Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 22 April 2021

ADDENDA

8. Community Services Strategy (Pages 1 - 32)

12:00

An update on the Community Services Strategy.

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Health Overview and Scrutiny Meeting

Thursday 22nd April 2021

- ***Diane Hedges*** *Deputy Chief Executive Oxfordshire Clinical Commissioning Group*
- ***Dr Ben Riley*** *Executive Managing Director for Primary Care and Community Services, Oxford Health NHS Foundation Trust*
- ***Stephen Chandler*** *Corporate Director of Adult and Housing Services, Cherwell District Council, Oxfordshire County Council*

Oxfordshire Community Service Strategy: update for HOSC April 2021

- Resolution for OX12 and Wantage community hospital
- Design and improve community services provision
- Maximising independence and interdependence for people in Oxfordshire
  - A strategic approach supported by the Health and Well Being Board March 2021
- Developing approaches through engagement and active learning

Maximising Independence in Oxfordshire Residents

As part of our Community Services strategy, we are developing new approaches to improving community services in Oxfordshire for people at all stages of life – Start Well, Live Well and Age Well.

The Health and Well Being Board Older Persons Strategy sought to support our older people in **Living Longer, Living Better** identifying some key actions to do this

Mandate for action on the life stage of Age Well:

- Increasing independence and health and wellbeing outcomes for our population
- Working with our population to make best use of our people, our systems and our assets

Approval given from Oxfordshire Health & Wellbeing Board for a system-wide strategic approach to deliver these above outcomes

Wantage Community Hospital and OX12 project

Factors identified in the OX12 project that need to be addressed included:

Certainty on the inpatient beds and enhancing the model for rehabilitation

Travel and access to services **Healthy living** **Addressing Loneliness**

To address these issues we are proposing a whole system strategy for both health, care and daily living. Very significantly our **learning from COVID has shown** how much more we deliver together in partnership with Councils, Local stakeholders and in working in new ways.

Expanding our thinking to **maximise independence** and **best deployment of assets (staff, money and estate)** we will address the OX12 considerations. We will review the function, numbers and professional skill mix of the community inpatient provision required for the county, addressing the factors found in the OX12 work and also informing our approach for those people who need specialist rehabilitation only possible in an inpatient (bedded) setting.

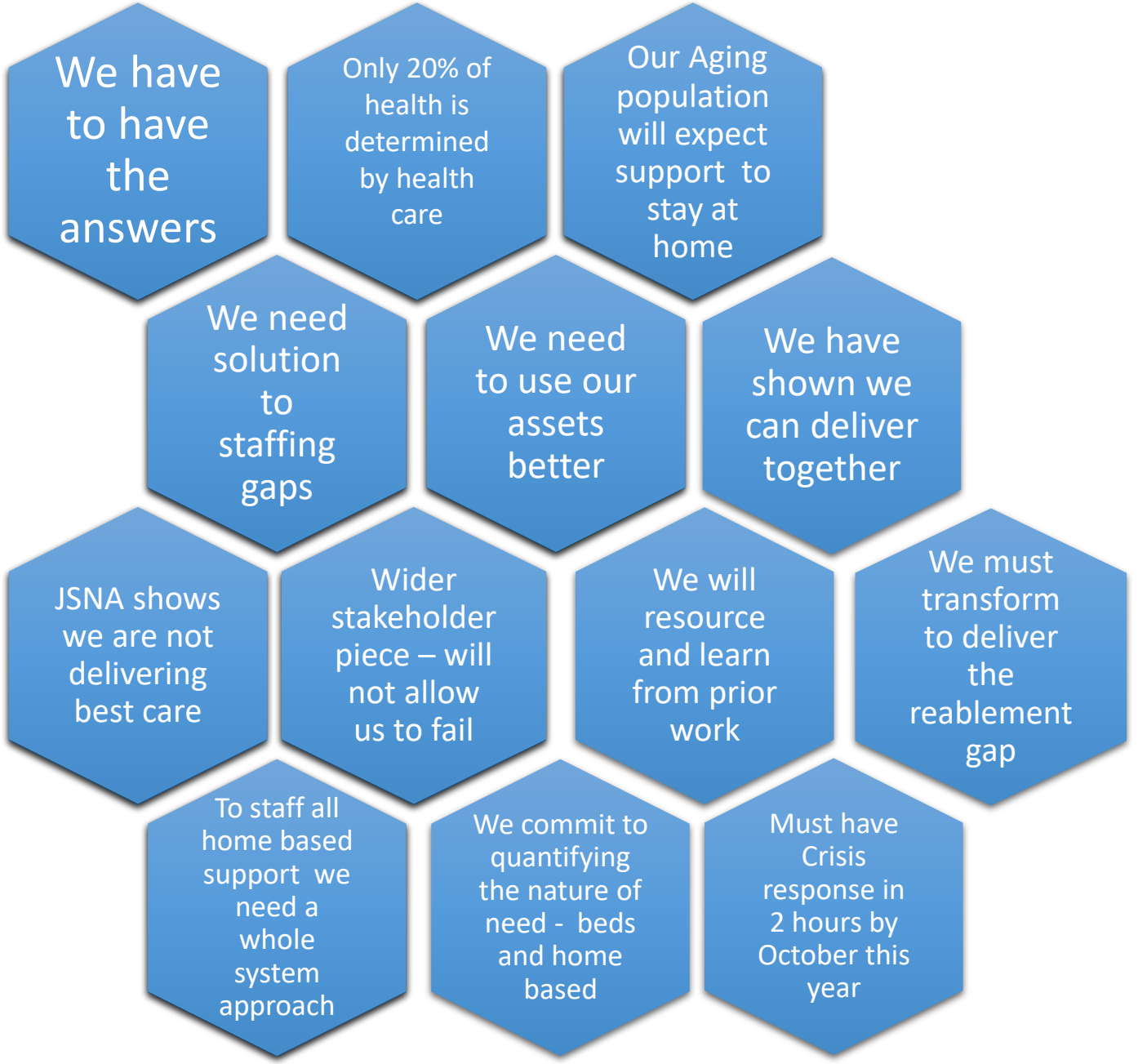
The system-wide Community Services Strategy project will work to address answers for OX12 by taking the very significant learning from the pandemic and optimise ways to enable independence for our residents and will be informed through public engagement and where substantial change is indicated full consultation.

