Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 17 November 2016 at 10.00 am
County Hall

Membership

Chairman - Councillor Yvonne Constance OBE
Deputy Chairman - District Councillor Nigel Champken-Woods

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Jane Doughty	Andrew McHugh	
	Monica Lovatt	Susanna Pressel	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *2 February 2017*
Private Pre-meet for Committee*: 9:15am, 17 November 2016*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman - Councillor Yvonne Constance OBE
Email: *yvonne.constance@oxfordshire.gov.uk*
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Peter G. Clark
County Director

November 2016

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 - 34)

To approve the minutes of the meeting held on 15 September 2016 and the Special Meeting held on 30 September 2016 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 35 - 36)

10:10

A draft Forward Plan is attached at **JHO5** for consideration.

6. Healthwatch Oxfordshire - update (Pages 37 - 44)

10:15

Eddie Duller OBE, Chairman of Healthwatch Oxfordshire (HWO) and Rosalind Pearce, Executive Director, will update the Committee on the activities of HWO since the last meeting and provide information on key messages from the public in relation to items on the Committee's Forward Plan. The update is attached at **JHO6,** together with HWO's quarterly update 2016.

7. Understanding GP Surgery Closures (Pages 45 - 62)

10:30

Diane Hedges, Chief Operating Officer and Deputy Chief Executive, OCCG, and Julie Dandridge, Deputy Director and Head of Primary Care and Localities, OCCG will provide an overview of general practice in Oxfordshire; the pressures on primary care; and the work being undertaken to ensure the sustainability of general practice **(JHO7).**

8. Oxfordshire Transformation Plan and Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire & Berkshire West - Updates (Pages 63 - 92)

11:30

Diane Hedges, Chief Operating Officer and Deputy Chief Executive of OCCG will update the Committee on the development of system-wide Transformation Plans (TP), including a draft plan for consultation and engagement for consideration by the Committee **(JHO8).**

Ian Cave, Sustainability & Transformation Plan Programme (STP) Director will present an update on the Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire (BOB) **(JHO8).**

9. Community Nursing (Pages 93 - 96)

12:45

Sula Wiltshire, Director of Quality & Innovation, and Lead Nurse, OCCG, together with Ros Alstead, Director of Nursing & Clinical Standards, Oxford Health, will attend to provide an overview of community nursing provision and the 2015/16 review **(JHO9).**

10. Chairman's Report (Pages 97 - 98)

13:30

The latest Chairman's report is attached at **JHO10.**

11. FOR INFORMATION ONLY (Pages 99 - 110)

The following papers are attached for the information of the Committee (**JHO11**):

- Update on the temporary suspension of obstetric services at Horton General Hospital
- A briefing on Community Pharmacy in 2016/17 and beyond.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 15 September 2016 commencing at 10.00 am and finishing at 3.35 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Les Sibley District Councillor Jane Doughty District Councillor Monica Lovatt District Councillor Susanna Pressel
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Corporate Services); Director of Public Health

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

44/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for absence were received from District Councillor Nigel Champken-Woods and Cllr Jenny Hannaby attended in place of Cllr Alison Rooke.

District Cllr Ian Corkin attended and took part in the Committee as a representative from Cherwell District Council but not in a voting capacity, as the vacancy had not been filled formally as yet.

45/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

46/16 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 30 June 2016 were approved and signed subject to:

- Minute 38/16 - references made on pages 6 and 7 to the STP (Sustainability & Transformation Programme) being amended to TP (Oxfordshire's) Transformation Programme;

- Minute 39/16 – page 8, paragraph 2, final sentence – to amend the sentence to read 'However, they would have been assessed prior to their release'.

Matters Arising

- Minute 38/16 – it was confirmed that Damon Palmer had circulated the Transformation Programme web link to members of the Committee;

- Minute 38/16 – final summing up, page 7 – confirmation was given by Stuart Bell that the Committee's request for separate chapters on proposed services in each locality to be included in the consultation document would be actioned. Also , in relation to the need for changes to IT systems to be placed firmly on the agenda for consideration, David Smith, OCCG, confirmed that he had invited Cllr Nick Carter to a meeting to discuss the matter;

- Minute 39/16 – Councillor Pressel undertook to specify the areas of interest in relation to performance data on healthcare in prisons and IRCs in order to inform the request for further information.

47/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following speakers, all of whom would make their address at the start of Agenda Item 8:

Representative for Victoria Prentis MP, Catharine Gammie
Keith Strangwood, 'Keep the Horton General'
Cllr Lawrie Stratford, Bicester resident
Cllr John Christie, Local Member

48/16 FORWARD PLAN

(Agenda No. 5)

The Committee had the draft Forward Plan before them for consideration (JHO5).

The Chairman advised that a report on the allocation, contracting and provision of District Nurses across Oxfordshire would be presented to the November meeting.

49/16 HEALTH & CARE TRANSFORMATION IN OXFORDSHIRE - UPDATE
(Agenda No. 6)

The Chairman welcomed Stewart Bell, Oxford Health (OH); David Smith, Dr Joe McManners and Damon Palmer, Oxfordshire Clinical Commissioning Group (OCCG) attended for this item.

Stuart Bell gave a presentation - the objectives for which were to:

- summarise the key messages from the public conversation regarding the case for change in transforming health and care in Oxfordshire and the emerging models of care;
- give a summary of the key messages from the public conversation;
- primary care development;
- to seek views to help inform the thinking and development of plans as part of the ongoing process of engagement.

Mr Bell pointed out that one of the key messages from the public pre-consultation was that there needed to be an interconnection between all services so that any questions relating to other services could be raised and may engender more useful work.

David Smith reported that there would be a delay in launching the consultation It was currently anticipated that the new date was early January 2017. He added that the Clinical Senate and NHS England had to sign it off primarily. He also stated that the earliest a final decision could be made was May 2017 and the implementation period would be up to 5 years.

Stuart Bell confirmed that transport matters were high on the public's list of priorities.

The Committee asked to receive a summary of information given out at all the roadshows, as it was a useful method of informing their constituents.

Damon Palmer confirmed that the next stakeholders meeting would be on 22 September. The Chairman confirmed that she would attend this event and relay any information to all members of the Committee.

Members of the Committee urged Health representatives to give more information on the ongoing remedial work that was currently underway, for example in relation to the closure of certain GP surgeries. More flesh was needed on the bones, for example what criteria was being used to determine which were to close. Mr Bell responded that access to services was a major factor being considered. He added that the Deer Park surgery, Witney was a slightly different situation in that the provider was proposing a difference in quality. He added that the issue was how do small practices continue to make ends meet in the plans for the future integration of primary care with the hospital sector and the community services. GPs and PML were looking at the whole primary solution trying to work it out for the whole population. With regard to a question about provisions being made to transfer patients to other surgeries, the current plan was to expand other practices to enable them to take on more patients. He stressed that patient support was the key issue. In answer to a question about the

sustainability of care provision via primary care providers, David Smith responded that this came back to the importance of getting as much right before the consultation began. He added that lessons learned from elsewhere had informed them that if the consultation was to start too early, the outcome might result in it having to be repeated. Furthermore, the difficulty was that each part of the system ie. voluntary care, primary care and social care was under pressure. They needed to be as clear as possible about their assumptions on what could be provided not only in the NHS, but by other providers.

Stuart Bell was asked about the long-term sustainability of care provider services funded by the County Council. He responded that traditionally the care sector had been regarded as a separate world, but the Plan recognised its importance. At a practical level, the current outreach work being provided in nursing homes had proved to be very successful because patients were helped to leave hospital quickly. Integration of social care could increase the stability of the system, for example, the rotation of staff through the whole system. Part of the work being undertaken was to ensure that this would not be exposed to problems such as that of recruitment.

David Smith responded to questions about the possible closure of community hospitals and the impact of that on villages and rural areas with no available transport; what help or incentives would be available for key workers? and would the private sector be subsidised? He advised that the OCCG could not proceed with 'half-baked' proposals and it was far better to conduct a proper dialogue using information that was correct. He added that if the Health system did nothing, by 2020 there would be a £200m deficit, and in the face of demand rising significantly faster than the 2% financial growth monies that Health was receiving, this was not a reality. Should there be work undertaken with other sectors, there would need to be a radical series of trade-offs and a series of choices. Dr McManners explained that the Government had requested each area to provide cuts in service provision. £5m had been top-sliced from the NHS England budget to pay to nursing homes. Furthermore, acute hospitals were starting to work on locality planning. GPs were looking at services in localities, for example, what out-patient provision could be undertaken in their area. Also the future co-location of social workers, GPs and nurses was also in the process of being discussed for each locality. Once this had been completed then discussions would begin with the public.

