At OUH the Deputy Chief Medical Officer for Patient Safety coordinated a response to the alert with doctors, specialist nurses, pharmacists from

adult and paediatric Neurology departments and the Medicines Safety team. Progress to the alert is regularly reported to the Trust's Medicines Safety Committee, which reports to the Patient Safety and Effectiveness Committee. Updates are also shared through the Trust's Safety, Learning and Improvement Conversation forum.

12.4. There is a separate paper that has been written for HOSC that describes the impact of medicines shortages; we have not experienced any recent supply problems with valproate or topiramate.

12.5. Within the Epilepsy department in OUH, team members (Consultants and Epilepsy Specialist Nurses) regularly attend the meetings of the Medicine Safety Committee and the Task and Finish Group, and the Valproate Regulatory Measures Working Group.

12.6. Professor Sen leads local, national, and international collaborative clinical research projects and is Topic Advisor to the National Institute of Health and Clinical Excellence (NICE) for the Epilepsies. Dr Adcock has led work on National Audits of Seizures.

12.7. At an individual level, every patient seen by the team in clinic has safety advice and SUDEP risk regularly discussed. All women of childbearing potential have regular discussions about contraception and pregnancy and the potential risk to the unborn baby from uncontrolled seizures and anti-seizure medication.

13. The support being provided to tackle SUDEP, suicide and other epilepsy-related premature mortality in Oxfordshire

13.1. We work very closely with our Neuropsychology and Neuropsychiatry colleagues at the John Radcliffe Hospital who help advise and manage psychiatric co-morbidities including depression and feelings of suicidality in our patients with epilepsy, together with the support of our General Practitioners who are at the forefront of managing our patients.

13.2. Professor Sen has worked closely with the patient group SUDEP Action and has published research in the topic of SUDEP, working collaboratively with SUDEP Action.

14. How you plans to continue to develop and to improve epilepsy services moving forward. Is there any planned co-production with the voluntary sector in Oxfordshire and patients with epilepsy and their families?

14.1. A business case has been submitted for approval to appoint at least one additional full-time Consultant Neurologist with an interest in Epilepsy as well as an additional half-time administrative assistant. A permanent long-term appointment is preferred to ensure the sustainable future and safety of epilepsy care in Oxfordshire. Business cases for additional Epilepsy Specialist Nurses will continue to be submitted. An advert for an Epilepsy and Sleep Fellow has also been placed.

14.2. We will ensure that the voluntary sector and patients with epilepsy have a strong voice in developing services across Oxfordshire. The department already has strong links with SUDEP action and actively engages with patients in shaping services.

15. Progress of the implementation of the Valproate requirements so far in adults

15.1. At present, 50 of the first 100 patients have fully completed dual signature MHRA valproate risk acknowledgement forms after valproate MDT meeting discussions for second opinions. We have not cancelled any clinics or any other clinical commitments to implement the MHRA regulations, because we are so concerned about the very long waiting times for patients with epilepsy to be reviewed in clinic and the risk to patient safety if clinics are cancelled. We are therefore conducting the valproate MDT meetings in addition to our usual workload, often after-hours. As many of our patients are very complex, we have chosen to discuss the patients at a multidisciplinary team meeting to ensure maximum safety and governance.

16. Impact on Primary Care and community pharmacy

16.1. Valproate is a ‘shared care’ medicine for epilepsy, in that it should be initiated in secondary care by the specialist with follow-on prescription and monitoring according to a drug specific Shared Care Protocol (SCP). Prescribing may be continued in primary care following the SCP. Shared care depends on good communication between the specialist, GP and patient. The intention to share care should be explained to the patient and accepted by them. The BOB oral valproate medicines SCP specifies the responsibilities of the specialist, primary care prescriber, commissioned GP/sexual health clinic and patient/carer.

16.2. Changes to legislation came into effect in October 2023 requiring dispensers to dispense for all patients (male and female) all licensed valproate containing medicines in the manufacturer's original full pack. The original full pack includes specific warnings and pictograms, including a patient card and the Patient Information Leaflet, and will therefore alert patients on the risks to unborn child. In rare cases, pharmacists can make an exception to the requirement to dispense valproate-containing medicines in the manufacturer's original full pack on an individual patient risk assessment basis.

17. Conclusion

17.1. This is a briefing paper submitted jointly from OUH and BOB ICB for information and assurance regarding the current and proposed provision of epilepsy services in Oxfordshire, with particular reference to the recent changes in legal regulations for the prescription of Sodium Valproate and Topiramate.

17.2. HOSC are asked to accept this paper as assurance of the services provided to people with epilepsy and support an increase in investment into these services in order to improve their delivery and safety to the population served.

Statement on Epilepsy from Sarah Fishburn (Senior Clinical Quality Improvement Manager)

1. *Whether patient safety concerns about the MHRA policy are being listened to nationally?*

   The South East regional team has been working with colleagues across the region to gain a clear understanding of the issues being encountered in practice, and has also been working with experts by experience and organisations supporting people taking valproate to understand the issues. We have now met twice with the team at MHRA to express the concerns and alert them to the issues. They have told us that they are monitoring the situation and rely on data to make any decisions.

2. *Does NHSE welcome the Patient Safety Commissioner consultation on the requirements of improved patient safety that are being consulted on nationally?*

   We fully support any increased focus which leads to improved safety and quality of care for patients.

3. *What would need to happen in respect of the MHRA policy for patient safety and patient priorities to be relevant and in place for people with epilepsy who need timely access to life saving and life enabling medication?*

   The key requirement from MHRA is to have data on any actual harm caused by the changes in policy. We have made them aware of the increased delays in neurology clinics as a result of the requirement for a second check for all valproate prescribing and the cancellation of clinics. They are monitoring the situation and any data which becomes available. They have had sight of a report from Liverpool which details no increases in deaths but an increase in people attending hospital with seizures.

4. *What is NHSE able to put in place now and what else would be needed to support local systems?*

   NHSE SE region is developing a pilot digital programme to enable the annual ARAF process to be more streamlined. This will enable clinicians and service users to view the ARAF form, and will help to set up the regular reviews digitally.

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OXFORDSHIRE COUNTY COUNCIL

Work Programme 2024/25
Joint Health Overview and Scrutiny Committee

Cllr J Hanna OBE Chair | Dr Omid Nouri Omid.Nouri@Oxfordshire.gov.uk

COMMITTEE BUSINESS

12 SEPTEMBER 2024				
Adult and Older Adult Mental Health	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report from the Oxfordshire system with an update on Adult and Older Adult Mental Health.	Overview and Scrutiny	
Winter Planning	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report on the systemwide preparations and plans to manage the pressures of the ensuing winter months.	Overview and Scrutiny	
Epilepsy Services	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an outline on the nature of Epilepsy Services delivered throughout the County.	Overview and Scrutiny	

Medicines Shortages	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on medicines shortages, and how these are affecting patients and residents in Oxfordshire.	Overview and Scrutiny	
21 NOVEMBER 2024				
Oxfordshire Healthy Weight	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on Oxfordshire Healthy Weight 12 months since this item previously came to HOSC.	Overview and Scrutiny	Ansaf Azhar David Munday Derys Pragnell
Health and Wellbeing Strategy Delivery Plan	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an outline as to a delivery plan for the updated Health and Wellbeing Strategy for Oxfordshire.	Overview and Scrutiny	
Maternity Services in Oxfordshire	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report with an update on the state of maternity services within Oxfordshire.	Overview and Scrutiny	
Local Area Partnership SEND Improvement Journey	Tackle Inequalities in Oxfordshire	To receive a report with an update on the Local Area Partnership's SEND improvement	Overview and Scrutiny	

	Prioritise the Health and Wellbeing of Residents.	journey, with a view to examine the impacts of the improvement journey on the physical and mental health of Children with SEND.		
3 JANUARY 2025				
Emotional Wellbeing of Children	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on the Emotional Wellbeing and Mental Health Strategy for Children.	Overview and Scrutiny	
Oxford Health NHS Foundation Trust People Plan	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report from OHFT on the Trust's People Plan, with a view to examine the Trust's support for workforce.	Overview and Scrutiny	
Director of Public Health Annual Report	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To review the Oxfordshire County Council's Director of Public Health Annual Report, which has a specific focus on climate action and health.	Overview and Scrutiny	Ansaf Azhar, Director of Public Health.

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Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 6 June 2024.