Wantage Community Hospital will play a key role in supporting any new integrated model.

Reflections

- We recognise that there has been a long delay in providing local residents with a firm conclusion for the future of the Wantage Hospital inpatient rehabilitation unit and for progressing the outcomes of the OX12 project more broadly.
- It is important that OX12 residents get certainty of service provision and can have confidence in their access to effective rehabilitation whether in beds or at home and how this is equitable
- The National Level 4 incident announced 3 March 2020 required a total NHS and Care focus on managing COVID
- Despite unprecedented challenges this winter, important work has progressed. A summary is given in the HOSC substantial change toolkit document.
- A range of services have also been re-established at Wantage Community Hospital, following the building work to address the Legionella risk, including the re-opening of the maternity/birthing unit and the provision of local services such as podiatry, community therapy and school nursing. Plans are in development with partners to pilot consultant-led outpatients and mental health services from the hospital
- The NHS System **MUST** deliver the Operational and Planning Priorities for 2021/22 – there is synergy with getting the answers for OX12, linking Primary Care Networks, Local stakeholders and delivering better services for all. These Planning priorities will guide our approach
- The strategy will be shaped by the ambitions set out within the NHS Long term plan and the Oxfordshire Joint Health and Wellbeing Strategy and will reflect the need to ensure community services are sustainable
- The COVID risk continues and we remain at a Level 3 incident. When this moves to Level 2 we commit to progression of the planning and engagement work as a priority. The pace at which we can progress will be subject to COVID staying at Level 2 but we need to assure residents we will reach a clear resolution soon
- The strategy will address gaps in best care, guide effective solutions on a broader landscape and result in a decision about community hospital beds in Wantage

Why different this time? Why will it deliver?



Development and implementation timetable

Month	Set up and Engagement and External dependencies
COVID period	Piloted in OX12 the first 2-hour crisis response rolling out the learning to other areas of the county Piloted alternative ways to support people – Examples include Home First project and system response, Hotel model and beds solution for plus size people, remote monitoring in peoples own home - such as pulse oximetry to see if a person is deteriorating with COVID New ways of working will continue to be tested throughout the programme in a Pilot and test and learn approach
March 2021	Mandate approved with involvement agreed from County and all Districts and City as part of Oxfordshire Health & Well-being Board
April 2021	Oxfordshire A and E Delivery Board urgent care work defined and set alongside to ensure completeness Community Strategy described in terms of how it resolves outstanding beds questions for Oxfordshire JHOSC
May 2021	Engage Primary Care Networks and District/City Council network to determine how we will engage and learn from our residents and recent partnership COVID experience to deliver the changes we need Establish engagement working group, looking at existing evidence work and determining further gaps in knowledge and how these will be addressed taking approach to the June HWBB
June 2021	Programme authorised by Oxfordshire Health & Wellbeing Board Programme with plan and required deliverables finalised Programme plan and engagement plan presented to HOSC for review and comment

Subsequent programme milestones subject to step down to NHS COVID Level 2 and remining at that level

Some dependent programmes will continue at COVID Level 3 where critical to delivering direct care

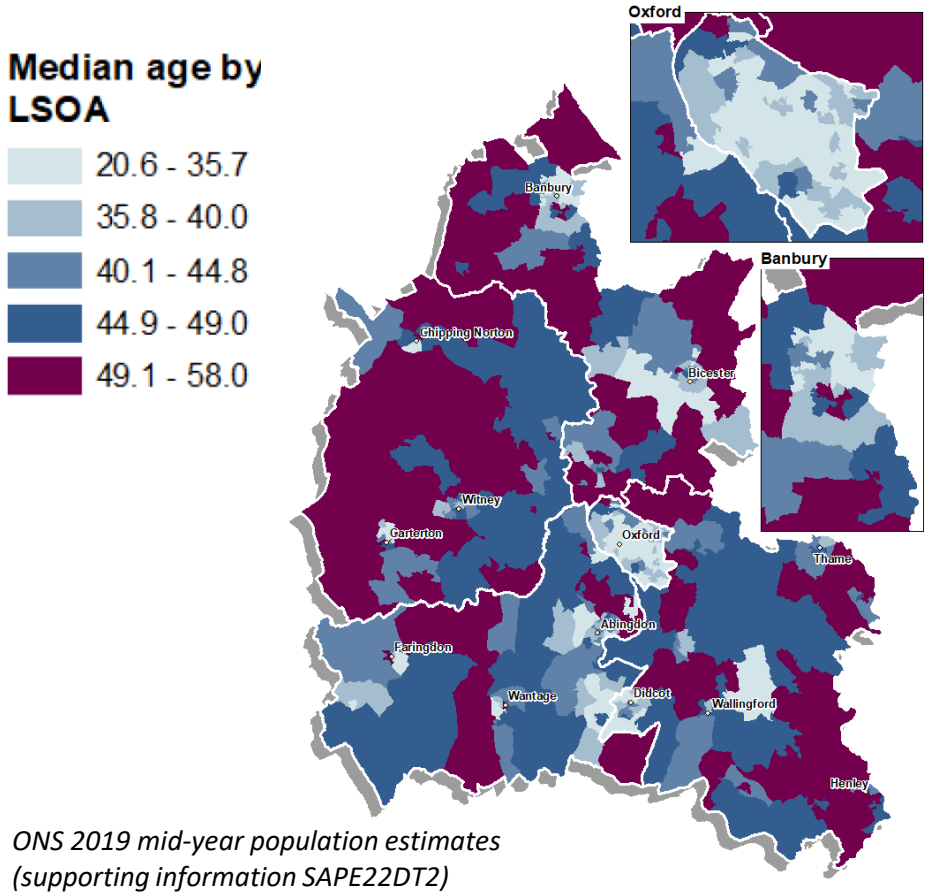
Month	Programme actions	Additional actions required where a substantial change to service delivery could be impacted on a permanent basis (eg OX12)	Timescale/ dependency
1	Confirming a Knowledge Base; • Oxfordshire system wide data to be brought together (giving demand and capacity mapped and compared with the need for care, housing & population growth) • Engagement programme to help draw together and inform experience and priorities Developing a whole Oxfordshire system approach to strength based approach for our residents using engaged approaches in the system to maximise independence and community interdependence	Agree potential areas of substantial change – (to include OX12)	Update and reporting to JHOSC to be agreed
2			
3			
4	Share learning from our work and how it informs future planning using the knowledge base and develop new ways of working across the system	Additional targeted engagement (some before and then concurrent with Option development)	
5		Options – overall process, stakeholder event(s), agree criteria and develop options Recommendations to HWBB, ICS, Oxfordshire System Partnerships and review with JHOSC	(4 months) subject to relevant organisation sign off
6	Oxfordshire system wide review and agreement on model for maximising independence and community interdependence (excluding any substantial service change requiring consultation)		
7		Preparation of Pre – consultation business case including evaluation of pre business case models	(up to 2 months – assumes some overlap with above)
8		CCG Board approval of Pre – consultation business case	CCG Meeting in Public
9	Phased implementation of new model begins where agreed by system (excluding any substantial service change requiring consultation). Successful pilot work developed into business as usual	NHSEI Assurance process to include Clinical Senate support (can run concurrently with consultation preparation but must be successfully concluded before consultation launch)	(estd 3 months) NHSE and clinical senate support
10			
11		Preparation of consultation materials and resources	(1 month/6week)
12		Formal public consultation	(up to 3 months) CCG Meeting in Public
15		Consultation review and write up – share with Partnerships	(up to 2 months)
17	Oxfordshire system approach known including any substantial change	Final Business case to CCG/ICS Board for Decision	CCG Meeting in Public