Cllr Doughty, local member for Witney, expressed concern about the urgent issues to be addressed at the Deer Park surgery in Witney and the need to take on board the views of the residents in relation to future plans for primary care in Witney. Dr McManners responded that there was a need to organise an urgent briefing. The Chairman made reference to a similar situation in Bicester (see Chairman's report later in the Agenda) where members of this Committee had invited local Councillors and the local patient groups to a meeting about supporting people to transfer to other practices and the future of North Bicester Surgery.

A member asked why there had not been a road show in Abingdon, to which Stuart Bell responded that an event was planned to take place in that location during stage 2.

In response to a question about whether the possibility of more extra care housing in new developments had been considered in Banbury and other areas, David Smith informed the Committee that the OCCG's modelling assumptions had to include the best projections for housing across the patch and activity. He stressed that there was not the same activity everywhere. Following that the OCCG would look at what primary care facilities were required.

A Councillor added his concern that Bicester had not been included within the list of sites in the emerging whole system options, making reference to the additional growth in housing in this area. He called for more forward thinking on the part of OCCG and more care given to the residents who are impacted by the closure of a GP surgery, citing as an example, the imminent closure of the surgery in North Bicester on 30 September where local residents had not had sufficient time to register with a new GP surgery. David Smith responded that Bicester was not the only area across Oxfordshire that was under pressure and the OCCG was trying to support primary care as much as possible. He added that there were specific issues that they were addressing, such as how to make some areas more attractive to GPs and how to introduce more funding into primary care to make services more sustainable.

Stuart Bell was asked how the Transformation Plan (TP) for Oxfordshire would fit into the BOB (Berkshire, Oxfordshire and Buckinghamshire) Plan (the Sustainability & Transformation Plan (SDP) and how it would feature in terms of available funding. He responded that the TP process for Oxfordshire pre-dated the STP process. He added that it had not been helpful that the STP Plans had not been published, but reassured the Committee that all the discussions taking place in this local arena were part of the STP and there would not be anything new when they were finally published. He reassured the Committee also that the Horton Hospital would be included in the pre-consultation and in the TP consultation. In response to a question, he confirmed that there would be data available on each option contained within the consultation, together with comment on whether this would be affordable or not.

The Chairman thanked Mr Bell, Mr Smith, Dr McManners and Mr Palmer for their attendance.

50/16 REBALANCING THE SYSTEM - PILOT EVALUATION AND NEXT STEPS
(Agenda No. 7)

The Chairman welcomed the following representatives who were attending the meeting in order to give details on the end of the pilot review and to give information on the next steps:

Paul Brennan – Director of Clinical Services, Oxford University Hospitals Foundation Trust (OUH)
Lily O'Connor – Divisional Head of Nursing and Governance & Liaison, Hub Manager, OUH
Karen Fuller - Adult Social Care Service Manager, City and Hospitals, Oxfordshire County Council
Dr James Price - Divisional Director for Medicine & Clinical Lead for Gerontology, OUH

Paul Brennan gave a brief overview of the information contained in the report JHO7 about the review of the pilot. He concluded by stating that the Hub was now in operation using 55 beds – a reduction from 150 beds at the start of the pilot. He added that patient feedback had been good overall, particularly as people were being moved out of a busy acute ward to a different environment.

Mr Brennan agreed to provide the Committee with the key performance indicators which had been used to monitor during the evaluation.

A member asked from which areas were the staff recruited. Mr Brennan reported that 70% were targeted from retail with an attractive package, including a good wage, full-time work for those who wanted it, access to a full NHS Pension Scheme, possible access to a nurse's induction programme or development into the Healthcare system.

In response to a question, Paul Brennan reported that the 55 patients still in hub beds were there for further assessment and work with the family. The beds were used as though they were community beds and were not classed as delayed transfers of care as they were not in the acute sector. Lily O'Connor explained that many patients in community hospitals were there for rehabilitation reasons and were not categorised as delays. She added that it normally took a long time to work out their long-term care, requiring talks with the patients themselves and with their families. Paul Brennan further explained that the pathway had been changed for patients in acute beds, so that before they became a delay, they were moved out and placed in intermediate care beds. A member commented that it was difficult to tell where the 476 patients cited in the report had been placed. Paul Brennan explained that one third had been placed with nursing or care homes, one third had gone home and one third had either died or been readmitted to hospital. Karen Fuller further explained that social workers worked very closely with community colleagues to ensure that patients were moved out and negotiated into homes. Their presence in the Hub put Social Care in a position to ensure that the market was managed well. Paul Brennan added further that when the audit of the first 150 patients had been undertaken there had been no expectations as to where they would be placed.

In response to a question, Paul Brennan reported that the total number of delated transfers of care was currently 78 and 30 were in community beds. He added, in response to a further question, that Oxfordshire was no longer near the bottom of the national table and these figures had reversed the trend (expected 185). He added the view that nationally the measurement tool had changed a number of times. The focus was always on getting patients home quicker.

Dr James Price commented that in the experience of patients, and in that of expert staff, all were very motivated to deliver. Staff working in the Hub Teams were very positive about both because of the good outcomes for patients and because of the learning and innovations gained over the period. He added that care homes had learned the important capability to manage change, the Trust had learned how to apply principles more generally and families and carers how to manage people in their own homes as a result of the changes.

Dr Price was also questioned about the mortality rate from those readmitted to hospital. He reported that mortality figures had fallen during the study, adding that

many patients want to return to their own home, even if it may mean a readmission was necessary a few days later.

A Committee member commented that it was pleasing to see that family carers had been included in the figures. Karen Fuller responded that this was shared and updated in the Hub at present. A member also commented that it was also pleasing to see the inclusion of medicine management so that patients arrived in homes with their prescribed medicine.

In response to a question about the availability of nursing home beds, Paul Brennan explained that there was now a partnership approach to this. Karen Fuller commented that currently at any one time there were over 200 beds available at different prices and staff in the Hub had been successful in providing beds. She assured the Committee that there was an availability of beds in Oxfordshire.

A Committee member asked if Health and Social Care were experiencing problems in getting homes adapted for patients. Karen Fuller commented that it was very unusual to have a delay regarding home adaption. Social workers worked closely with District Councils who were very proactive in dealing with it early. Across the board there were very few delays regarding adaptations and alternatives were considered if there was a problem to ensure that patients were not remaining in acute care.

The Chairman thanked all the representatives for responding to questions about the evaluation of the review. She then introduced the next part of the discussion the purpose of which was for the Committee to understand the next stage of the reconfiguration, which it was understood would not be funded by the OCCG. Prior to this she invited Councillor Mrs Judith Heathcoat, Cabinet Member for Adult Social Care, to make a written statement to the meeting, as follows:

‘As the Cabinet Member for Adult Social Care I am hugely concerned about the paper before you today, Before I talk of my concerns can I say that I do wish there to be a ‘working together ‘ of Health and Social Care so that the system is more joined up and easier to navigate. I attend Transformation meetings representing Adult Social Care.

Adult Social Care in Oxfordshire is nationally high performing, being the sixth best rated authority in the national outcome framework for social care. There is a high level of satisfaction from people who use the service – 90% of our users are reasonably/ very/extremely satisfied. Nationally in the last 12 months social care delays vary by 32% whilst here in Oxfordshire they fell by 36%. The numbers of people we support has not fallen and the amount of home care we buy has almost doubled since 2010.

I am genuinely concerned about this paper – ‘plans for acute bed and service reconfiguration’, the word ‘reconfiguration’ has an air of permanency. The proposal is to shed a further 118 beds – the word ‘release’ keeps being used but there is no mention of a trial period, so to go through all this upheaval must mean permanent. The paper discusses ‘details of Ward Relocations’ which sees an immense amount of work for a pilot. With the 74 beds already released, plus the proposal for 118, this brings the figure to all but 200 beds to be released. What period of time is being

envisaged to be given to this pilot? The 74 beds that were released initially were for a 'pilot' but we have no end date for this I believe?