	Item	Action/Recommendation	Lead	Progress update
1	Minutes of 23 September 2022	Health partners to be invited to the next OCC scrutiny training	Tom Hudson / Omid Nouri	To be actioned in the new municipal year for 23/24. In progress *Update – OCC scrutiny are working up a training proposal with CfGS.*
	24 November 2022 Meeting			
2	Primary Care	Recommendation: Specified roles are filled within the ICB with the primary responsibility to work with District Councils at Place Level to coordinate use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.	Julie Dandridge/ Daniel Leveson	Progress/update response: The ICB have managed to recruit a Primary Care estates manager who will have a key role in working with Districts in terms of planning for new housing developments. The successful candidate starts in December 2023. Unfortunately, recruitment was delayed due to lack of suitable candidates.

	Item	Action/Recommendation	Lead	Progress update
3	Cllr Barrow's infection control report	OCC carries out a regular review of current infection control procedures in care homes and the support provided.	Karen Fuller, OCC	This is built into our routine procedures in relation to infection control and monitoring outbreaks. OCC works in partnership with Oxford Health care home support service, CQC and UKHSA. *UPDATE – Subsequent Care Home Visits to be arranged in conjunction with the Director for Adult Social Care.*
	10 March 2022 **Meeting**			
4	Access and Waiting Times	Information is supplied on the new elective care access offer across the BOB footprint (the provider collaborative)	Omid Nouri/Titus Burwell	BOB ICS Elective Recovery plan & provider collaborative would need to be presented by BOB ICS colleagues - In progress *Update – A scope is being drawn up for Titus Burwell, Chair of BOB Elective Recovery Backlog Group, to brief the Covid-19 Elective Recovery Backlog group on the subject with a particular focus on Symptomatic breast cancer 2WW and in respect of Urological Cancer referrals.*

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 6 June 2024.

	Item	Action/Recommendation	Lead	Progress update
5	Access and Waiting Times	That Members meet separately with James Scott to explore workforce challenges across Oxfordshire/the NHS	BOB HOSC, BOB ICS	*Eddie and OCC BOB HOSC Members to ask for the item to be placed on the BOB HOSC Work Programme.* In progress *Update – To be considered as part of future discussions amongst the BOB HOSC*
6	Chairs Update	That Members of the Committee come forward in which to develop a glossary of NHS acronyms.	Omid Nouri/ Cllr Nigel Champken-Woods	*Cllr Champken – Woods came forward at the last meeting to start an early draft. It was identified that Wokingham's HOSC glossary as a good model to follow.* In progress *This is currently being collated with Cllr Champken-Woods and will be appended at the back of HOSC agendas once finished.*
	14 July Meeting 2022			
7	Integrated Improvement Programme	Establish a sub group on the Integrated Improvement Programme to provide NHS / OCC colleagues the opportunity to engage with HOSC outside of formal Committee meetings (as well as in addition to). It should cover all aspects of comms and engagement and any issues relating to services at Wantage.	Cllrs Hanna, Edosomwan, Barrow and Barbara Shaw Omid Nouri	In progress – *UPDATE- The Integrated Improvement Programme met as a Member-only forum on 20 September 2022 and agreed to meet with a ICB representative in respect of the ICB's involvement in the IIP. The Group also agreed that a group would engage with representatives at OH in respect of the maternity closures and maternity closures across Oxfordshire.* *Terms of Reference for the Group will be drawn up for engagement in respect of the consultation and delivery plan relating to the IIP.*

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 6 June 2024.

	Item	Action/Recommendation	Lead	Progress update
	22 September 2022 Meeting			
8	Action and Recommendation Tracker	NHS England Health and Justice to fill out the Committee's substantial change toolkit in relation to the SARC in Bicester; this is to then be reviewed by Members via email, with a view to meeting the Commissioner in person.	Lisa Briggs	In Progress - The Substantial Change Toolkit form has been received and was considered by Cllrs Champken-Woods, Hanna and Heywood. It was considered that there was no substantial change. However further information in respect of the service has been requested and waiting a response.
	24 November 2022 Meeting			
9	**Primary Care**	The Committee is informed as to how much Community Infrastructure Levy funding has been received by the Oxfordshire CCG and subsequently the BOB ICB (from Oxfordshire), the amounts received from the 5 individual District Councils, how much of those CIL funds have been spent, which health related CIL funded projects have been commissioned; and what projects have been completed or are in progress using executed Section 106 funds.	Julie Dandridge	In progress – The ICB has been reminded of these questions and will feedback to the Committee outside the formal Committee process. *UPDATE – Julie Dandridge to provide an update on a list in respect of where the funds currently sat, time restrictions and other obligations.*
10	**Serious Adult Mental Health**	A workshop on serious adult mental health is co-produced to allow further Committee exploration of the area.	Omid Nouri, OH, Karen Stephen Chandler	In progress – To be scoped after the 9th of February 2023 HOSC Meeting.
	9 February 2023 Meeting			
11	**SCAS Improvement Programme Update**	SCAS' performance data be regularly reviewed by the Committee's Covid-19 Elective Recovery Sub-Group.	Omid Nouri/SCAS	In progress- The Committee is to be advised when the wait-time performance data can be broken

	Item	Action/Recommendation	Lead	Progress update
				down into (Middle Layer Super Output Areas) MSOA level. Likely to be Autumn 2023
12	**Committee Work Programming**	A Work Programming Meeting be arranged with all Committee Members	Omid Nouri/ Tom Hudson	In progress – a partial work plan has been suggested, but in light of the appointment of a new Scrutiny Officer the completion of the new work plan is to take place once they are in post and are better placed to help the committee deliver it.
	11 May 2023 Meeting			
13	**Dentistry Provision in Oxfordshire**	To collaborate with the Place Based Partnership, Public Health, and providers with a view to creating a base line dentistry data set that will mean local improvements to poor dental health of residents can be achieved and clearly communicated.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The Oxfordshire Joint Strategic Needs Assessment (2023) contains information about the oral health of 5 year olds in the county. This information is derived from national epidemiological surveys. The ICB will work with Public Health colleagues to review and update this information. The ICB is developing a Primary Care strategy including dental services. This will include a review current data and the development of datasets to inform future commissioning plans. There is a strong link between socio-economic factors and health. The aim is to develop a strategy outlining how primary care via service delivery and partnership working with other agencies will improve the health of the

	Item	Action/Recommendation	Lead	Progress update
				population with oral health to be a key element of the strategy.
14	**Dentistry Provision in Oxfordshire**	To resolve any remaining uncertainty regarding the local flexibilities available to the ICB, and to consider investment of the underspend in Oxfordshire in targeted action to improve access to health and better serve Oxfordshire's children and residents with the greatest need.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The BOB ICB Flexible Commissioning pilot commenced on 1st June 2023. The pilot scheme will run to 31st March 2024 and is designed to support access to NHS dental care for patients who have struggled to access NHS dental care. The scheme supports access for patients who have not attended a local dental practice for 2 years; who have relocated to the area; Looked After Children, families of armed forces personnel, asylum seekers and Refugees. Practices can also see 'other' patients of they believe it to be clinically appropriate. It allows practices to convert up to 10% of their contractual capacity from the delivery of activity targets to access sessions, where more time can be set aside for patients likely to have higher treatment needs. 30 practices in BOB are taking part in the scheme (18 from Oxfordshire) with plans to provide nearly 3,000 Flexible Commissioning access sessions in the period July 2023 to March 2024. In the first 4 months about 900 sessions were provided with 3,000 patients attending (3,500 attendances). About 70% of patients attending to date have not attended a dental practice for 2 years; 14% have relocated to the area; 12% 'other' (includes patients who have

	Item	Action/Recommendation	Lead	Progress update
				been unable to access care, urgent patients, maternity, patients with an on-going clinical need that requires dental intervention, vulnerable patients, children's emergency trauma and cancer patients needing dental treatment as part of their care). 4% of attendances have been from Looked After Children, families of armed forces personnel and asylum seekers and refugees. The service is subject to on-going review and development. National guidance in respect of Flexible Commissioning was issued in October 2023. Whilst access to NHS dental services is continuing to improve, some capacity has been lost following decisions by some practices to leave the NHS or reduce their NHS commitment. The ICB is working with local practices on a re-commissioning plan to replace this capacity from 2023-24 onwards.
	21 September 2023 Meeting			
15	**Oxfordshire Healthy Weight**	Recommendation: To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024):

	Item	Action/Recommendation	Lead	Progress update
				We currently commission two healthy weight services at Local Authority level, one that works with adults and another working with children. We also link closely with partners (NHS) who offer services at tiers above and below our own with a view to offering a seamless pathway. We identified some gaps in service as part of the recent Health Needs Assessment (HNA) on Healthy Weight. The current contract is coming to an end and we are planning to commission an 'all age service' with some additional elements to meet the gaps identified in the HNA. We are also planning a review and refresh of opportunities to raise awareness of support that is available. Update April 2023: We are in the process of recommissioning an all age, Tier 1 & 2 service,and will know the outcome by late Spring 2024. The service will commence on 1st September 2023. The new Tier 1 and 2 service will include a range of programmes for residents to chose from, as well as developing innovation pilots with specific populations as identified by the HNA, to test and learn what works with these residents to support achieving a healthy weight. Communications and campaigns will be part of this contract to increase awareness of the service for residents and professionals.