Building on what we know

- Key lessons from the JSNA and quality standards we need to deliver
- Community health services

JSNA 2021 – themes for older people

In 2019, older people aged 65+ made up 20% of the estimated population of Oxfordshire's four rural districts, compared with 12% of the population of Oxford City.

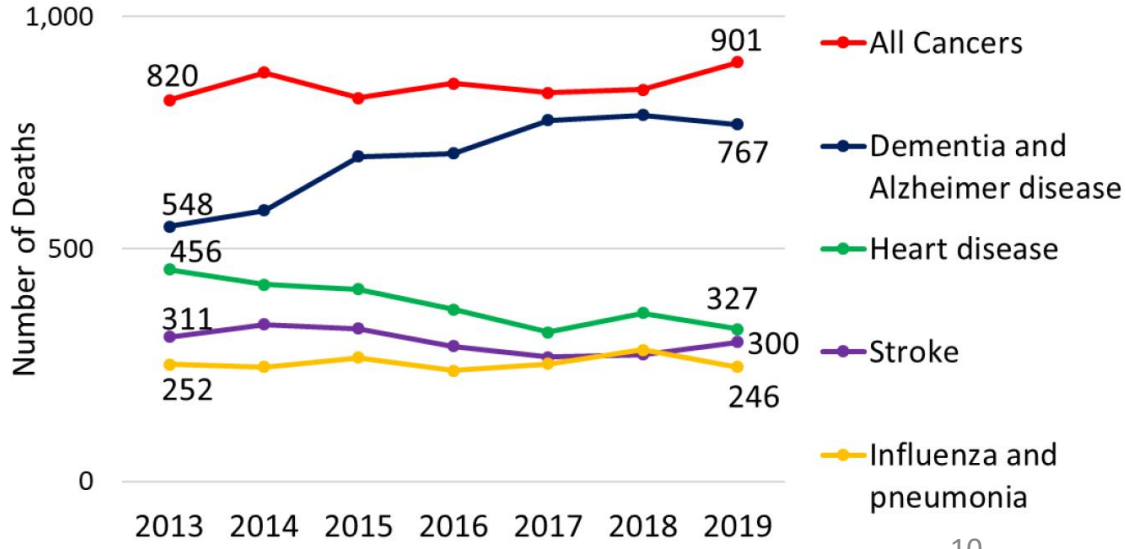


ONS 2019 mid-year population estimates (supporting information SAPE22DT2)

Four health conditions in Oxfordshire were above the England average 2019-20:

- Cancer
- Cardiovascular disease
- Depression
- Osteoporosis

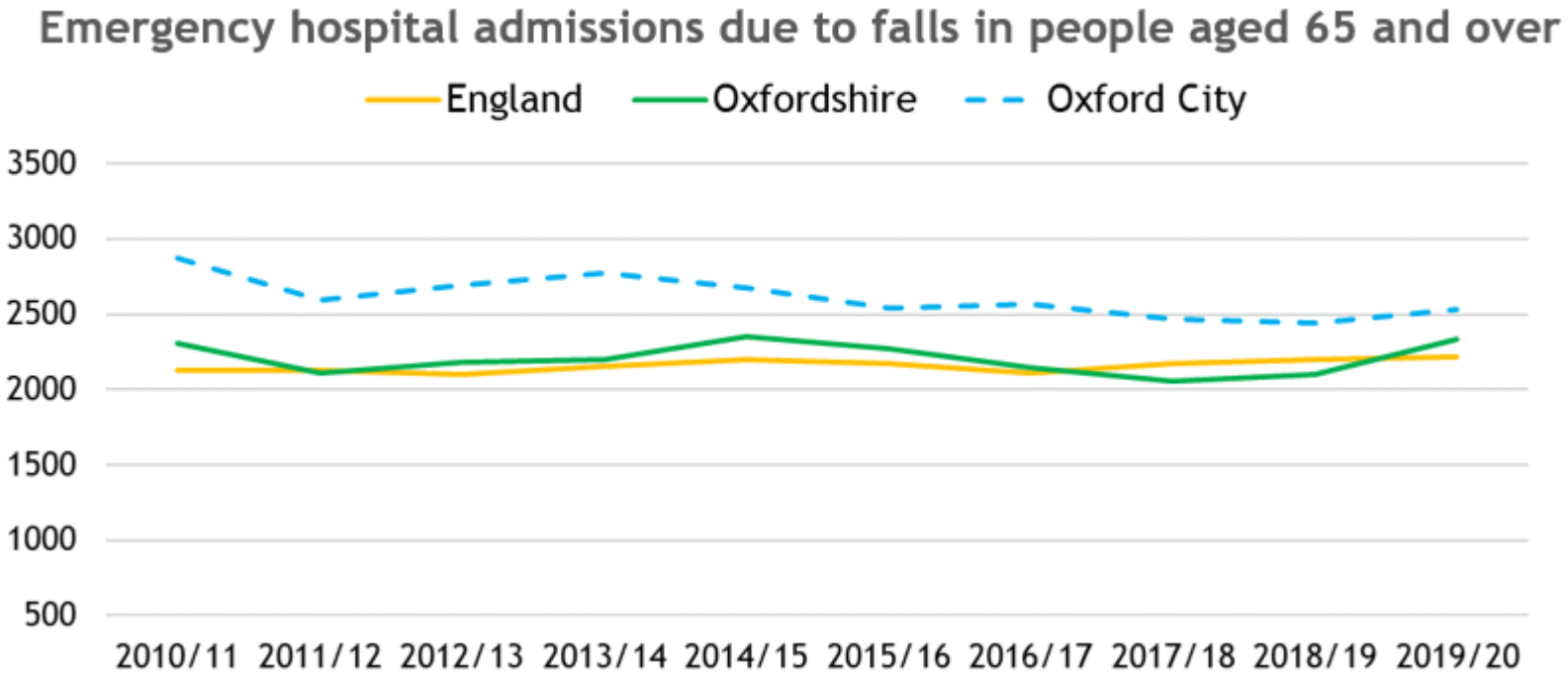
Leading causes of death for those aged 75+ in Oxfordshire:



Hospital admissions due to falls

Falls are the largest cause of emergency hospital admissions for older people. In 2019/20 there were 3,165 hospital admissions due to falls in people aged 65 and over in Oxfordshire. This rate is higher than national rate (2,331 per 100,00 population in Oxon compared to 2,222 in England).

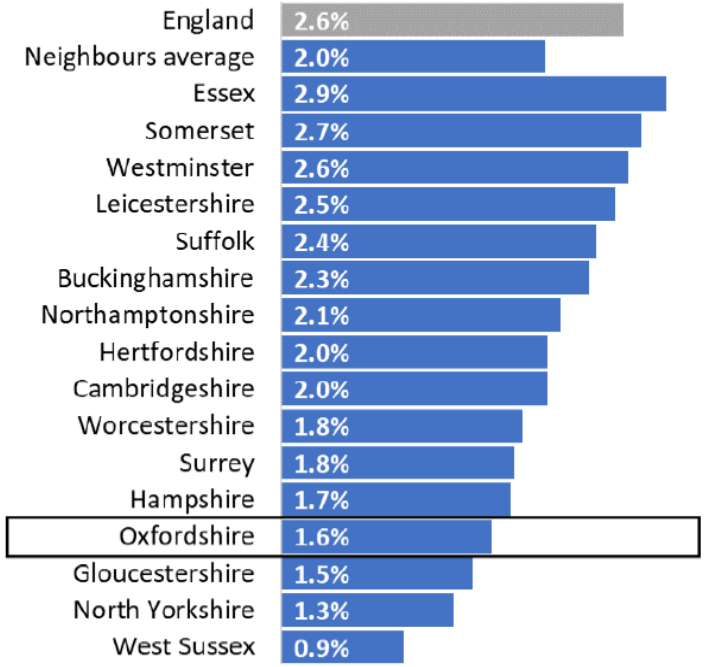
The five district areas in Oxfordshire have similar counts of hospital admissions (500-800 per district), however over the last ten years, the rate has been consistently higher in Oxford City.



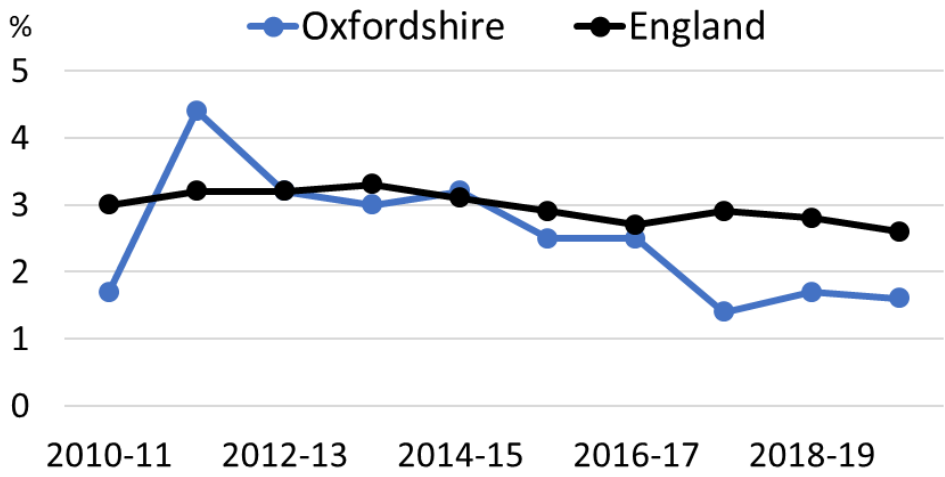
Indicator	Period	Oxon			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Emergency hospital admissions due to falls in people aged 65 and over	2019/20	→	3,165	2,331	2326	2222	3,394		1,325
Emergency hospital admissions due to falls in people aged 65-79	2019/20	→	975	1,074	1049	1042	1,847		627
Emergency hospital admissions due to falls in people aged 80+	2019/20	→	2,185	5,977	6029	5644	8,227		3,348

Reablement services

Between April 2019 and March 2020, 2,601 people in Oxfordshire received reablement. Of these, 1,461 were helped to leave hospital, 366 were diverted from hospital and 774 were supported via a community referral. As of 2019-20, Oxfordshire was ranked 13th in its group of 16 statistical neighbours on the % of older people offered reablement services following discharge from hospital. Oxfordshire has remained below the national average.