I understand that there is no funding from the CCG for this further closure of beds. Adult Social Care had not been able to quantify the costs and the impact on the Care Home provider market or the Home Care market. The OCCG did support financially the 76 beds 'released' in November 2015 and Adult Social Care absorbed the costs. It was believed that the releasing of the 76 beds was a pilot.

The question for me now is whether the Committee sees this as a substantial change. If the 'Toolkit 'assessment made by the Trust states that this is not a substantial change, I would disagree and I would suggest therefore that these proposals should go forward and be put into the forthcoming consultation. The release/closure of beds will have an impact on beds'.

Paul Brennan, in responding to Cllr Mrs Heathcoat's statement, commented that he had been involved in a number of conversations with adult social care colleagues regarding this to ensure that any changes were supportable. And no-one had been able to identify an impact on social care costs. He asserted that, apart from the 55 already in situ, there was no intention to purchase any more beds. He added that the Trust was investing £4.1m on services to support patients in their own home which included social worker support. The OCCG had funded part of the Hub work to the amount of £900k and the OUH had funded the balance. The OUH was also pump-priming that funding. By moving out of the bed base, all monies would be invested up front and there would be no impact on nursing homes.

In response to a question asking how the closure of 118 beds was being managed, Mr Brennan explained that the OUH had appointed 50 staff and OCC has awarded the reablement contract to OUH at a fixed cost, to which OUH would add to if it was found to be necessary. The Trust was investing £1.6m in the development of an Acute Hospital at Home service and was also investing in a discharge service (45 nurses, medics and therapy staff). Patients would be managed on a Treatment Pathway. Dr James Price further explained that arrangements would be made for those patients suffering with transient episodes who would usually require prompt assessment. He added that hospital care for frail elderly patients with social and psychological problems could be risky and it did not benefit them overall. Moreover, an in-flow system-wide access to hospital when necessary, together with a capable team situated in the community (including families) was very important, and would make for very good decision making. He added that the current arrangements across the system were not as good as they needed to be. Capable people were required to make a diagnosis and deliver a treatment plan as quickly as possible. The paper laid out a whole range of options and support arrangements with patient care, SHEDS (Supported Hospital Discharge Service), multi-disciplinary teams and community based teams to aid better outcomes and a better patient experience. Dr Price commented further that much thought was being put into rebalancing physical space. Historically there had been too many overnight beds for patients, even when it wasn't in their interest. A rearrangement of clinical support was required to give better care. In working with patients, carers and families, patients could be supported better and at the same time better support could be given to those who did benefit from being in hospital. Furthermore, it could be particularly difficult for many patients in hub beds

and in intensive support settings, or who were in the last year of their life. For the above reasons, this was a very strong model, supported by local clinical opinion and by the National College of Physicians and the future Hospital Commission. A member of the Committee asked if there was a precedent. Dr Price responded that there was national evidence that such services were successful, and also local examples had supported the principles, for example, Abingdon EMI (Emergency Multi - Disciplinary Unit) and the assessment unit at the JR Hospital.

Paul Brennan stated that it was his view that this was not a substantial service change because patients would still access health care in the same way – there would just be a change in the care pathway. He stated also that the direction the Trust was going in was consistent with the national view and with the Liaison HUB strategy. He added that the changes would take 12 months.

A member commented that in the face of the closure of 118 beds, demand for services was growing, waiting lists were longer, and ambulances queuing up at Accident & Emergency. She asked why a report had not been written from a GP's perspective – which would serve to give a feel for the Committee of the patient pathway. Paul Brennan responded that the report sought to explain this with the description of the creation of the Unit at the JR Hospital. He added that GPs had already stated they wanted access to acute professionals when needed, to help support them when dealing with patients at home. It was confirmed that GPs would have this access from November.

The Chairman referred to a further aspect of the proposals which was the purchase of care home beds at a high price than that offered by Social Services, thus causing possible blockages when patients were moved out of acute care, supported by adult social care. She stated that this had not been understood by the public and by the patients affected. The question of timing of the proposal needed to be considered in relation to the timescale for the Transformation Plan. The role of this Committee was to ensure that patients and the public alike understood the situation. She added that the Committee had asked that a substantial change assessment be completed by the OUH, although a completed version had not been received in time to enable the Committee to meet with the Trust prior to this meeting. Furthermore, the proposals needed to be considered in light of the Transformation Plan on which consultation had been delayed until early in the New Year. It was therefore

AGREED (nem con) that it was this Committee's view that this stage of the Rebalancing the System work was a substantial change of service and therefore required full public consultation. According to the terms of the legislation, the Committee should attempt to come to an agreement before referring it to the Secretary of State. Therefore, further discussion with the Trust would take place at a special meeting of the committee on 30 September 2016 in relation to the following issues:

- The impact of the Plan on other providers, including Social Care; and
- The Plan in relation to the forthcoming Transformation Plan consultation.

51/16 OBSTETRICS AND THE STRATEGIC REVIEW - THE HORTON HOSPITAL
(Agenda No. 8)

Prior to consideration of this item, the Committee was addressed by the following speakers:

Catharine Gammie – speaking in behalf of Victoria Prentis MP

Firstly the decision to suspend obstetric services at the Horton Hospital was made with no consultation at all. Victoria Prentis's staff were made aware of the OUH's plans at a meeting of the Horton on 20 July. It was thought that the object of the meeting was to discuss the Transformation Plan proposals affecting maternity provision at the Hospital and Victoria could not attend the meeting. At no point did anybody forewarn her of the imminent announcement relating to the temporary closure of obstetrician provision. The Trust's decision affects not only her constituents in North Oxfordshire, but those beyond her own Parliamentary constituency boundary, for example, the Cotswold Birthing Centre in David Cameron's former constituency transfers 50% of emergency closures to the Horton. Yet at no point did the Trust inform them of their plans.

Secondly, no effort has been made to engage with clinicians or the public. There is considerable bad faith locally and this is exacerbated by a total lack of engagement. The consultants feel excluded and do the Banbury GPs, many of whose patients would now have to decide whether to give birth in the midwife-led unit or to make the 90 minute journey to the JR Hospital. Together the GPs wrote to the Trust in advance of the Extraordinary Board Meeting to express their opposition to the proposals. Their letter expressed many of the concerns they expressed to the Independent Reconfiguration Panel in 2008 ie. safety, sustainability and the reduction in access to base health care and choice for their patients.

Thirdly, the decision to suspend obstetric services is not evidence based. Despite asking to see the risk assessments on many occasions, it was not until this Committee's Agenda was published was there one in the public domain. She has grave concerns, that without controls and contingency plans, there were a number of 'high risks' on the register, including the timeliness of the transfer of patients; the impact on the JR Hospital's maternity service and the retention of staff. Whilst she recognised that without sufficient obstetricians the service was not safe, the transference of mothers who had encountered complications during or post-labour when that transfer would take at least 45 minutes in an ambulance, not taking account of loading and de-loading the patient was extremely worrying.

In conclusion she expressed her fear that lives would be lost and urged this Committee to do everything in its power to intervene and hold the Trust to account. He understood that when there was an emergency, there could not be a statutory consultation process, but the decision needed real scrutiny. She asked the Committee to refer the Trust's actions to the Independent Referral Panel as a matter of urgency and at the same time to ensure that the Trust remained under pressure to recruit, either by being more creative with the advert and job offer, or by outsourcing responsibility to dedicated recruitment consultants. Despite being told consistently

that this is will be a temporary suspension, she stated that it would be and there would be a domino effect which would be a fatal blow to the future provision of acute services at the Horton General Hospital. She called for the Committee to ensure that a full obstetric service resumed in the New Year.

Keith Strangwood

Keith Strangwood referred to a third option that he had put forward to the Trust on behalf of 'Keep the Horton General' which was that instead of transferring the obstetric service to the JR Hospital, to keep the theatre open at the Horton so that elective caesarean operations could be carried out by senior gynaecologists. He expressed his concern that unlike the Horton there were no beds at the JR Hospital and to transfer patients from the Horton would cause an overflow. Mr Strangwood commented that the efforts of the OUH to recruit and employ obstetricians was 'ridiculous'. He expressed his belief that the OUH had manipulated the situation and urged the OCCG to utilise the facilities offered by the Horton to take the pressure off the JR. He also expressed his concern that patients could suffer and a life could be lost.