	Item	Action/Recommendation	Lead	Progress update
16	**Oxfordshire Healthy Weight**	Recommendation: To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): The current healthy weight service has specific programmes for ethnic groups who are more likely to develop excess weight. This includes innovation pilots working in mosques, women only sessions, and tailoring content to be specific (e.g. on food types) The new service will build on this learning/modelling and is likely to have community development as a delivery component within key priority areas and populations, including ethnically diverse. Update April 2023: This detail remains the same. We can provide specific numbers and details of groups if HOSC require
17	**Oxfordshire Healthy Weight**	Recommendation: To work on providing support to the parents, carers, or families of children living with excess weight, and to help provide them with the tools to help manage children's weight.	Derys Pragnell	Recommendation Accepted, HOSC will receive future progress update in April 2024. Update April 2023: Current Tier 1 and 2 services commissioned by public health have bespoke services for children. From September 2024 the new service will have innovation pilots to test and learn what works with cohorts aged 0-3 and teenagers. In addition, a range of digital

	Item	Action/Recommendation	Lead	Progress update
				and print resources for adults and families will be available from the provider to support a healthy weight. The provider will also be part of wider systems working, linking up a range of partners, for example NCMP and 0-19 providers. A children's healthy weight toolkit for health, social and voluntary/community professionals is in redevelopment. A 'You Said, We Did' response has been developed for Early Years professionals following a survey and interviews to support knowledge and skills in healthy eating. This includes Lunchbox Planners, Child Feeding Guide Training and a range of other resources. Finally, Public Health have led a working group to develop a suite of resources and assets to support uptake of Healthy Start across the County, including in ethnic minority groups. This has recently gone live.
18	**Oxfordshire Healthy Weight**	Recommendation: To explore avenues of support for residents who may struggle to afford healthy diets in the context of the cost-of-living crisis.	Derys Pragnell	Comment on Recommendation: This should be an action/link for Food Strategy work across Oxfordshire, which is led by Laura, Rushen, Senior Policy Officer at OCC– each District Council has been commissioned to undertake work for their District. Update April 2023:

	Item	Action/Recommendation	Lead	Progress update
				Action plans have been developed and adopted by the following councils: Cherwell – 4 March Oxford – 13 March West Oxfordshire – 9 March South Oxfordshire and Vale of White Horses' action plans are being finalised.
20	**Oxfordshire Healthy Weight**	Recommendation: In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this.		A separate response to this recommendation will be sought from BOB ICB.
21	**Oxfordshire Healthy Weight**	Recommendation: To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils and lead officer responsible for advertising/sponsorship policy as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and the advertising of HFSS products.	Derys Pragnell/ Omid Nouri	Health Scrutiny Officer (Omid Nouri) to liaise with relevant officers to facilitate this meeting in the near future. Update April 2023: We believe this meeting was being co-ordinated by HOSC. We have met several times with planning leads and provided detailed backing information and evidence to support each District/City Council to put in place a policy to restrict Hot Food Takeaways if they choose. Public Health have commissioned Bite Back to develop a youth manifesto on food environments for Oxfordshire, including focusing on vending and HFSS advertising in different locations across the County.

	Item	Action/Recommendation	Lead	Progress update
22	**Health and Wellbeing Strategy**	Recommendation: To ensure careful, effective, and coordinated efforts amongst system partners to develop an explicit criteria for monitoring the deliverability of the strategy; and to explore the prospect of enabling input/feedback from disadvantaged groups as part of this process.	David Munday	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): The Health and Wellbeing board has committed to the development of a delivery plan and outcomes framework for this new HWB strategy. This is to ensure the strategy is delivered by the partnership. We expect that an initial version of this will be presented to the HWB in March 24 and it will build on the strong public engagement that has already occurred in the strategy formation to date. Update April 2023: The Health and Wellbeing Strategy Outcomes Framework was agreed at the Health and Wellbeing Board in March 2024. The Outcomes Framework has broken each of the 10 priorities down into more tangible Shared Outcomes- between 3 and 5 of these per priority. It also maps existing programmes of work against each of the 10 priorities. The Framework also lists suggested metrics to monitor delivery- these are Key Outcomes (a measure of the strategic impact we want to see) and Supporting Indicators (the process measures that support achievement of the strategic change). Finally, the Outcomes Framework lists the governance forums within the Oxfordshire

	Item	Action/Recommendation	Lead	Progress update
				System that is the primary partnership responsible for delivery against each of the priorities. It is these forums and work programmes they have oversight of that ensure relevant engagement with residents over the monitoring of progress in their work areas. It has been agreed by the board that it will review progress, data against the metrics and received narrative update on only one part of the strategy at each of its quarterly meetings, so that over the course of a 12 month work programme it will have reviewed once delivery against all parts of the strategy. Full papers on the Outcomes Framework are available on HWB March agenda.
	Local Area Partnership SEND	Recommendation: For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Partnership leadership, assurance, and oversight of SEND provision is by the Oxfordshire SEND Improvement Board (SIB). The Board provides transparent visibility of progress, constructive and robust challenge, as well as celebrating what is working well and improving. The progress of improvements will be routinely scrutinsed by appropriate scrutiny arrangements (People Scrutiny, HOSC and ICB Quality Group).

	Item	Action/Recommendation	Lead	Progress update
				Operational delivery of the Priority Action Plan (PAP) is via the Partnership Delivery Group (PDG), supported by time-limited Task and Finish groups. SIB, PDG, and Task and Finish groups all include Parent/ Carer representation. Continued improved communication with families and stakeholders is a key focus of our SEND action planning. It underpins our governance arrangements, is a key priority within the PAP, and is a focus area of our Working Together Task and Finish group.
	Local Area Partnership SEND	Recommendation: To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to develop explicit Key Performance Indicators for measuring the effectiveness of improvements that are open to scrutiny. The Committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent. The SIB will consider at its inaugural meeting how best to ensure information easily and publicly available.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): The Priority Action Plan includes development of an Integrated Local Area Partnership SEND dashboard, based on partnership KPIs, with performance overseen by the SIB. As above, ongoing PAP action planning is operationally overseen by PDG and Task and Finish Groups. PDG reports monthly to the SIB.
	Local Area Partnership SEND	Recommendation: For the Leadership to adopt restorative thinking and practices with utmost urgency to reassure affected families, and for this thinking to be placed at the heart of any co-production exercises	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Restorative Approaches are well-established within Children's Services. Co-production with children and families is at

	Item	Action/Recommendation	Lead	Progress update
		to help families feel their voices are being heard as well as for the purposes of transparency.		the heart of PAP and wider action planning. As noted, they are represented within all leadership & delivery bodies for SEND improvement.
Page 143	**Local Area Partnership SEND**	Recommendation: To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be considered in tackling the systemic failings highlighted in the report. The Committee also recommends that the Partnership considers timely allocation of seed funding for the development of co-production involving people with lived experience; and for joint commissioning of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector, and families.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): SIB responsibilities include ensuring that co-production is embedded in the culture of SEND services. Our Multi Agency Quality Assurance (MAQA) forum has the purpose of setting out consistent, service specific processes for the quality assurance of Education, Health, and Care Plans, ensuring that good practice and learning is shared, informs training and professional development for all professionals involved in the process, underpinning our vision for shared responsibility for improving outcomes, on the improvements achieved and next steps. Partnership training, and impact measures, are included in the PAP. All PAP actions are time-specified, ranging from December 2023 to post-July 2025, dependent on prioritisation and practicability.