Percentage of people aged 65 and over offered reablement services following discharge from hospital, Oxfordshire and Statistical Neighbours (2019-20)



Percentage of people aged 65 and over offered reablement services following discharge from hospital – trend

Isolation

Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. From Age UK's 2015 loneliness analysis, the following areas are in the highest risk quintile of all neighbourhoods in England:

- Cherwell: Banbury, Bicester Town
- Oxford: Blackbird Leys, Wood Farm,
- Barton, St Clements, Jericho, Cowley
- South Oxfordshire: Didcot South

Isolation in older people is exacerbated by sight loss

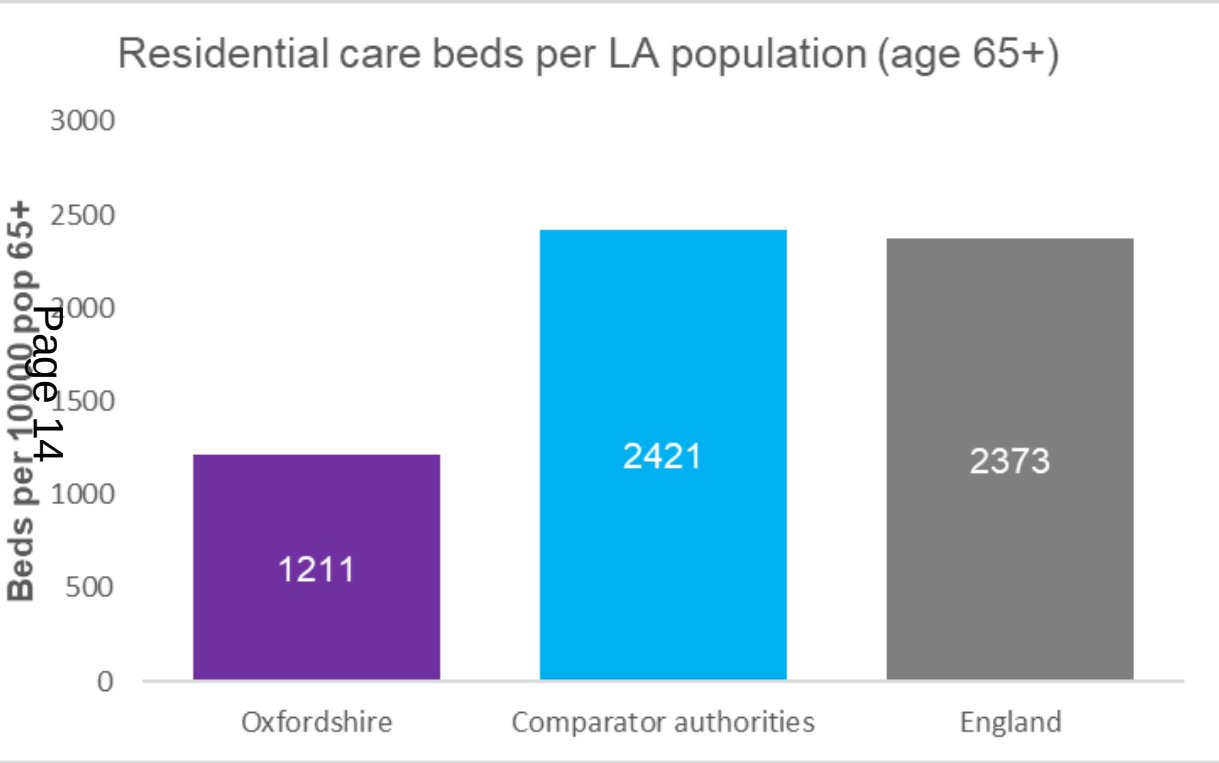
Sight Loss: Number of people estimated to be living with sight loss in Oxfordshire (2016 and future estimates to 2030)

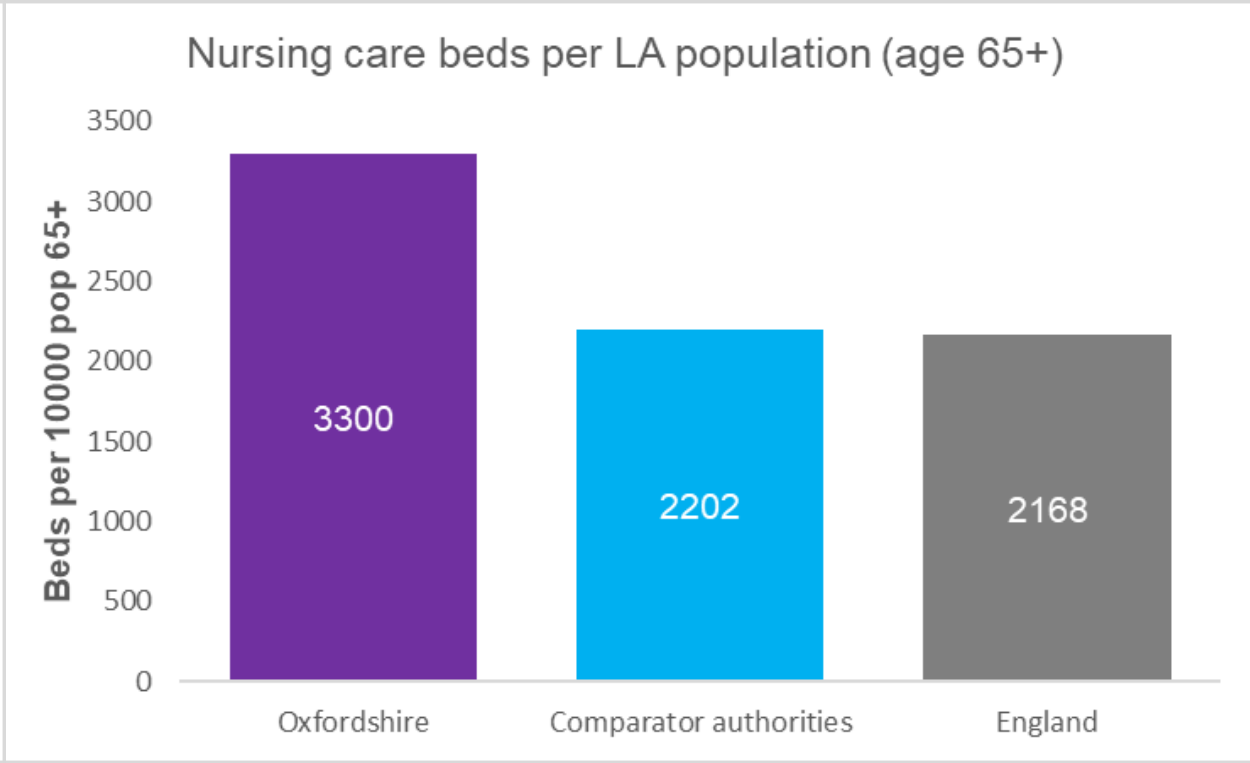
	2016	2020	2025	2030
Mild	13,630	15,050	17,090	19,560
Moderate sight loss	4,690	5,160	5,800	6,570
Severe sight loss	2,800	3,130	3,620	4,200
Total	21,110	23,340	26,510	30,330