Cllr Lawrie Stratford

Cllr Lawrie Stratford, a former member of HOSC and a resident of Bicester North where many of his constituents resided, were, or had been Horton patients, including himself. He stated that during the past number of years, the Horton had been a recurring item for this Committee. Back in 2008, following a very substantial review of NHS proposals for the Horton by the Committee, the Independent Reconfiguration Panel was asked to examine the proposals and report back to the Secretary of State. One of the key proposals at that time was, and he quoted:

'Obstetrics, gynaecology, and the special care baby unit.

- Replace consultant-led obstetrics and gynaecology services with a midwifery-led maternity unit;
- Transfer obstetric-led services and the special care baby unit to Oxford Women's Centre;
- Transfer emergency and inpatient gynaecology services and care to Oxford Women's Centre.

Cllr Stratford asked if there was some familiarity with the above proposals and stated that the detail IRP report response , made in 2008, made several references to 'could put mothers and babies at risk' whilst transferring them to Banbury from the Oxford area. It was summarised as follows:

'The IRP does not support the Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the Special Care Baby Unit at the Horton Hospital. The IRP does not consider that they will provide an accessible or improved service to the people of North Oxfordshire and the surrounding areas.'

Cllr Stratford also stated that to help demonstrate this point a 'test run' was organised where two HOSC members were 'rushed from Banbury to Oxford' to ascertain the 'safety' issue. The test was undertaken in a blue light car as an ambulance was not

readily available and it took place on a Wednesday afternoon. The outcome demonstrated that it was not a viable or safe option. Since 2008, there was an estimated 20% more traffic and considerably more roadworks especially around the City. He concluded that if it was not safe then, how could it be safe today? He therefore urged Health to 'think again', adding that it was his view that people had lost faith in NHS management. He added that Health had to greatly improve its engagement with residents and patients in the north of Oxfordshire if it was ever going to regain their trust going forward.

Cllr John Christie

Cllr John Christie addressed the meeting in his capacity as a County Councillor for Banbury Ruscote and also as Chair of the Banbury Locality Group of County Councillor who were united in support of the Horton. He stated his view that residents were concerned that the underfunding of the NHS was putting at risk vital acute and maternity services at the Hospital, as outlined in the earlier presentation on the STP. He added that it also made clear that the projected 2% annual growth in the NHS budget was insufficient, and implied cuts to services as well as efficiency gains. He reported that what residents did not understand was how cuts to the Horton were even being considered when it had existed for over 140 years, and in light of the population growth in demand for services in Oxfordshire. In addition to this, they could not understand it in the face of the 'atrocious' nature of current access to Oxford from North Oxfordshire, and when the JR site itself was being restricted. He concluded by stating that residents saw the emergency cessation of maternity consultant provision at the Horton as 'the thin end of the wedge' which could lead to permanent cuts under the STP. They were concerned that the current staff training and recruitment exercise would fail without some innovative approaches to staff redeployment across both sites which may include incentives. He ended by stating that there must be more ways of ensuring the continuation of such vital services.

The Chairman welcomed Paul Brennan and Andrew Stevens to the meeting to explain why the temporary removal of the consultant-led service would be implemented at the end of October.

Mr Brennan recognised the value north Oxfordshire residents placed on the Horton, but the Trust did not want to be put in a situation where it would be held responsible for patient safety. The Obstetrics service carried out very complex work and emergency work and a senior doctor was required to be in situ 7 days a week, otherwise it was deemed unsafe.

With regard to the recruitment and employment situation, Mr Brennan explained that on 3 October there would be 3 doctors in post. One had resigned and was leaving in November. The number of doctors required to maintain a safe rota for individuals who would have the opportunity for exposure for training at the JR also was 9. Furthermore, due to the low number births since March 2015 (1,466) it had been found that there was insufficient exposure for doctors who needed to keep up their exposure to complex births. Given these numbers, this service was suitable for a midwife-led service, of which there were 3 across the County. Thus a decision had been made at a meeting of the Trust to temporarily close the Obstetrics Unit on 1 October, and to open as a Midwife-led Unit. In the meantime, the Trust had been

continuing with their efforts to recruit doctors and had recently offered 4 doctors a consultant post. All had indicated their wish to take up their offer but not all resided in the UK and 2 were not registered with the UK Medical Council. The Trust was trying to support then, but there were limitations with what they could do. Any new doctors would require a 6-8 week induction and would need to be overseen by senior clinicians at the Horton. He added that there was currently a new advert out and then a further one would go out following its expiry.

Mr Brennan reported also that the Trust had responded to public comment that the salary was too low and, for new advertisements, it was set at £62-76k and incorporated banding and premium rate payments. Also in response to public comment, the advertisement had been altered to include the possibility of the appointment being extended after one year. He explained that doctors needed to attain equilibrium of exposure and that, after that period, they would be moved onto larger centres. The recruitment cycle would be continued and if in the event that more doctors were recruited, the Trust would make their decision on 30 October to re-open the Unit on 9 January 2017 as an Obstetric Unit. In the event that this did not happen, then the Trust would continue to run a series of advertisements and if the correct contingent of doctors could be found, the Trust would re-open the Unit on 1 March 2017.

The Chairman thanked Mr Brennan for his report, commenting that the question of maternity services remaining open in the longer context were to be incorporated into a set of clinical options for the Horton to be considered by the Trust. This was not yet in the public domain and would feature as part of the Transformation Plan. She reminded members that today the Committee were only considering the immediate decision to close the consultant-led Unit on the grounds of urgency.

A member asked if the Trust had considered any other options to make the post more attractive. Mr Brennan responded that the Trust was paying more for the entry level of a consultant and was also helping to support doctors who required a visa. The Trust was also receiving help and support from local MPs on the latter. He pointed out, however, that obstetricians, were very specialised in terms of training and there was a general shortage of doctors. Currently there was a vacancy rate in trainees of 24%. There was no designated assisted training by the Deanery available at the Horton. He stated that he believed the Trust was doing everything possible to recruit obstetricians, although there had been recruitment challenges such as some not attending their interviews, or changing their minds after being offered the post in favour of going to larger Units.

Mr Brennan was asked about the alternative option as presented by the Keep the Horton General group. He responded that this would be costly (at a cost of £1.2m) and was not practical as many doctors at the JR could not be moved to the Horton because the training designation by the Deanery had been removed in 2013.

A Committee member expressed concern that one thousand new maternity cases would be relocated into the JR. Andrew Stevens responded that it was impossible to ‘grow’ birth numbers and there was a need to decide the safest course of action for women in north Oxfordshire. He added that part of the risk assessment was to look at additional capacity at the JR, as outlined in the paper. The risk assessment showed

that the JR would be able to accept additional births. He also pointed out that the Trust had worked very closely with the planning authority and with statisticians and it had been ascertained that even with the level of population expansion, the birth rate would only rise by 10%.

In response to a question, Mr Brennan stated that the Trust would pay staff transferring from the Horton any excess travelling expenses incurred and provide designated parking permits for the period end of October to January, when it was anticipated that the Unit would re-open. Also, when asked about the knock on effect of the new arrangements on the gynaecological services, Mr Brennan explained that there would be an additional theatre to be staffed by a sufficient number of midwives.

A member asked if this emerging situation had been created in order to support long term plans for the Horton. Mr Brennan stated that this was not so, explaining that a difficult position had emerged in 2013 when training had been taken away, as outlined in the paper. He added that the Trust came up with an innovative solution to keep it running, via a Clinical Research Fellowship, but it needed to be recognised that its continued success had been due to EU doctors and nurses coming into the EU. Unfortunately, this pipeline had dried up.

Mr Brennan confirmed that there would be no change to the Special Baby Unit and screening would remain.

Mr Stevens, in responding to a question about whether a viable consultant-led maternity service at the Horton would be viable in the future, stated that there were concerns as to whether it is clinically sustainable for a variety of reasons. He added that if a viable option emerged, then there would have to be a trade-off.