	Item	Action/Recommendation	Lead	Progress update
	Local Area Partnership SEND	Recommendation: To continue to improve working collaboration amongst the Local Area Partnership to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are existing arrangements to enable the sharing of information across partners. The effectiveness of these will be considered as part of the improvement journey.
	Local Area Partnership SEND	Recommendation: For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/ alternative services available which a child may also need a referral to. It is also recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council, using the budget agreed by cabinet immediately following the Ofsted report.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Priority actions within the PAP include co-production of both refreshed Local Offer and development of local area partnership early help and early intervention strategy. Together with improved EHCP assessment process, and Team Around the Family, this will enable the delivery of needs-led provision and the progression of outcome led plans with families. As noted above (Paragraph 8), continued improved communication with stakeholders and families is a key priority.
	Local Area Partnership SEND	Recommendation: To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Timeliness and quality of EHPCs, along with improved parental access to the digital portal, are addressed within PAP item 3. Actions include ensuring accurate, timely, and effective assessment, and effectively meeting needs, particularly at

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				points of transition. Assessment timeliness is improving, despite increasing demand. Timeliness of completion within 20 weeks has improved from 40% in June 2023 to 50% in the last month.
	Local Area Partnership SEND	Recommendation: For SEND commissioning to be developed using the Ofsted report as a baseline, and to place person-centred mental and physical health of children and their families with SEND at the centre of decisions on how funding is spent to maximise social value. The Committee also recommends for the Local Area Partnership to map all funding sources available for, and to explore joint commissioning of services and training that could improve the overall health and wellbeing for children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): PAP priority actions include a focus on improved commissioning and strong relationships with commissioned providers, to improve capacity, meet demand, and meet the needs of children, young people, and their families. The PAP is also focused on ensuring commissioning arrangements support timely decision making and transition arrangements, and that there is a multi-agency approach to meeting the needs of children with emotional and mental health difficulties. The Leadership and Partnership Task and Finish group has responsibility for integrated commissioning of SEND services. The Oxfordshire Joint Commissioning Executive, which plays a key role in the delivery of many Priority Action Plan actions, reports into the Partnership Delivery Group.
	Local Area Partnership SEND	Recommendation:	Stephen Chandler/An	Initial Response (additional progress update response to be provided in April 2024):

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		To ensure that there is clarity of information on any physical or mental health services for children with SEND, to reduce the risk of confusion and lack of awareness of such services amongst parents, carers or families of children who require support for their mental or physical health.	ne Coyle/Rachel Corser	A local area pathway is being developed for children and young people with emotional wellbeing and mental health concerns. The i-THRIVE framework (an integrated, person-centred, and needs-led approach to delivering mental health services for children, young people, and their parents/carers) will be linked to the Early Help Strategy and Team Around the Family.
	Local Area Partnership SEND	Recommendation: To exercise learning from how other Counties and Systems have provided well-coordinated and effective SEND provision; particularly where measures have been adopted to specifically reduce the tendency for poor mental or physical health amongst affected Children and Young People.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Our response to the SEND inspection, including development of PAP and KPI dashboard, has been informed by learning from other local authorities. Children's Services senior leadership bring a wealth of experience in delivering transformation and service improvement within other local authorities. This includes both the recently appointed independent chair of the SIB, Steve Crocker (Former President of Association of Director of Children's Services) and new SEND/ Children's Services Improvement. We have invested in an additional Assistant Director for Early Help & Prevention, and Strategic Lead for Specialist Projects. Deputy Directors for Children's Social Care/ Education are likewise experienced.

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	Local Area Partnership SEND	Recommendation: To ensure that staff involved in Health, Care, Education, and any relevant Voluntary Sector organisations are sufficiently trained and aware of children that may be neuro-divergent, have a learning difficulty or a disability (SEND); and for such staff to be adequately aware of the support and resources available, and the processes for referring such children for any relevant mental or physical health services that they might require.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): As noted above, partnership training is embedded within the PAP. The Working Together Task & Finish group leads on Workforce Development.
	Local Area Partnership	Recommendation: For HOSC to continue to follow this item and to evaluate the impact of any changes or improvements made, with specific insights into the following; the Partnership's Action Plan as requested by HMCI; the overall measures taken to address the concerns raised by the Ofsted/CQC inspection; the progress made by CAMHS in reducing waiting times for treatment of children with SEND who require mental health support; and on how the NHS is working to increase the overall acquisition and availability of data on SEND children's mental health from key mental health providers.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are clear governance and reporting structures, as outlined above. We can provide updates as required.
	23 November 2023 Meeting			
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is		Recommendation Partially Accepted: Initial Response (additional progress update response to be provided in June 2024):

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		recommended that piloting such navigation tools in specific communities may be a point of consideration.		We work closely with partners across Oxfordshire who offer advice, support and interventions for children, young people and their families and are currently tendering for a peer support app for CYP to support their mental health and well-being with a directory of local services to meet their needs. We recognise the importance of ensuring that local communities and neighbourhoods are connected to service provision in their areas. This is also important to the workforce so that they know who their local link is for support and services. This recommendation applies to all system partners to ensure that information is made available. HOSC can also support this approach with members of the scrutiny committee sharing information through their networks. The new SEND Local offer also provides details how to apply for help and includes a directory of local provision that both CYP and their families as well as professionals can access. This has been co-produced with Oxfordshire Parent Carer Forum and is key action in the priority action plan the link for the new website: Oxfordshire SEND local offer | Oxfordshire County Council As part of the early help strategy refresh this year OCC Children's Services will be ensuring the offer of early help is

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				accessible to all families to find information to support them along with resources available within the local offer and linked with FIS. Co-production is a critical part of the strategy development and the commissioning cycle. This approach was adopted for the development of the emotional health and wellbeing strategy and in the commissioning of the digital offer. The Council recognises that improvements can be made and in future tenders we would like CYP to be able to be part of the evaluation process. We are working with procurement and legal colleagues to enable this to happen without being at risk of breaching contract procurement regulations and legal challenge. We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available; to include		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): Co-production is a critical part of the strategy development and the commissioning cycle. This approach was

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		testing with neurodivergent children and other children known to be at higher risk of mental ill health.		adopted for the development of the emotional health and wellbeing strategy and in the commissioning of the digital offer. The Council recognises that improvements can be made and in future tenders we would like CYP to be able to be part of the evaluation process. We are working with procurement and legal colleagues to enable this to happen without being at risk of breaching contract procurement regulations and legal challenge. We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long-run.		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): Funding for supporting emotional health and wellbeing comes from a number of government departments and organisations. This includes Department for Education and NHS England as well as funding provided to the voluntary and community sector and for research and evaluation to grow the evidence base on what works. As a system we will strive to identify sustainable sources of funding for Oxfordshire. Local funding streams will be

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				determined by the financial envelope provided to us nationally for this work. Any proposals to increase resources to better meet the needs of CYP in Oxfordshire are being managed by the SEND Priority Action Plan to address priorities identified during the Local Area SEND inspection by OFSTED and CQC.
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To ensure that children and young people and their families continue to receive support that is specifically tailored toward their needs. It is recommended that a Needs-Based Approach is explicitly adopted, as opposed to a purely Diagnosis-Based Approach. This could allow for early intervention to be initiated as soon as possible.		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): System partners recognise the recommendation to be needs led and provide support to children, young people and families at the earliest opportunity utilising the Think Family Approach and as endorsed within the Early Help Strategy to offer the right support at the right time. Oxford Health are already taking this needs-led approach through Universal Public Health Services for CYP. Oxford Health CAMHS service also commission Autism Oxfordshire to give CYP and their families pre-diagnoses support for those waiting for a Neuro-development Conditions assessment. We are exploring different ways of commissioning and delivering Neuro-development Conditions assessment services across the BOB ICB as long waits are a national issue. Addressing waits for

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				Neuro-development Conditions assessments is also an action in the SEND Priority Action Plan.
Page 152	**Children's Emotional Wellbeing & Mental Health Strategy**	Recommendation: That consideration is given to the use of a simple and evidence-based standardised evaluation measure, that is suitable across all services that are working on Children's mental health in community settings.		Recommendation Partially Accepted: Initial Response (additional progress update response to be provided in June 2024): Evaluations tell us what works and what does not. An evaluation should be a rigorous and structured assessment of a completed or ongoing activity, intervention, programme or policy that will determine the extent to which it is achieving its objectives and contributing to decision-making. Collecting feedback, data and local intelligence from children and young people, communities and services is essential to inform a needs-led approach. We will explore what guidance and evidence-based practice is available to address this recommendation. We would also like to recommend that this is broader than 'children's mental health in community settings' to recognise the impact of wider determinants on emotional health and wellbeing for children, young people and their families.