Indicator	Period	Oxon			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Social Isolation: percentage of adult social care users who have as much social contact as they would like (65+ yrs)	2019/20	➡	1,425	39.1%	42.9%	43.4%	30.4%		53.8%
Social Isolation: percentage of adult carers who have as much social contact as they would like (65+ yrs)	2018/19	–	110	30.3%	32.7%	34.5%	11.1%		50.9%

There is huge potential to address this with all partners and particularly the Voluntary Sector. This will build on some important work already underway and our learning from COVID partnerships

Long term care - Oxfordshire has 50% higher number of nursing home beds





Source: CQC registered care home beds April 2021; ONS 2019 population estimates

How we use long term care

We support more people in long term bed based care than similar authorities; 45% are supported in care homes compared to 40% nationally. Equally we place significantly more people in nursing home care

Rate per 10,000 people supported:

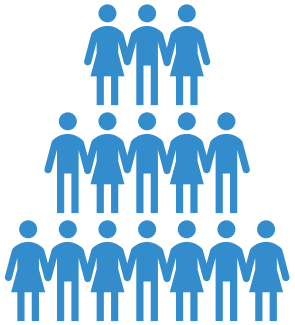
	65+
Oxfordshire	472.6
England	608.7
Similar Authorities	479.0

% of older people supported by care type:

	Residential care	Nursing home care	At home
Oxfordshire	22%	23%	55%
England	27%	13%	60%
Similar Authorities	29%	14%	57%

Oxford Health Foundation Trust Community Services

Over **2000** staff



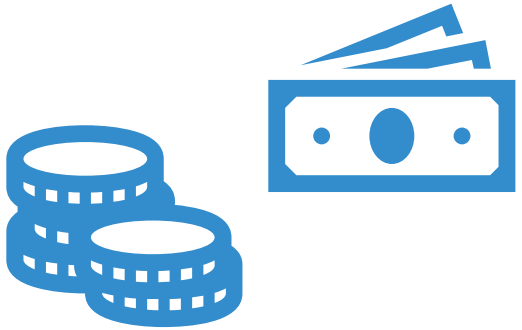
9 community hospitals

Deliver services from over **75** sites and people's homes

1,350 admissions to community wards

Over **680,000** appointments per year

£97.8m annual budget



Data as at financial year 2019/20

Action we need to take

- Collective approach across Oxfordshire

Maximising Independence in Oxfordshire Residents

As part of our Community Services strategy, we are developing new approaches to improving community services in Oxfordshire for people at all stages of life – Starting Well, Living Well and Ageing Well.

The Health and Well Being Board Older Persons Strategy sought to support our older people in **Living Longer, Living Better** identifying some key actions to do this

Mandate for action on the life stage of Ageing Well:

- Increasing independence and health and wellbeing outcomes for our population
- Working with our population to make best use of our people, our systems and our assets

Approval from Oxfordshire Health & Wellbeing Board for a system-wide strategic approach to deliver these above outcomes

Independence & better outcomes

To improve the health, wellbeing, independence and care experiences of individual residents, while strengthening the interdependence of people, families and communities across all of Oxfordshire.

What do we mean by independence?
Enabling individuals to strengthen and draw on their personal capabilities and resources, their social networks, services and communities to live healthier lives and, to the maximum extent possible, take informed actions to improve their health and care.

What do we mean by interdependence?
Interdependence recognises the importance and value of mutually supportive social connections, reciprocal relationships and the interactions between the determinants of health and wellbeing, in improving the long-term health of people, families and communities.

Drivers and Opportunities

- Patient experience
  - When older people cannot access support with independence they are at risk of avoidable harm, whether at home (for example falls) or in beds, and risk deterioration or escalation
- National drivers
  - Hospital Discharge, Oxfordshire needs to increase the proportion of people discharged home with no support or with reablement support
  - Need to review resources to deliver integrated planned care closer to home and urgent community response when people are at risk of going to hospital
  - NHS Long term plan, more joined-up care and integration of primary and community services
- Opportunities
  - Learning from covid response: integrating community resources that extend the reach of health and social care to support independence
  - Redeploying sites to support more planned and preventative care delivery

Areas of focus

Population groups based on key life stages

Quality
Achieve the best health outcomes and experiences

People
Be the best possible place to work in community care

Sustainability & Partnership
Enable people and communities to stay healthy and resilient

Research & Training
Continuously improve health in our communities

START WELL

Improved opportunities and outcomes for Children and Young People – and more effective support for vulnerable families