Mr Stevens was asked if there was a hospital, consultant-led Unit closer to the Horton which would compare more favourably to the travel time to the JR. He responded that the Trust had undertaken some detailed modelling and, as part of this, had conducted discussions with hospitals in Warwickshire and South Northamptonshire. Mr Stevens commented that there was a need for the Committee to look at those options, adding that he had spoken to Northampton Hospital and midwives were speaking to all women giving birth, giving them the choice of where they wished to have their baby. He added that the Trust was currently working out the maximum number of women who may choose to give birth at the JR.

The Committee **AGREED** to request Mr Brennan and Mr Stevens to attend the special meeting of the Committee on 30 September in order to discuss further the following issues:

- timing issues of travel between the Horton and the JR in relation to safety;
- other options open to the Trust with regard to the successful recruitment of obstetricians; and
- why the number of births at the Horton had decreased in number from 1,700 to 1,466.

52/16 DIRECTOR OF PUBLIC HEALTH - ANNUAL REPORT

(Agenda No. 9)

The Committee had before them the Director of Public Health's Annual Report (JHO9). Members were asked to consider the key issues which they would like to take forward in the year ahead.

Dr McWilliam was congratulated on a very interesting, easy to read and comprehensive report.

In relation to alcohol related hospital admissions and illness, Dr McWilliam was asked what was in place to educate the public in relation to the dangers of alcohol. He responded that Public Health Officers addressed it to the best of their ability, it was also part of the schools' curriculum and part of the school nurses remit. He added however that drinking rates among young people were falling, along with teenage pregnancy numbers, but both needed to be kept under surveillance. Public Health advocated a growth in referrals, but also a good and timely service. The key element of the new service which had been put in place was that of outreach for people in psychological distress. School health nurses also dealt with mental health problems and help was on hand for children suffering from stress. However, it was his view that services were still not dealing with this aspect quickly enough and there was a need for him to keep a watching brief.

Dr McWilliam was asked to expand on what services were in place for children aged 15 – 19, in light of the recent surge in mental health issues experienced by this age group. He reported that the Care Quality Commission had highlighted the matter of increases in waiting list times and assessment at first appointment. The Chief Medical Officer had highlighted a more stressful lifestyle as the cause for this and had advised young people to come forward earlier in life if they were experiencing problems. He added that the Child & Adolescent Mental Health Service (CAMHS) provided access to school counsellors and school nurses had been invited to attend a conference on alcoholism which was held every two years. He also added that he had been very pleased with the outcomes of the alcohol prevention project when Oxfordshire Fire Service had been involved.

At the request of the Committee, Dr McWilliam gave a flavour of the areas in which Public Health had been involved over the last year. This included:

- A breast feeding project in Brighton with an aim to increase support in areas where there was a low uptake.
- A person had been employed to telephone primary care patients with the aim of encouraging them to take up their health check.
- School nurses were keen to know what outcomes they should meet and were thinking of a way to use these to target help where it was needed most.
- Pegasus Theatre had staged some excellent plays on Health issues.

A Committee member asked about Health services and transport (in the face of reduced bus subsidies) for older people in villages in light of the closure of some GP practices. Dr McWilliam agreed that there big issues for Public Health if the proposal to concentrate medical services in Oxford was to come to fruition. He reminded the Committee that practices were independent businesses and people were starting to

shop around for services more frequently. He added that the advent of evening surgeries would attract more people in the future.

A member asked whether 'shimmies' (wired in equipment in new homes giving advice on local services) would come at a cost, or would they be free of charge. Dr McWilliam was unsure of whether there would be a cost. He commented that there was a need to raise this initiative in planning committees or as part of the Healthy Town initiative.

A member asked how it was ensured that pockets of deprived areas were included within Public Health initiatives. Dr McWilliam responded that Public Health initiatives were available across the board. However, the bigger issue was more about how the NHS met the needs of the population. There was discussion in the report about whether there is sufficient differentiation in how services were delivered in these areas. This would be included in the Health Inequalities Commission report later in the year.

A member of the Committee wondered if the TP and STP were intending to deliver a link with local planning to deal with prevention and Health inequality issues and with low target groups. He referred to the distribution of indicators contained within the report for disadvantaged groups, and in particular, those for children with mental health and behavioural issues and the inherent difficulties with data collection. He applauded the Director and his Team for trying to get into these areas. Dr McWilliam responded that it was down to all parties to ensure that the Plan was differentiated down to all groups in the population and how they would be served. He added that Health Inequalities was another focus. He pointed out that it was disadvantageous that the data was only available at the top levels and there was a need to drill down to a local level, for example, on relation to mental health.

A member asked if the Public Health status had grown and was more visible now that it was situated in the ambit of Local Government. Dr McWilliam responded that at the moment it still had a ring-fenced grant worth £32m, with a guarantee that this would remain until the end of 2017/18, after which it was not known whether it would be ring-fenced.

In response to a question about whether Public Health would be underspent again this year, Val Messenger, Deputy Director of Public Health, came up to the table to report that there was a possibility that there would be an underspend of £125k this year, but the level of a grant would be reduced next year. Public Health was trying to make the budget more sustainable so that it would not have to make any further service changes next year.

The Committee was pleased to see more actions taken during the year documented in the report, and that they were undertaking some good campaigns. Even more information on these, together with a view on what the Team had achieved would be welcomed in the future. The Director responded that the Team were trying to gain an overview of the health of the whole 'body politic' of Oxfordshire and trying to make Public Health the 'soul' of Oxfordshire.

The Committee also complimented him on the interesting section on Health Checks. Dr McWilliam responded that it had been noted by the OCCG that this was a good programme and would be delivered in the future using OCCG money, though this was unconfirmed as yet.

The Committee **AGREED** to inform Cabinet that the Director and his Team were to be congratulated on the report for the above reasons.

53/16 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 10)

The Committee had before them the report (JHO10) by Healthwatch Oxfordshire (HWO). Tracy Rees, Vice-Chair of the HWO Board attended in place of the Chairman, Eddie Dyer whilst he was on leave. She was accompanied by the new Executive Director, Rosalind Pearce, who had only just taken up her post. Rosalind Pearce explained that initially she intended to follow the current programme, but was working with the Board on it. She added that although the overarching Policy would not change, it was intended that there would be an increased HWO presence in different parts of the county with a view to meeting and listening to the views of the patients and public. She also intended to develop the current reporting mechanism with agencies of the third sector and stated that she would like to be more proactive with HWO's 'enter and view' role, in order to gain a clearer idea of issues and to aid horizon scanning.

There was a discussion on the study being undertaken by HWO on Minor Injuries Units (MIU) and what equipment was available to them. Rosalind Pearce commented that it was the view of HWO that MIU's needed to promote more information about what services could be offered at these sites and agreed to follow it up. Tracy Rees added that the primary focus would be on the Abingdon MIU, as its situation and issues were mainly similar at all the sites around Oxfordshire.

A member suggested that HWO and HOSC might work together utilising the roles each had. As an example, it was suggested that as Oxfordshire had a new contract for school nurse provision, it would be helpful if HWO could talk with some young people who had experience of the service in order to produce some feedback for the future scrutiny of this service by the Committee. Rosalind Pearce commented that HWO were keen to work with young people, and were already doing some work in schools. She undertook to let the Committee know what could be done at the next meeting.

A member commented how effective and helpful HWO had been when contributing to the pre-consultation engagement meetings on the Transformation Plan. Rosalind Pearce responded that high on HWO's agenda was to work actively with the OCCG on this, sharing knowledge on the engagement process, but at the same time maintaining their independence. She added that there was to be a HWO/Voluntary Sector conference towards the end of January to ensure that these organisations get a voice in the engagement process. Tracy Rees flagged up the need for information to be in plain English, to provide translations and for there to be good information on the website, to ensure people had all the tools to enable them to make up their own minds.

The Chairman thanked Rosalind Pearce and Tracy Reese for their attendance at the meeting.

54/16 CHAIRMAN'S REPORT

(Agenda No. 11)

The Chairman introduced her latest report (JHO11). She highlighted the report on the closure of the North Bicester Surgery and the action taken by the Committee. This entailed asking the OCCG to complete a Toolkit assessment, in order to glean the information required, and then meeting with the Patient Participation Group (PPG) attached to the surgery, local councillors and OCCG representatives to hear the issues.