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				Children's Services already utilise SDQ's to measure and evaluate children's Mental Health for Children We Care For and we could look to expand this practice to a wider cohort of children to further explore their needs.
	8 February 2024			
	Director of Public Health Annual Report	For the fully published DPH Annual report to come to a future HOSC meeting, with a view to further scrutinise the report and the deliverability of the commitments around climate action and health.	Ansaf Azhar	Recommendation Accepted: We have agreed to bring the 2023/24 DPH Annual Report to a future HOSC meeting to enable members to consider the deliverability of its recommendations.
	Director of Public Health Annual Report	For the full DPH report to incorporate a section with insights into Population Health, and to include an update on progress on recommendations from the previous DPH Annual report.	Ansaf Azhar	Recommendation Accepted: The DPH report now includes a summary profile of Oxfordshire's Health and Wellbeing with signposting to the Joint Strategic Needs Assessment which provides more detailed and live data.
	Director of Public Health Annual Report	For there to be clear and thorough engagement and co-production with key stakeholders around the commitments to climate action and health after the publication of the report. It is recommended that the local contexts and sensitivities are taken into account, with a view to balance these with national directives around climate action and health.	Ansaf Azhar	Recommendation Accepted: This recommendation is reflected in the engagement plan for the report.
	Director of Public Health Annual Report	For there to be clear transparency and indications as to the barriers and enablers surrounding commitments to climate action and health. It is recommended that sufficient avenues of funding and resources are secured	Ansaf Azhar	Recommendation Accepted: All relevant avenues of funding and resources will be pursued to support delivery of the Report's recommendations.

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		for the purposes of delivering these ambitions, and for collaboration with key system partners for the purposes of this.		
	Director of Public Health Annual Report	For there to be clarity around any governance structures or processes around climate action and health. It is recommended that there is transparency around any key leads responsible for relevant policy areas around climate and health to understand individual/organisational commitments, as well as to understand any associated regulatory or legislative barriers to these commitments.	Ansaf Azhar	Recommendation Accepted: The report has already been submitted to the Future Oxfordshire Partnership Environment Advisory Group, which provides governance of system wide action to address climate change; it was welcomed and endorsed by this group. Within OCC the Climate Action Programme Board provides internal governance mechanisms for monitoring progress.
	Director of Public Health Annual Report	To ensure that clear processes are in place for monitoring and evaluating the measures taken as part of climate action, with specific attention to the implications that such measures may have on residents' health and wellbeing.	Ansaf Azhar	Recommendation Accepted: The report's recommendations are aligned with metrics that are reported against as part of OCC's Unity performance monitoring system. In addition, impact on health outcomes will be reported through the Joint Strategic Needs Assessment.
	Director of Public Health Annual Report	To raise educational awareness and understanding of the importance of climate action and its implications on health.	Ansaf Azhar	Recommendation Accepted: As part of the engagement plan, schools will be engaged as part of a coordinated approach to secure the support of schools' strategic leadership teams for action on climate and health.
	Director of Public Health Annual Report	For next year's DPH Annual report to be brought as a full draft to the Committee's spring meeting, with a view to scrutinise the	Ansaf Azhar	Recommendation Accepted: Next year's DPH Annual report will be brought to the Committee's spring meeting

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		draft and provide feedback in a public meeting ahead of its official publication.		with a view to scrutinise the deliverability of its recommendations.
	John Radcliffe Hospital CQC Improvement Journey	For the Trust to continue to take improved measures to improve patient safety at the John Radcliffe. It is recommended that staff are sufficiently supported and trained in being able to maximise patient safety.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: As a Trust, we take patient safety and quality improvement very seriously and so this work has been at both strategic and operational levels. As noted in our report to HOSC in February 2024, numerous developments across the Trust have taken place since the last inspections at the JR; all of which support and deliver improvements across each of the key questions: Safe, Responsive and Well Led. We continue to review all patient safety incidents with moderate or above impact at our daily Patient Safety Response (PSR) meeting which is chaired by senior clinical leaders with medical, nursing and governance representation from across the Divisions. In line with national requirements, we introduced Patient Safety Incident Response Framework (PSIRF) in 2023. This is an approach to developing and maintaining effective systems and processes for responding to patient safety incidents focussed on learning and improving patient safety. We have a new policy with associated training, and it is supported by a detailed Incident reporting and learning procedure. This has included the appointment of patient safety partners. We continue to monitor key patient safety metrics both internally and against national

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Page 156				benchmarks. The latest Summary Hospital-level Mortality Indicator (SHMI) for October 2022 to September 2023 is 0.92 (0.89-1.12). This is banded 'as expected'. From May 2024, the Trust level SHMI will exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts. Provisional NHSE data shared with the Trust shows a SHMI excluding the hospices of 0.86 for January to December 2023, which is banded as 'lower than expected'. The Trust's Hospital Standardised Mortality Ratio (HSMR) is 88.8 (95% CL 85.1 – 92.6) for September 2022 to August 2023. The HSMR remains banded as 'lower than expected'. The HSMR excluding both Hospices is 80 (71.5 -97.6). All deaths undergo a mortality review to identify and implement any potential learning. Huge emphasis has been placed on core skill compliance. This includes statutory and mandatory training across a range of clinical and non-clinical domains; patient safety training; and role specific training. Compliance is monitored via our MyLearning Hub electronic learning platform and through appraisal. Similar emphasis is placed on appraisal completion and monitoring to support staff in their personal development and delivery of the Trust objectives. Compliance is now recorded on a central system, with rates published in the monthly 'Integrated

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				Performance Report' monitored by our Trust Board (papers are published on our website). We introduced a values-based appraisal (VBA) window for the first time in 2022 which has had a positive impact. 94.2% of Trust wide staff completed an appraisal in the last financial year compared to 65% in 2021-22. The OUH CEO launched our new 'Kindness into Action' programme in October 2022 with a Leading with Kindness training programme for our leaders and managers, something that has been integral to the improvement and development of core services across all sites. By the end of March 2024, 519 leaders in the organisation had completed this comprehensive training package and a further 969 leaders were in the process of completing the training. In addition, 1060 other members of staff had completed the complementary 'Kindness into Action' training for all staff. Underpinning all that we do is a strong focus on Quality Improvement (QI), with ~1,500 staff now trained in Quality Improvement. Reflecting this is our positive feedback from the NHS Staff Survey, which highlights a significant cultural shift within ourorganisation towards greater staff autonomy and involvement in decision-making processes related to their work areas. These survey results reflect our staff's increasing ability to contribute to improvements and compare favourably

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				with many other NHS Trusts. The staff survey includes 3 questions on quality improvement. In all three questions OUH has seen improvement over the last few years and the scores remain above the average for staff survey results in England.
Page 158	**John Radcliffe Hospital CQC Improvement Journey**	For ongoing stakeholder engagement and coproduction to be at the heart of the John Radcliffe Hospital's efforts to address the concerns identified by the CQC, and for there to be clear transparency and further evidence of this to be provided.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: HOSC are thanked for their recognition of the importance of stakeholder engagement and co-production in NHS services. Stakeholder engagement is a vital part of both our strategic and operational efforts. The views of patients, families, carers, staff and partners help shape our services across the JR and the wider trust. By way of an example of our commitment to this, since the last CQC inspections we have published "Your Voice: Patient Experience and Engagement Plan 2023 – 26" which sets the vision and direction for improving how the Trust learns from lived experience and then puts this into practice with experts by experience working alongside us to implement change. We hold an annual patient safety engagement event which is geared to engage patients the public and our governors in helping set our annual quality priorities. In addition, as flagged in our report to HOSC, patient experience stories are presented to the Trust Board and our Integrated Assurance Committee, providing an insight into an individual's experience of our services. They often provide opportunities for learning.

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Page 159				Supporting and involving staff and patients after a patient safety event is one of the four key elements of the Patient Safety Incident Response Framework and the integral work of our Patient Safety Partners. For our staff, we have worked to ensure everyone in the organisation feels they can have a say and that their voice is heard and listened to. Their views are taken into account when decisions are being discussed that affect them. Where we have improvement programmes across the Trust, we ensure there is a 'Development Programme' structure where staff can input, shape and influence those improvement programmes. We have also put mechanisms in place to enable an ongoing conversation with our staff, in different ways, to ensure every voice is heard and actively listened to and the feedback used to guide action plans to address issues raised and celebrate when things are going well.
	John Radcliffe Hospital CQC Improvement Journey	For clear transparency around the Trust's efforts to address the CQCs concerns around the John Radcliffe. It is recommended that there are clear indicators that could help determine how improvements in the John Radcliffe are being driven overall as well as in the specific service areas of Gynaecology, Maternity, Surgery, and Urgent & Emergency Care.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: We acknowledge the importance of transparency around the quality and improvement in our services. We have therefore ensured that the key reports for us, that play a central a role in monitoring, compliance and improvements, are routinely taken through the Trust's governance structures up to the Trust Board. This includes the publication of

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				associated papers on our website. For example, our Integrated Performance Report (IPR) is reported to the Board and it contains performance indicators, assurance reports and development indicators. The IPR identifies actions to address risks, issues and emerging concerns. This help assist us understand the progress and impact of improvements. The outcomes and overview of our progress in response to CQC Inspections have been reported in the Trust's Annual Reports and Quality Accounts. These are also published on the Trust's website.
	John Radcliffe Hospital CQC Improvement Journey	For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Partially Accepted: The Hospital at Home service (H@H) is a successful initiative that has been introduced, providing an alternative to acute hospital admission, for the treatment and monitoring of patients, enabling them to stay at home during an acute illness. We are committed to having a continuous focus on improving our urgent and emergency services; of which the H@H initiative is an important part. We look to deploy our limited NHS financial resources and workforce according to the needs of patients. As models of care evolve, the range of healthcare roles develop and technology advances evolve, we will continually innovate to ensure the care we provide meets the needs of patients within the financial envelope we have available.