Healthy development

Preventative care and safeguarding

Children's nursing and therapy

LIVE WELL

A healthier life for people living with long-term conditions and improved outcomes for people who need unscheduled care

Health and wellbeing for people with long-term conditions

Anticipatory care and personalised care planning

Effective care for unexpected illness and injury

AGE WELL

Healthier older people able to live independently for longer - with improved experiences for those who need care

Intensive community care (step-up / crisis response)

Rehabilitation and recovery (step-down / complex reablement)

Care towards the end of life

Approach

- Working with local communities and stakeholders across the system
- Building on learning from Covid and other community engagement
- Identifying opportunities to test and learn pilots that can support co-produced solutions e.g.
  - Rethinking bed-based models of care
  - Exploring which services can be offered from community sites
- For success and delivery in reasonable time frames we need this to be resourced and established within system governance structures

Engagement approach

Review what we already know

- Gather existing patient experience & feedback from engagement with patients, carers and families.
- Gather together information from previous engagement; reducing delays; the OX12 project and the Big Conversation and Consultation
- Draw out key themes and insights to support strategy development.

Engage stakeholders

Communities and patient groups
- Focus groups/meetings. Either face to face, if allowed, or virtual small group engagement.

Patients and families
- Interview patients and carers/family/visitors.
- Group discussion toolkit – while under COVID restrictions.

Staff
- Team meetings and dedicated engagement sessions will be used to explore staff feedback and shape proposals.

General public
- Surveys will be used to gather feedback. Healthwatch and local community groups will be asked to help to publicise.
- Local print and broadcast media and social media will be used to raise awareness.
- OCCG and OH websites. Dedicated space made available to host documents and information about the project.

How will things change to meet these needs?

To meet the needs of our ageing population, we will work with all key partners to Maximise independence through collective action for **Living Longer, Living Better**

Improved health & wellbeing	Maximising residents' strengths through joint working with local communities and stakeholders across the system. Building on learning from COVID and community engagement
Anticipatory & preventative care	Proactive care for people with long-term conditions and frailty coordinated by locally integrated MDTs; plans to improve health and independence will be supported and actively monitored by PCNs and neighbourhood teams, working collaboratively
Urgent Community Response	Developing existing community and primary care visiting services into a more accessible and effective 24/7 response, that provides the right response from the right professional at the right time
Intensive Community Care	Expanding our existing ambulatory care services into a more robust, safe and effective alternative to acute hospital admission, tailored for the needs of older and frailer people, operating 365 days a year
Community Rehabilitation	Streamlined in- and outpatient care delivered in / supported by Community Hospital Hubs, 7 days a week including: Intensive rehabilitation pathway, Bariatric / Plus-sized care pathway, Stroke rehabilitation pathway, Sub-acute frailty care pathway

Pilots being developed

ANTICIPATORY AND PREVENTATIVE CARE

Creating community capacity so that people can help themselves as part of the *Oxfordshire Way*

VIRTUAL WARDS

GPs and community services supported by acute clinicians to keep people in their own home

URGENT COMMUNITY RESPONSE

Rolling out a 2 hour response to people in their home to help them to avoid having to go into hospital

HOME FIRST

Reablement and rehabilitation to enable more people to stay at home when their independence is at risk or return home after a stay in hospital

ENHANCED CARE HOME SUPPORT

GP and community health collaborating with care home providers to help people stay safe and well in their home

SPECIALIST REHABILITATION CAPACITY

Testing streamlined care pathways for specialist rehabilitation such as bariatric care

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Community Strategy; how this approach will encompass and take forward OX 12

The OX12 Project successfully tested and utilised the Oxfordshire Health and Care Needs Framework to identify the health care needs of the OX12 population; this work indicated that in general these needs were being met though there were some issues that could be considered for improving access. Its conclusions were presented and accepted at the Oxfordshire Health and Wellbeing Board on 30 January 2020 and HOSC were updated as to how the conclusions would be taken forward at its meeting in February 2020. In June 2019 HOSC acknowledged there were challenges to the timelines on progressing the detailed work required when proposing significant service change requiring public consultation. The expected September 2020 deadline advised in February 2020 was completely overtaken by the essential NHS response to COVID in a level 4 Pandemic where the entire NHS was instructed to drop all non COVID/non priority work in a National Command and Control incident management structure.

There is not alignment of views to the Oxfordshire Task and Finish group on a number of assertions in the report, however we wish to give assurance and confidence that our approach is well structured, comprehensive and robust.

We also have demonstrated the delivery of the programme on maternity services in response to the SoS referral and will very much build on the successful approaches from this.

Approach in Community Strategy	**Relevant extracts from Task and Finish Group**
Setting a holistic strategy	
The Community Strategy starts with the life stages and a preventative approach. The links to the HWBB approach will be evident. The Programme will design the interface with PCNs as a key building block. Inclusion of District and City Councils will bring great strength in pooling knowledge and delivering outcomes in the heart of our communities. The JSNA is already giving key pointers. We will be able to ensure this work is aligned to and informed by Oxfordshire 2050. COVID has shown us a great deal about pooling information and acting upon it collectively. This strength can be built upon further. OHFT has developed data dashboards which will better inform planning and there is increasingly patient tracking data showing the journey of patients using all services developed for the A and E delivery Board.	The key themes included Health and Well-Being (HWB) at all stages of life taken from the Oxfordshire HWB strategy. There was no indication at all of how this would be implemented and integrated with the PCN and community hospital. P3 Health Needs Evidence: P 4 i. The link between the JSNA and the local data sources including district planning and housing data should be strengthened. ii. Information gathering and analysis methods should be reviewed including the use of more sophisticated software for data analysis and future projections