Katie Read, Policy & Partnership Officer, asked the Committee if this approach could be established as a process to be followed with similar issues in the future. Dr McWilliam pointed out the GPs were a commercial enterprise and the process was more about ensuring that NHS England had the processes in place to deal with issues around surgery closures. He questioned whether the Toolkit process added anything to the process of patient care.

Katie Read clarified that elements of the Toolkit assessment, which were normally initiated by Health organisations if they were unsure as to whether a change in service was substantial or not, could be used to find out how many people would be affected by a change in service, for example, so that this could inform similar issues as they emerged.

Some members of the Committee suggested that important messages around changes in Health care from NHS England and the OCCG were not being communicated sufficiently well enough. For example, residents were not aware that once they had re-registered with another surgery, following the imminent closure of a surgery, they could not attend their previous one. Local Councillors had distributed letters to residents in their local areas in Bicester, reminding them that they must register with another practice.

The Chairman informed members that the Committee's visit to the Hub was to be arranged shortly.

55/16 FOR INFORMATION ONLY

(Agenda No. 12)

The Committee was briefed on 'Healthcare & Justice Commissioning for Prisons and IRC in Oxford – Deaths in Custody' - as requested at the previous meeting (JHO12).

At the request of the Committee, Katie Read undertook to seek information on what issues caused the deaths in custody and what the Service were doing to reduce suicides, and to circulated this information to all members of the Committee.

..... in the Chair

Date of signing .....

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Friday, 30 September 2016 commencing at 10.00 am and finishing at 1.30 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods (Deputy Chairman) District Councillor Jane Doughty District Councillor Monica Lovatt
Co-opted Members:	Moira Logie and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Corporate Services)
Part of meeting	Nick Graham (Corporate Services)

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

56/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from District Cllr Susanna Pressel and Dr Keith Ruddle.

District Cllr Ian Corkin attended and took part in the Committee as a representative from Cherwell District Council but not in a voting capacity, as the vacancy had not been filled formally as yet.

57/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

58/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 3)

The Chairman had agreed to the following speakers, all of whom would make their address at the start of Agenda Item 4:

- Valerie Ingram - Administrator of 'Save our Horton' Facebook page
- Keith Strangwood – Chairman, 'Keep the Horton General' Group
- Dr Peter Fisher FRCP – Member of the Public and retired consultant in General Medicine at the Horton Hospital
- Sarah Ayre – retired midwife

59/16 EMERGENCY CLOSURE OF CONSULTANT-LED MATERNITY SERVICES AT HORTON GENERAL HOSPITAL

(Agenda No. 4)

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

Valerie Ingram

Valerie Ingram informed the Committee that she was the administrator of the Facebook page 'Save our Horton' and communicated with just over 16,000 members on a daily basis. It was her view that Banbury and the catchment area was growing at an unprecedented level and key to the Core Strategy was sustainability, adding that to allow the maternity unit to be downgraded even temporarily was contrary to those principles.

She stated that Oxford was not close to Banbury and very difficult and expensive to get to. She added that in 2008, the Independent Reconfiguration Panel had deemed that the distance between Banbury and the JR was too far and not safe, stating that this was as relevant today as it was then and in fact transport had worsened nowadays making it even more difficult to access services.

She informed the Committee that a recent FOI request made in June had revealed that a blue light run from Banbury to the JR revealed an average time of 43 minutes, which did not take into account loading times at either end. Furthermore that an emergency C Section, category 1, was recommended to take place within 30 minutes; and the clock did not begin ticking until the doctor had agreed the procedure, adding additional time to be factored in, but which was not included in the Trust's contingency plan. She added, moreover, Chipping Norton Midwife –Led Unit (MLU), when in difficulties, tended to send their patients to the Horton as it was easier to access. The outcome of this would be that this option would be removed, thus increasing the risk to patients, and overloading the JR. She further stated that the JR had been on divert on two occasions the previous week and Warwick had the week before, thus highlighting existing pressure. She added her view that GPs and ambulance staff in the Banbury area were not happy with the proposals.

Valerie Ingram also suggested that downgrading to an MLU would possibly see the removal of the on call 24 hour House Consultant anaesthetist, thus bringing into jeopardy the Children's ward and Accident & Emergency. The Trust has made no guarantees that this position would remain and FOI requests had gone unanswered.

She stated that, in her view, recruitment had been 'lack lustre and appalling' and it had taken letters from Facebook members to get the adverts back onto the system.

She referred to a proposal that had been made to the Trust which would utilise existing facilities, retain staff and utilise the services already in Banbury, which had been refused. At the Trust's recent AGM the Trust had commented that agency staff would be employed if staff did not wish to be moved to Oxford. She commented that the same should then happen for the doctors, that locums could be employed in Banbury in the interim period until doctors could be found. She concluded by stating that the residents in the Banbury area wanted equality of care and 'were being treated as second class citizens and expendable collateral.'

Keith Strangwood

Mr Strangwood began by referring to a petition (which was not submitted to the meeting) which was in circulation and which had accrued 3,000 signatures to date. He also referred to the Trust's statement that there was no alternative to the temporary closure of the Hospital's Obstetric service, due to safety reasons, stating that the risk to mothers and babies was an even greater risk. He added his view that the advertising for the post for doctors was 'more than inadequate' as it had only appeared in the British Medical Journal and no other site. Mr Strangwood also referred to the pressure on the JR of the additional 1,000 births. He asserted that the 'whole proposal', including the lower number of births at the Horton had been engineered by the Trust. He concluded by requesting the Committee to refer the temporary closure to the Secretary of State.

Dr Peter Fisher

Dr Fisher informed the Committee that when he worked at the Horton he was one of 10 consultants. On his retirement there were approximately 40. The hospital had been allowed to develop an integrated service with colleagues
at the JR. Later the OUH had moved these staff to the JR. He added that it was very significant that the number of births had dropped and no advertisements had been made until April. As a result, the earliest the service could re-open was January 2016. He concluded that throughout there was uncertainty and the people in north Oxfordshire were bewildered. There were a series of questions that needed to be answered and the only way to receive answers was via referral to the Secretary of State.

Sarah Ayre

Sarah Ayre explained that she had been employed as a midwife at the Horton Hospital up to last year. She wished to convey the concern felt by the midwives who had successfully served mothers and babies in the north of the county, for the wellbeing of the mothers and babies affected by the proposal. The midwives strongly

supported all models of care which supported the Horton. They also feared that the new proposals would not be a temporary measure. They felt that the contingency plan was unsound. A main area of concern was that, despite the presence of a 24 hours a day ambulance, the JR was too far away from the Horton for safety. She added that the staffing levels outlined in the contingency plan ignored NICE guidelines and the Trust was ignoring crucial timings required to provide the service safely. She urged the Committee to refer the contingency plans to the Secretary of State for a full and frank examination of the proposals that were both 'insulting and negligent'.

At the start the Committee were advised of the following by Nick Graham, Chief Solicitor, OCC. He advised that this was an emergency closure on the grounds that it was a threat to patient safety and welfare; and therefore the duty to consult did not apply. However, he advised that under the legislation, the Committee had the powers to still refer to the Secretary of State if it was not satisfied with regard to the adequacy of the reasons given for emergency. He further advised that some of the proposals might be caught up in the broader context of future change for which a major consultation was planned to take place in the New Year. He advised that this would not prejudice the Committee's ability to make a referral.

The following representatives attended:

- Paul Brennan, Director of Clinical Services, OUH
- Andrew Stevens, Director of Planning & Information, OUH
- Veronica Miller, Clinical Director, Women's Services Directorate, OUH;
- Catharine Greenwood – Consultant in Obstetrics & Fetomaternal Medicine, OUH;
- David Smith, Chief Executive, OCCG

Paul Brennan began by giving an update on the situation. He reported that the recruitment process was ongoing, and as soon as a full complement of staff were in place, then the Unit would be re-opened, together with a definitive agreement with SCAS for a 24 hours a day ambulance to be situated at the Horton. He further reported that currently the Trust was down to three doctors, making it unsafe to operate the Obstetric service. Since the last meeting of this Committee, four doctors had been interviewed and had all been offered and had accepted their post. However two of the doctors were not registered with the General Medical Council and this would take a minimum of 6 weeks. Victoria Prentis MP had offered to assist with the process as far as she could. One of the doctors required a period of induction to enable him/her to work independently. The outcome of this was that 2 doctors would not be available until the New Year to carry out operations. He added that a further advertisement was out at the moment and the closure date was that day, 4 applications had been received to the advert. He added that the most risky area that of the special care nurses, which was a difficult area to recruit in across the country. An advert was out at the moment. Once all the doctors were able to operate independently and the special care nurses recruited, then the Trust would re-open the Unit.