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	John Radcliffe Hospital CQC Improvement Journey	For a site visit to be orchestrated for the purposes of providing the Committee with insights into the measures taken by the Trust to improve patient safety at the John Radcliffe.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: OUH would be happy to host a delegation from HOSC to visit the JR to provide first hand illustration of some of the measures taken to improve patient safety.
	18 April 2024			
	GP Provision	To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation; and for the ICB to provide evidence and clarity around any engagements adopted, to include evidence on key feedback themes and from which groups within Oxfordshire such themes were received from. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.	Julie Dandridge, Daniel Leveson	Recommendation Partially Accepted: The ICB has publish a summary of feedback received. This feedback has not been collected on an Oxfordshire footprint. The summary feedback can be found 20240521-bob-icb-board-item-11-bob-icb-primary-care-strategy.pdf More details on the implementation of the strategy is now included in the Primary care strategy. This will be further developed over time.
	GP Provision	To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.	Julie Dandridge, Daniel Leveson	Recommendation Accepted: The ICS has a number of clinical networks including stroke, diabetes and respiratory that focus on prevention and improved pathways for these long term conditions. More details can be found in the BOB ICB Joint Forward Plan.
	GP Provision	To review ICB capacity with a view to increasing this to ensure adequacy, with a view that the ICB can work in a timely way with all District/City Councils across Oxfordshire on the securement and spending of health-infrastructure funding.	Julie Dandridge, Daniel Leveson	Recommendation Rejected: The ICB is not in a position to increase its workforce capacity but welcomes the opportunity to work closely with all District/City Councils across Oxfordshire

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				on the securement and spending of health infrastructure funding
	GP Provision	That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons, and that it is also checked as to whether/how the public have been communicated with around such closures. It is recommended that there is improved clarity and communication about the statistics concerning access to appointments.	Julie Dandridge, Daniel Leveson	Recommendation Partially Accepted: Practices that are temporarily unable to receive telephone requests for urgent appointments should inform the ICB. The main reason for this request is staff sickness. When informed the ICB advises practices to update their answer machine message and their website so informing patients. We do not currently have a method of monitoring when practices close of online consultations but are exploring what might be possible.
	GP Provision	For there to be clarity and transparency around the use of any competency frameworks as well as impact and risk assessments around the role of non-GP qualified medical staff who are involved in triaging or providing medical treatment to patients. The Committee urges that the advocacy needs of patients are considered/provided for, and that patients are clearly informed about the role of the person who is treating them and the reasons as to why this is a good alternative to seeing their GP.	Julie Dandridge, Daniel Leveson	Recommendation Accepted: There are some national sources of information for patients about the different roles in general practice. We will look to making these available on the ICB website.
	GP Provision	That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.	Julie Dandridge, Daniel Leveson	Recommendation Accepted: There are many legal agreements that need to be in place to progress the Great Western Park project. The ICB will update JHOSC when progress is made.

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	Dentistry Provision	It is reiterated that underspends should be spent in Oxfordshire, and that priority is given to areas within Oxfordshire that have experienced the worst shortfall in capacity. It is recommended that the ICB prioritises areas within Oxfordshire in light of the increased need within the County relative to other areas under the BOB footprint.	Hugh O'Keeffe, Daniel Leveson	Recommendation Rejected: BOB ICB is the delegated commissioner for dental services across the footprint. With this comes a BOB level budget for provision of services The ICB does not receive separate budgets for each county. However, the first principle being pursued is that the levels of activity should be re-commissioned, at the very least to the levels that have been lost as a result of contract handbacks and reductions. There has been a loss of 91,049 UDAs in Oxfordshire since April 2021 and BOB ICB is actively looking to replace these. The ICB will prioritise areas of greatest need across the whole footprint.
	Dentistry Provision	To support the creation of new practices within Oxfordshire with urgency, and to explore avenues of funding to support the ICB in developing solutions in this regard.	Hugh O'Keeffe, Daniel Leveson	Recommendation Accepted: The ICB has agreed to commission 5 new NHS practices (in Abingdon, Bicester, Carterton, Faringdon and Witney). The re-commissioning of services in these areas is being carried out as part of an NHS South-East programme. Significant levels of activity have been handed back in all SE ICBs. The Commissioning Hub for Dental services (hosted by the Frimley ICB) is working with each of the ICBs to understand proposed levels of activity to be commissioned with the aim of commencing the process in late 2024. The BOB ICB is investigating how it may move

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				the programme forward more quickly if necessary.
Page 164	**Dentistry Provision**	That urgent progress is made in improving the accuracy and the accessibility of information on dentistry services available to people; and that where groups are targeted for help, they can benefit from an effective outreach.	Hugh O'Keeffe, Daniel Leveson	Recommendation Accepted: The ICB has carried out a review of practices' reporting new patient acceptance on https://www.nhs.uk/service-search/find-a-dentist in June 2024. This information is available to all patients. In Oxfordshire: • 25 practices are advising they open to all new patients (when availability allows). • 4 practices are open children only • 28 practices are not open to new practices. The ICB has written to these practices who have not recently updated their profile to seek confirmation of their plans to update their information.
	Dentistry Provision	For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.	Hugh O'Keeffe, Daniel Leveson	Recommendation Partially Accepted: 1. Whether the ICB or other relevant system partners have any ability to play a role in supporting a local public consultation/engagement around fluoridating Oxfordshire's Water Supply.

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				The ICB would not have a role as the responsibility for consultation on water fluoridation lies with the Secretary of State and central government. 2. Whether the ICB/partners are even supportive of fluoridation in the very first instance. The ICB has not considered water fluoridation, but officers are aware of the benefits for the oral health of the local population and the potential to reduce oral health inequalities.
	6th June 2024			
	Oxford Health NHS Foundation Trust Quality Account 2023/2024	For the Trust to take measures to tackle workforce shortages and to reduce reliance on agency staff, and for the Trust to seek support, alongside the wider system, for an Oxfordshire Weighting.	Britta Klinck, Rose Hombo	Recommendation Accepted: Workforce shortages are recognised as one of the Trust's key risks within the Board Assurance Framework (BAF) and is acknowledged as a current, live risk that could increase in the future, further to national challenges outside of the Trust's immediate control around cost of living, national pay scales, industrial action, education and training, and nationally available supply of key professions. We accept, and plan for a tolerance of temporary staffing usage to enable flexibility in our workforce to respond to ebbs and flows in demand. Oversight of workforce planning and associated risks is provided by the trust

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				People Leadership & Culture Committee chaired by a trust Non-Executive Director, ultimately reporting to the Trust Board. Our Chief People Officer continues to work with national groups and initiatives as well as in partnership with BOB colleagues to consider additional ways and alternatives to address shortages of staff and future planning, considerations of changes to pay and/ or additional geographical weightings are undertaken at national government level in line with the national Agenda for Change contracts through the NHS Pay Review Body. The South East Regional Staff Partnership Forum is currently considering a piece of research undertaken considering the potential impact of an additional allowance for staff in high cost of living areas across the region. Our strategic plan for the medium and longer term incorporates measures to reduce temporary staffing usage, such as development of more sustainable workforce models, working with universities on clinical training, better demand and capacity modelling, career, and organisational development interventions to link to retention and linking with national and regional teams to maximise learning from other Trusts and national exemplars. We are also aligning more closely, through the Annual Planning processes, the OHFT People Plan with the NHS Long Term