The taking forward of a county wide approach will enable us to use the strengths of the Health and Care framework to inform our thinking and apply at a wider scale. The strategy will build on the Oxfordshire Health and Well Being strategy and the NHS Long Term Plan ambitions.	Synthesis: P4 i. It is recommended that the local framework fits into wider county-wide and national policies on community health and social care (in-patient beds/domiciliary care, etc). This should also include Oxfordshire Health and Wellbeing Strategy, and other place-based documents. ii. Greater clarity is required on how the three separate sections of the Framework are combined and used to formulate conclusions
Delivering better outcomes for residents	
The Community Strategy comes from a place of recognising we can do even better by our residents – enabling them to attain more independence, stay longer at home and have less reliance on institutional solutions. The collaboration between primary care and the District and City Councils has been game changing and delivered excellent results in relation to known ingrained inequalities. We need to build on the benefits of these partnerships from the PCNs and local communities outwards.	
The Community Service strategy will be about Home First for all residents – this is the area we have already made some progress - but can clearly do much more. Our numbers of people on bedded pathways and leading to placements in nursing home care show we need to maximise Home First. We will seek to place all these opportunities centre stage in this work.	So much more could have been done in terms of arguing the cases for the "Home First" policy, presenting new opportunities arising from new technologies. These opportunities were missed completely. P5
The COVID period has shown we can deliver different solutions if we innovate and recognise each individuals strengths. We have shown we can have shorter lengths of stay, less delays, avoid admission to hospital and need to provide more specialist support when there are no home based alternatives. There has been continued work in OHFT on building the evidence base plus the system experience of doing things differently through COVID. These will evidence new ways to support people home to retain/regain their optimum fitness and inform pathways. We have found specialist needs are requiring more focus in the inpatient area -- plus size/bariatric and stroke for example. A commitment in this strategy is to share all best practice and cover all relevant bed bases including Wantage. We will	any decision made on the future of in-patient beds should be evidence based and include the pros and cons of bed closures and of alternative provision and include consideration of Wantage Hospital within the proposed wider county strategy P4

use the evidence base to work together to explore the best options for future provision including all pros and cons.	
Programme Overview	
A project timeline has been outlined. This will be developed further with District, City and County colleagues including laying out the full governance of this programme to offer an effective programme approach for Oxfordshire. This needs to cover well-being approaches with the community, primary care network engagement through to the interface with known urgent care programmes. It is intended to sign off the project plan at HWBB, with description of the required project resources and include the approach to evaluation. The engagement phase will need to determine the outcome measures and indicators of residents experience against which we need to evaluate the programme. The approach to evaluation against outcomes will be laid out and agreed. In developing outcomes we are aware of some key process markers we need to have improved that would most likely contribute to improved outcomes for our residents • % of people over 65 offered Reablement • People supported home on pathways 0-1 – maximising the number going home with no support and reducing the numbers on a bedded pathways -- meeting national best practice • Reducing numbers of people going into nursing home care • Offering residents a response to a crisis with 2 hours to prevent admission • Reablement support in peoples own home within 2 days • Reducing admissions from falls • Reducing those expressing loneliness More should be determined through the engagement work and we need to include mental health outcomes	The project plan: a. Evaluation should be an integral part of the project plan, and a project should not be signed off by the Health and Well-being Board (HWBB) without an evaluation plan in place. b. A clear project plan should be made available which describes the time required, the workforce needed, the skills and equipment needed, and the costs of such a project c. The project plan should set out the process for the programme of work, so that it is clear to all those involved. P3

Deliverability of any service proposals	
Key to our success will be ensuring we have the staff and other resources to deliver. Working with the full breadth of stakeholders in the system has already shown how much more we can deliver together and this strategy will work to tap into this wider opportunity. Matching capacity to the demand for key workers such as home care/reablement, nursing and therapy staff is driving urgency for this work and will form a key element of the design. We will need to develop a workforce plan to support these pathways -- OHFT have already identified this as a key priority of their internal strategy. A Primary care estates strategy has already been approved and will inform the Community Service strategy 2020-12-08-Paper-6-1-Estates-Strategy v3.pdf (oxfordshireccg.nhs.uk) All prior engagement work will be pulled together to inform the thinking Digital is proving an excellent opportunity to drive different solutions. The way we deliver services has been transformed. The pulse oximetry work has shown how people can be safely supported in their own home with remote monitoring overseeing any need to escalate and bring people into more supervised care. We have supported many people with pulse oximetry in the community.	Assets Evidence: P4 i. There needs to be a review of workforce issues, and how these might impact on service developments including re-opening in-patient beds, GP and community nursing staff. ii. There needs to be a review of GP premises and if they are fit for an increasing population as identified in the Health Needs section iii. There needs greater clarity as to how the detailed information provided by the population questionnaire was used to formulate solutions The use of digital communication combined with face-to-face events would have increased transparency and mutual understanding. P6

Decision making	

The strategy is clear about the problems that need to be solved. It has a mandate for action on the life stage of Age Well:
• Increasing independence and health and wellbeing outcomes for our population
• Working with our population to make best use of our people, our systems and our assets
Further in its approach it will be
• Identifying opportunities to test and learn pilots that can support co-produced solutions e.g.
  • Rethinking bed-based models of care
  • Exploring which services can be offered from community sites
  •
The challenges we face are being laid out more clearly and we will welcome the open discussion on what is possible within staff and other constraints but also the opportunity to do so much more with our available assets.
 	
The submitted toolkit and all other assertions have identified that inpatient bed changes equate to a substantial change an we know we need to conclude the issues around beds in Wantage.
	CCG did not lay out their aims and arguments in clear daylight for a full discussion from the beginning which could have led to a full, frank and fruitful discussion even if this was likely to become animated P6

As was done in the Maternity work recently we will lay out a clear pathway to decision making so all can be clear how and by whom any decisions would be made and any criteria to be applied. Any changes which require substantial change – such as any inpatient changes would be developed with an option appraisal with agreed criteria. This would explore the positives and negatives of any option.	Transparency in meetings where decisions were made is a crucial issue, of particular importance as the whole system has become more centralised.. . P4 Policy development is that the executive body develops a strategy based on a number of options, coupled with an outline of the limitations intended to manage expectations P5 The use of digital communication combined with face-to-face events would have increased transparency and mutual understanding. P6

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