Mr Brennan gave his reassurance that the 24 hour ambulance was an additional vehicle which had been secured by the Trust in response to concerns raised by the public.

In response to a question, Mr Brennan confirmed that the salary range and banding for the consultants posts comprised a percentage increase in salary and a £5k premium to make them more attractive.

Andrew Stevens stated that he had worked for the Trust for 17 years and had been proud that Obstetrics had been kept going at the Horton since the loss of the accreditation in 2012. He added that other Trusts in the south of the country had lost their service, notably, Buckinghamshire, Berkshire and Gloucestershire. Furthermore, for training posts, the vacancy rate of just below 25% was replicated across the county. He added that the problem of safety had to be faced, if there were an insufficient number of doctors then the service could not be provided.

Catharine Greenwood stated that she had worked on the labour ward for over ten years. She added that other units had closed across the area, for example, in Royal Berkshire. That service had been transferred to the Horton or to surrounding areas, such as Basingstoke.

Veronica Miller referred to the costs to run the neonatal network which had not come over. There was in the region, an improved network and beds would be made available for premature babies, level 3.

A member asked why the numbers of births had reduced from 1723 in 2013 to 1466.Veronica Miller explained that there existed a national guide to complex pregnancy which had to be adhered to. The rise in 2013 had been the result of a period of refurbishment at Chipping Norton Hospital. Catherine Greenwood also explained that the recognition for training for the Horton had been removed in 2012. Sometimes even consultant-led services did not meet the needs of women at the Horton and they had to go to the JR anyway. She added that there had been a reduction in numbers for higher risk births going to specialist teams as a result of national guidance.

When asked about whether the JR had ever been on divert, Catharine Greenwood stated that she had not known it to happen. A member asked if some mothers had not been given the option to use the Horton, which might have then lowered the birth figures. She asked if the Unit would remain in Banbury in the future. Veronica Miller responded that the maternity service was proud that mothers were given choice. She added that nowadays pregnancies were more complex for a number of reasons and there had been many studies and much evidence on the subject of keeping mothers safe and about how to look after them. The Horton did not have specialist teams in situ and it worked across the county when it needed to gain access to them.

With regard to the issue of recruitment a member asked why, if it was known that a consultant was to retire or leave, that a recruitment agency had not been approached? Mr Brennan responded that nobody had resigned in 2015 and the first doctor had resigned in February 2016. He added that the Trust had gone to the Agency and asked them to fill 4 posts. Unfortunately they had been unable to provide any suitable applicants. In response to a question, Mr Brennan explained that currently, 3 doctors were in place for the next week, but 1 of these was leaving, 4 doctors had been recruited and required induction training, 2 required registration

with the GMC and 1 required a visa application. Therefore reopening would be in the New Year at the earliest. Furthermore, whilst he was pleased that 4 posts had been offered, it had to be recognised that, in reality, doctors were applying for multiple jobs. They preferred to go to Units where there were more births. Many wanted to become consultants following the Article 14 Caesarian route. With just 3 births a day, the Horton could not provide the training and expertise they needed. The Trust was trying to rotate doctors through the JR to make the post more attractive for doctors. When asked if they were recruiting applicants with a view to reopening the Unit, Catharine Greenwood responded that they were. Appointees might need to work at the JR in the first instance, but when there were sufficient numbers appointed to the Horton this would be their main place of work.

A committee member asked for some idea of other options considered, for example, the question of the rotation of staff from the JR – and whether this could be with agency doctors. Mr Brennan responded that doctors at the JR were in training and therefore not permitted to go to the Horton as it was not accredited for training. Andrew Stevens reported that funding for the innovative post 'Clinical Research Fellow' (CRF) which had been created to try to keep the Obstetric Unit going since 2012, came out of the Research budget. He added that there were no CRF's now – the OUH was recruiting to Trust posts only. A member asked if there were other acute rotations at the Horton likely to be at risk in the forthcoming year. Mr Brennan responded that there were no rotas at risk at the moment, although it was impossible to predict the Deanery questioning viability for training. He added that a future area of concern might be the Accident & Emergency Department, but there were no problems there at present. David Smith stated that the OCCG was satisfied that, at this stage, this emergency action to close the Unit down had been taken because there was no other option. The Trust could not recruit doctors.

A member asked if there was sufficient staff to look after the increased numbers of babies taken from the Horton to the JR. Mr Brennan responded that 6 members of staff in the Special Baby Care Unit had decided to transfer to the JR to provide sufficient numbers with which to run the service. 3 members of staff had decided to stay at the Horton and 1 was an adult trained critical care nurse and had asked to stay at the dependency unit.

With regard to travel issues, a member of the Committee asked about the safety for mothers and babies when being transferred down the A34, which did not have a good accident record, and also what the travel times were from the Horton to the JR. Catharine Greenwood stated that the Trust had based its plans for temporary closure on NICE guidelines (made public in 2011) which suggested that for low risk mothers, it could be safer to deliver in an MLU as long as this is within 45 minutes of a consultant-led unit – the Horton met this criteria.

A member referred to Appendix 3 of the risk assessment, asking firstly where it was factored in that the clock only started to run when the ambulance arrived at the JR. Secondly, the NICE guidelines used kilometres, not miles, and there was the addition of a leading time of 15 minutes. Catharine Greenwod responded that nobody pretended that a category 1 C section could be offered in the Midwife Led Unit (MLU). She pointed out that mothers in other MLU's did not have access to category 1

C sections. Mr Brennan added that loading time did not apply as the ambulance would already be there.

A member asked if it would be appropriate to use the air ambulance to transfer women to the JR. Mr Brennan explained that this would not be possible due to flight paths which would have to be put in place. Andrew Stevens stated also that it would be less appropriate for maternity cases because it would take longer to mobilise it and load. Paul Brennan explained that, for people living in Banbury, major traumas, stroke, heart attack were all blue lighted to the JR nowadays. With regard to the route, SCAS had a control system which diverted to the most appropriate route. He added that many ambulances took the route down Banbury/Oxford Road via Islip, and arrived within 40 minutes. A Committee member commented that another route used was via Deddington and along the bus lane to Kidlington, which could take less than 30 minutes. Mr Brennan commented that data provided had shown that on a blue light run from the Banbury area, 88.4% would arrive within 30 minutes and 100% either less than, or equal to 45 minutes.

A committee member asked whether equipment was currently being moved to the JR. Catharine Greenwood explained that it was, because women in Banbury were having to travel to the JR. She reassured the Committee that it would be moved back when the Unit was reopened. A clear inventory had been taken. In response to a question about whether the JR would have sufficient theatres, Mr Brennan stated that an extra theatre had been brought in to use for C sections, with a capability of 22 sessions rather than 20 as now. In addition to this two extra rooms (on top of 5) had been converted to clinical use. Two extra delivery rooms were also being created and would be ready the following week. The Trust had moved people out of an office to make space for mothers after they had given birth. There was also capacity for two more rooms to be converted for the same purpose. He stressed that the Trust was doing its best in the face of this emergency.

The Chairman then summed up the issues relating to the grounds for emergency. These were:

- The timing of the closure, given the imminent reduction in consultants at the unit.
- A recruitment drive that had failed to deliver, although the Trust had not ceased its recruitment efforts. Appointees were being given the option of extending their contracts to make it more attractive.
- There was no pre-determination with regard to the Transformation Plan consultation – maternity services would be part of longer term proposals in the Transformation Plan.
- The question of travel times had been thoroughly explored – 88.4% in 30 minutes and 100% in 45 minutes meets 2007 NICE Guidelines.
- A special ambulance would be available 24 hours a day at the Horton to transfer complex cases to the JR.
- A decline in birth numbers at the Horton was related to an increase in risk factors during delivery and more people being advised to go to the JR.
- Three other free-standing MLU's in Oxfordshire – the results are safer – less at risk from medical intervention, although 25% transfer to consultant – led units.