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				Workforce Plan, with actions focused on key themes: Train: This relates to how we grow the workforce in the Trust and strengthen our pipelines for the professions where we are carrying the highest vacancies. There is a focus in the NHS Workforce Plan on increasing the supply of domestic education and training and therefore reducing our reliance on internationally educated staff. Enhanced Education and Training initiatives, including Apprenticeship programmes, and career development pathways from HCA to Advanced Practice. Retain: This relates to embedding the right culture and improving retention and in particular reducing the leaver rate which is the numbers of staff who leave the NHS (as opposed to moving internally within the NHS sector). With a continued focus on making the NHS People Promise a reality for staff utilising tools such as the NHS EDI Improvement Plan and High Impact Actions; publicising pension reform changes and continuing investment in wellbeing. Ongoing and consistent work to ensure that our people recognise OHFT as a good place to work and choose to stay working with us Reform: Working and training differently. New approach to recruitment and onboarding to better attract and secure talent to the Trust. Together with planning for future technologies and a focus on data quality and systems that enable and

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				empower staff to make better decisions. Continued focus on embedding a culture reflects a restorative, just and learning culture. Temporary Staffing: The trust is building on its established Improving Quality and Reducing Agency Programme to drive greater responsibility and ownership to directorates to deliver reductions in temporary staffing spend, whilst improving quality. The temporary staffing team provide oversight of the interventions to support the recruitment and retention of staff and the commercial contracts and delivery of temporary staffing Managed Service Providers. Additional workstreams relate to better workforce planning and the efficiencies that can be maximised through the E-Rostering.
	Oxford Health NHS Foundation Trust Quality Account 2023/2024	To ensure that there is a clear process for learning from deaths, to include bereaved families, and to improve services accordingly.		Recommendation Accepted: In addition to the information in the learning from deaths section in the 2023-24 trust Quality Account we can confirm there is a clear process for how we engage/involve/support families in our morality reviews to answer questions and identify/share learning. As part of embedding the Patient Safety Incident Response Framework (PSIRF) the outcome of our reviews and any areas for improvement are shared with families and the clinical staff involved. This is an important part of our duty of candour obligations and supporting a culture of openness and continual learning. PSIRF is

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				part of our commitment to developing a just and learning culture, building openness and transparency, ensuring everyone is treated fairly and that we learn from mistakes, incidents and errors. The Trust has two patient safety partners with lived experiences of using our services, working within the patient safety team. The partners work alongside clinical staff and patients/families to co-design and implement patient safety initiatives, training, resources, support activities around governance and other opportunities to improve the safety of care. We have a series of internal support mechanisms to help people involved and affected by a death including a bereaved family liaison service, staff psychological support service and trauma informed support conversations. These mechanisms support people to share their experiences and be open and compassionate to learning. Senior clinicians sign off actions to address areas identified for improvement. When we have significant learning from a case the actions to make a change are captured and progress to implement and embed actions by the teams and services involved are monitored centrally by the patient safety team. Evidence of completion is robustly scrutinised objectively by the Patient Safety Team as part of the action plan completion and closure process.

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Page 170				Learning from individual cases and themes arising across incidents that we have reviewed and investigate are disseminated in a range of ways supported by our quality governance framework, these include but this is not an exhaustive list – • Monthly team/ward business meetings • Regular incident learning events/webinars • Clinical directorate monthly quality meetings • Weekly patient safety meetings in each clinical directorate • Trust wide Quality Improvement & Learning Group • Trust quarterly mortality review group, • Quality Committee. We also feed learning into newsletters, staff training and to steer our QI programmes of work for example the work on end-of-life care, suicide prevention and early recognition of the soft signs of sepsis. Externally to OHFT learning and actions are shared through multi-agency forums/processes including the BOB Learning from Deaths Network, Child Death Overview Panels, Learning from lives and deaths – People with a learning disability and autistic people (LeDeR), Child Safeguarding Practice Review Panels, Safeguarding Adult Reviews, Mental Health Homicide Reviews and Domestic Abuse Related Death Reviews

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				and Local Authority suicide prevention groups. There is further detail about our approach to engaging bereaved families, reviewing deaths, and taking learning/actions forward in OHFTs Patient Safety Incident Response Approach which was signed off by the BOB system partners and ICB before being published in December 2023 at Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust.
Page 171	**Oxford Health NHS Foundation Trust Quality Account 2023/2024**	For the Trust to develop clear and demonstrably effective mechanisms for providing support to staff wellbeing.		Recommendation Accepted: Staff Health & Wellbeing The Trust has continued to offer a preventative, proactive and evidence-based approach to wellbeing for teams and individuals. This was achieved through collaborative working with many specialist teams across the Trust as well as colleagues across our BOB footprint and nationally. The Employee Assistance Programme (EAP) aims to help staff address personal problems that might adversely impact their work, health and happiness. It offers a freephone, confidential helpline available 24/7, 365 days a year, staffed by specialist independent BACP counsellors who can give face-to-face, online and telephone support for people working at the trust as well as for family members. Commissioning of the EAP by the trust has been extended for an additional year as it

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				continues to be an invaluable support, with positive feedback being received. The Trust continues to be supportive and collaborative with all health and wellbeing leads within the integrated care system. The Trust continues to offer the following to its employees: • Financial Wellbeing advice and guidance coupled with the new introduction of a financial Salary Sacrifice scheme. • TRIM (Trauma Risk Management) - for those who have experienced a distressing event, having secured a one-year post to pilot this in key areas. • Mental Health First Aid. • REACT (Recognise, Engage, actively listen, Check risk and Talk about specific actions) o training for managers to have wellbeing conversations with staff – a yearlong role has been secured to enable this to continue within the Trust; • Health and Wellbeing Champions are being roll out over 230 in place. • Staff Networks – have grown in popularity with staff reporting great benefits to the workforce. • Freedom to Speak Up Guardians are in the Trust, to enable staff to raise issues in confidence. • Schwartz Rounds - a proactive and preventative approach to support staff in managing the traumatic

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				nature of some of the situations they face through structured reflective practice and learning. • The Trust holds staff retreats with an emphasis on recovery and renewal. These continue to show positive results (e.g. helping staff come to terms with difficult situations and return to work more quickly than otherwise possible). The focus is on staff with long-term sickness, usually stress (work related or not), who would benefit from the opportunity to reflect and plan their recovery in a supportive environment. • The Trust has introduced many awards to recognise and value our workforce. Our recognition awards, including Bee, Daisy, Exceptional People, and the Annual Staff Awards. • The Occupational Health Team continues to build upon their dedicated psychological support offer for those staff members that have had the misfortune to be involved or affected by a traumatic event. This rapid support has been very well received by staff and their managers as a way of ensuring staff are looked after following a serious incident. • We have introduced and roll out the Professional Nurse Advocates (PNA) within the Trust. These are nurses who have been trained in

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Page 174				providing restorative clinical supervision (RCS) - the model supports staff emotional resilience, connecting the lived experience of the nurses with quality improvement and education and feedback into the local clinical governance agenda. The Trust signed the NHS England organisational Sexual Safety Charter in October 2023 committing to enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace. The charter sets the expectation that those who work, train, and learn within the healthcare system have the right to be safe and feel supported at work. Working alongside safeguarding colleagues, the wider BOB network, and national working groups we have undertaken a self-assessment exercise to inform our position and develop actions for improvement to ensure our colleagues receive the best support and guidance.
	Oxford Health NHS Foundation Trust Quality Account 2023/2024	That the Trust provides training and guidance to staff for the purposes of ensuring good staff attitude, conduct, empathy, and understanding toward patients.		Recommendation Accepted: As part of our OHFT People Plan 2022-24, we have committed to developing and continuing to build our compassionate culture - a culture, focused on the key principles of kindness, civility, and respect. Civility and Respect is the foundation for a Restorative, Just & Learning Culture. The 'Kindness into Action' culture change programme - run in collaboration with BOB ICS - is open to all colleagues right across

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				the Trust. and is now a cornerstone of the corporate induction for all new starters. We have actively encouraged our leaders and managers to make it a priority, as this will really support us to maximise the effectiveness of the programme, staff and managers utilising the tools and approach are reporting a positive experience. This approach will enhance our new leadership development project, which is in development for 2024/25. The importance of Civility, Respect and Kindness continues to progress as a proactive and preventative element of our Trust's cultural work, with the Restorative, Just and Learning Cultural (RJLC) element supporting fairness and learning from when things do not go to plan. The Trust takes a collaborative approach to implementation, including specific Quality Improvement (QI) projects as part of Race Equality Work Programme contributing to the trust wider Equality Diversity and Inclusion priority. Th trust also offers staff a number of Equality Staff Networks and support groups staff that create a 'community of support' that will actively influence and advance a culture of inclusive equality in all aspects of the workings of the organisation which will contribute to enhancing the way we communicate, understand and how we work alongside patients and carers.

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Page 176	**Oxford Health NHS Foundation Trust Quality Account 2023/2024**	To work to reduce inappropriate and extensive reliance on out of area placements. It is recommended that a review of those in out of area placements is undertaken to determine if their needs could be better addressed with partners through bringing them closer to their locality.		Recommendation Accepted: The Trust recognises that being treated away from home can have a significant impact on the patient and their family, having access to support from their own care team, local agencies and loved ones is a crucial factor in recovery. We are committed to treating patients as close to home as possible. There are occasions when an Out of Area Placement (OAP) may be intentional and appropriate, this would be considered on an individual basis considering individual needs; robust review plans would be established by OHFT at the onset of admission to the OAP. OHFT has made considerable progress to manage the use of OAP's and has developed robust review processes to support people to receive care within their home health provider. At present (12/07/2024) the trust has only one use of an OAP that is considered as inappropriate, and work is ongoing to resolve this. The below processes and actions demonstrate the meaningful focus we have developed for use when considering the use of an OAP as well as the significant effort and energy to reduce use and ensure that standards of care received within services outside of our provision are of highly quality, safety and experience for our patients.

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				Acute OAP's (acute inpatient care in private hospitals out of area) Meeting and reporting structure to support flow and coordinate escalations: • Twice daily patient flow calls Monday to Friday; Once daily patient flow calls weekends and Bank Holidays. Status of inpatient and community services (adults and older adults); all requests for inpatient care; allocation of beds. • Once daily Oxfordshire (Oxon) & Buckinghamshire (Bucks) patient flow teams 'huddle' – information sharing and agreement on admissions cross-county (e.g. admission of Oxon patient to a Bucks bed) • Twice weekly 'bronze calls' – senior leaders from inpatient and community services managing barriers to admission and discharge. • The inpatient teams in Buckinghamshire have good throughput but sometimes demand exceeds capacity • Twice weekly 'gold calls' – Heads of Service and Directors managing escalations; oversight of OAPs position. • Weekly Rapid Reviews in-line with Red 2 Green approach on all wards – focus on discharge planning and barriers to discharge.

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				• Weekly Rapid Review for all OAPs and weekly OAPs review jointly with Bucks and Business Services • Weekly meeting between Inpatient Social Work team and OMHP partners plus Housing partners to address housing and homelessness needs for inpatients. • Weekly attendance by the Directorate at the Oxfordshire System Tactical call where delays are scrutinised and problem-solved with wider system partners. • Daily reporting to the Oxfordshire system of Mental Health Opel status • Daily reporting internally within the Directorate regarding the 'bed state' and Opel status • 4 weekly escalation meetings are in place within the directorates to identify demand and pressures which are both focussed and useful to create local capacity and prevent OAP usage. • Any requests for OAPS are authorised at director level only when all options for local admission have been fully exhausted. Safe and effective management of patients in OAP's: • Patient Flow team case manage all OAPs for the duration of their admission.

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Page 179				• Clinical prioritisation of retuning patients to local provision where capacity allows. • Patient Flow team attend all Ward Rounds and involve Adult Mental Health Teams (AMHT) and Social Work colleagues as required. • Buckinghamshire flow team attend Weekly Elysium (block purchase 2 beds for Bucks) ward rounds and review jointly each patient with the Elysium team. • Approval for new OAPs is via Service / Clinical Directors • Quality and safety procedure for use when OAPs of less than 'Good' CQC rating are used, including visits to the patient. • 6-monthly visits to block-purchased provision (Elysium) and regular contract meetings with the provider supported by Business Services • Safeguarding procedure for addressing any safeguarding concerns with patients and providers. There are 3 Places of Safety in Oxon and 3 in bucks, these are intermittently used as admission beds where there is urgent need (including under the Trust's S140 MHA duties). Actions to improve flow (reduce length of stay and delayed discharges) and reduce OAPs:

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				• Inpatient Improvement program (in accordance with national guidance July 2023 and March 2024) – BOB-wide approach. • Full fidelity to model CRHT in phased development – full coverage of Oxford City and North East Oxon, and expanding in FY24/25 into the North & West of the county. • Patient Flow Team fully established and performing well. • Patient Flow Delivery Group, delivering on a varied program of service improvements which support flow through acute services, including nationally mandated 10-point • 'Discharge Challenge'. • BOB-wide focus on OAPs reduction to commence later in 2024. • Service Improvements and redesign regarding accommodation, care, and support in the community as part of the new Mental Health contract work in Oxon. • Strong connectivity to housing and homelessness landscape and strategic leaders in Oxon • Utilisation of Better Care Fund (BCF) & Additional Discharge Funding on initiatives and schemes to reduce length of stay, tackle delayed discharges and add in capacity to better manage homelessness within inpatient care:

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				○ Mental health capability additions to the Care Home Support Service – Phase 1 and 2 – targeted at supporting older adults requiring discharge to residential /nursing care settings by improving placement finding, liaison, discharge planning, transfers of care. ○ Improving discharge pathways for people with Personality Disorder. ○ Out of Hospital care team focused on accommodation and support needs of inpatients who are homeless (step-down housing, embedded housing workers, local authority housing officers and Multi – Disciplinary Team(MDT) ○ Support worker additions to the adult Inpatient Social Work team and Older Adult Community Mental Health Team (CMHT) 'step-up' out of hours function. ○ One-off Flexible Use Fund for purchasing single items for patients which would otherwise present as barrier to discharge. ○ Connections 'integrated' workers embedded within the adult inpatient service meeting practical needs of patients to remove barriers to discharge and provide additional support during the transition home.

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Page 182				○ Children & Adolescence Mental Health Services (CAMHS) Liaison and Transition clinicians working to facilitate timely flow through acute settings (MH and Acute Trust) Long term OAP's (specialist inpatient care in private hospitals out of area) In Oxon there are 4 patients who are in highly specialist inpatient services where these services do not exist locally. The AMHT's, Social Workers and Patient Flow team remain actively involved with their patients in ward reviews and planning options for their onward care needs. Three of the patients currently in specialist inpatient care out of area are due for discharge by the end of September 2024. Long term OAPs are rarely used, i.e. 1 a year or less, and are tightly managed. Long term OAP's In Bucks we have 2 patients who are in specialist placements as we do not have those services locally. The CMHT's remain actively involved in ward reviews and planning options for repatriating or finding appropriate placements.
	Integrated Neighbourhood Teams in Oxfordshire	That there are clear governance and management processes around both the development as well as the activities of Integrated Neighbourhood Teams. It is recommended that there is clear transparency around this.	Lily O'Connor, Dan Leveson	Recommendation Partially Accepted: We have a monthly Oxfordshire strategic group with senior representative from all stakeholders/providers, who oversee the following • Actual spend and predicted future funding required

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				• Overview of the design, outputs and the development of outcomes of each INT • Agreement of the order of the phasing and overall development of INT's within Oxfordshire Each INT has the following • A Senior Responsible Officer (SRO) and deputy SRO • Weekly to monthly meetings depending on the needs of the INT • Join working with County council, Health Protection and the voluntary sector. • Co-production of the INT with the local stakeholders and population Focus for INT's • Reduce length of stay for those in hospital • Reduce the risk of hospital readmissions within 30 days of discharge • Enhance the efficiency of same-day responses for high-need patient referrals to ensure the best possible outcomes • Proactively identify and manage patients with rising health and social care risks • Supporting holistic mental health support • Foster a supportive and healthy community environment • Focus on frailty, working with people to improve their quality of life and achieve greater independence • Reducing social isolation

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	Integrated Neighbourhood Teams in Oxfordshire	To ensure ongoing coproduction with neighbourhoods and key stakeholders around the formation as well as the activities of Integrated Neighbourhood Teams. It is also recommended that an agreed definition of coproduction is outlined by system partners in this regard.	Lily O'Connor, Dan Leveson	Recommendation Partially Accepted: We are following the County Council process for co-production. We have co-production on all areas where there are INT's. However, they are at different stages, City of Oxford mainly Barton is the most mature. I am attaching the process for co-production that we follow.
	Integrated Neighbourhood Teams in Oxfordshire	To develop a clear understanding of the health needs and population patterns for each locality, and to allocate resources for Integrated Neighbourhood Teams accordingly.	Lily O'Connor, Dan Leveson	Recommendation Partially Accepted: We have worked with public health, local councils and the information team in the OUHFT to create a data pack for each INT. This is to ensure that each INT understands their local population health and prioritise the areas that will make the most impact. Additionally, each INT as they develop recruit the posts/skill set required to meet this gap in health needs.