- Provision of two obstetric-type rooms plus two extra birthing-type rooms. The equipment had been moved to the JR, but could be moved back to the Horton. This had met the challenges by increasing space and staff.
- Rotation of doctors with the JR had been considered as CRF posts had come to an end.
- High risk patients were advised to go to the JR before they entered labour, so there was less need to transfer complex cases during labour, reducing risk.

The Chairman asked each member of the Committee in turn if each were satisfied with the reasons given for the emergency situation the Trust found themselves in, at the same time advising that if a member was not satisfied, then evidence was required for non-satisfaction. A vote was then taken and it was **AGREED** (by 5 votes to 3) that:

(a) on the basis of the evidence provided by the Trust, not to refer the Trust's decision to temporarily close the Obstetrics Unit at the Horton to the Secretary of State on the basis that it was satisfied that OUH had adequate reasons for acting without consultation on the basis of urgency relating to the safety or welfare of patients or staff but to monitor the situation carefully in the meantime; and

(b) to request regular updates on the status of consultant-led maternity provision at the Horton and the recruitment of obstetricians.

60/16 ACUTE BED AND SERVICE RECONFIGURATION

(Agenda No. 5)

Prior to consideration of this item the Committee received advice from Nick Graham, Chief Solicitor, OCC. He advised the Committee to determine the question of whether the closure of the beds amounted to a substantial change in service, and to try as far as possible to reach agreement with the Trust. If this was not possible then it had recourse to refer the matter to the Secretary of State.

The following representatives attended for this item:

- Lily O'Connor – Division Nurse, Medicine, Rehabilitation and Cardiac Division, OUH
- Paul Roblin - Chief Executive, Local Medical Council
- James Price – Consultant Gerontologist & Divisional Director for Acute Medical, Rehabilitation & Cardiology
- David Smith – Chief Executive, OCCG
- Stuart Bell – Chief Executive, Oxford Health
- Andrew Stevens – Director of Planning & Information, OUH
- Cllr Mrs Judith Heathcoat – Cabinet member for Adult Social Services, OCC
- Seona Douglas – Deputy Director for Adult Social Services, OCC

Paul Brennan began by stating his reasons for the proposal not being a substantial change in service. Firstly, the Trust was investing £4m in services to enable Health to

support patients in their own home. Secondly, there would be no change in access to services and no change in services provided. Thirdly, integration of non-bed services provided by Oxford Health and by OCCG would continue in order to make services more responsive to patients in the right environment. Finally patients could be managed in the most suitable environment to get the best care needed.

Mr Brennan clarified at the request of the Committee that the original plan in relation to DTOC (Delayed Transfers of Care) was, via the work of the Liaison Hub, to get to 150 beds, 137 was then reached, and it was then agreed to drop down to 55 beds, which took place in July.

Mr Brennan was asked if the Hub had managed to maintain the flow of patients through the system. He responded that this had happened, and more had been done due to investments made in hospital integrated services. The OUH had invested £1.2m jointly with Oxford Health (OH) and the OCCG to keep the Liaison Hub. £1.6m had also been invested in additional nursing and medical staff to run the community services. The Hospital Discharge Team was seeing more patients managed on a non-bed pathway despite rising demand (6 – 8% increase in emergency attendance). He added that taking forward stage 2 had not led to any additional cost to Social Care – there had been no evidence provided of this. He reminded the Committee that phase 2 of the programme had started 4 months ago and half of it had already been implemented, with no additional charge on Social Care.

A member asked about how this wider remit with the Liaison Hub was working out with Adult Social Care (ASC). Lily O'Connor responded that alongside the 55 beds already highlighted, there were 49 intermediate care beds at Chipping Norton, Isis and Watlington, working with Orders of St. John and Sanctuary Care. The Trust was also working with CHC (Continuing Health Care). She added that 18 interim care beds had been funded by OCC and that OUH was working with OCC to ensure that patients were identified. She added that no beds were lying empty unnecessarily.

A member asked whether this reconfiguration would create more bed blocking further down the chain, and whether preventing admission would cause a problem with sick people at home requiring the attention of GP's and ASC. Dr James Price explained that there were many studies which supported this care journey. One particular study focused on the quality of care for older people with emergency care needs, emphasising that it was essential that these services were person-focused and driven by the individual's needs. Early, good quality services were very important. He added that many patients were sensitive to delays in patient care, thus, initial, speedy decision-making focusing on ambulatory care (day care in a hospital, heart centre or other setting) which supported patients at home or closer to home overnight was vital. The historical model that saw patients being admitted to wards after having been assessed by a doctor, then by a ward consultant the next day, was no longer acceptable. He added that for some people who required frequent attention, this mode of care would not be right for them. Then their stay in hospital would be decreased and they would be cared for in their own home. Older people were often admitted due to a lack of timely care in their own home. Evidence had made clear that fewer patients require institutional care via the hospital path. Age UK research had shown that avoiding admission when appropriate made a significant difference to people's lives. Local experience and incremental evidence had shown (over a period

of 4 years in Abingdon) an early manifestation of this. Doctors, nurses and social workers were working closely together, and close to the patient's home, to make good quality decisions. Upon going home, OH and Principal Medical Ltd (PML) were giving good care at home. This had been extended to the north and south of the county and in day care assessment units.

It was Cllr Mrs Heathcoat's view that if beds were being closed, there was a need to consult. She asked why move ahead of the Transformation Programme plans for re-designed services? She added that ASC supported people in their own homes where they feel more secure, but asked if there would be increased activity to local primary and social care, as most people would require it.

Seona Douglas added that ASC did a lot of work on a joint basis, stating that it was difficult to quantify what prevention was. If patients were discharged into the community they may require assistance with mobility, cooking etc. Mr Brennan responded that talks about services required were in place. With regard to the prevention agenda, this could not be quantified because there was no resource to say how much it would cost. The Trust's commissioners had not received the modelling to be able to quantify it.

In response to a question from the Committee about what the impact would be on GPs, Paul Roblin stated that GPs supported the direction in travel. The move to daytime hospital care did however need resourcing in order to deliver more activity in the community. Discussions were ongoing on new models of care that may deliver new solutions. However, he warned that in a situation of national austerity, promises may not be delivered. He stated that there was a need to work together as an integrated Health service towards solutions and the direction of travel in terms of the practicality of delivery in the community needed to be looked at closely.

David Smith spoke from the financial position that the NHS was currently in. If one came to the heart of what needed to be done for the Transformation Plan, then resources wold have to be shifted in the GP/ASC direction, and things would have to be done properly. He added that unless there was proper integration of Health and Social Care via a single pooled budget then delivery would not happen. Mr Brennan, in response to the concerns of ASC and OCCG, referred to page 9 of the paper which stated that whilst releasing the beds, the Trust was spending an extra £1.4m on ASC (personal care) over and above what OCC were providing, in addition to the original £1.5m funding into ASC by the OCCG. He also pointed out that OCC's own strategy centred on the increased impact and demand on ASC, if patients stayed in hospital beds longer. All evidence pointed to reduced costs.

Seona Douglas added that there were issues regarding funding into the reablement service. Funding was predicated on 28 beds a week. She asked if it was over and above the 28 beds that was included in the costings for the original contract. She added that Social Care did not know the position at this stage 2 to make that assessment. Paul Brennan commented that OCC had spent £1.5m lower on the Supported Hospital Discharge Service (SHDS). He undertook to provide that information.

Members of the Committee commented that there was no argument with the principles of the changes. However there were concerns around pressures on GPs leading to the closure of a number of surgeries across the county, together with pressures on community hospitals. There were concerns about the sufficiency of staff to run Witney EMU, for example. In light of the interaction with ASC today, there did not appear to be a united front. There was also concern that the public had not had the opportunity to speak about the further closures of beds and the impact of this. There was also concern that it was not understood by the public.

Stuart Bell, OH, pointed out that, in circumstances that were in reverse to the national trend, to date the plans had largely worked out and patients had been moved to a more appropriate setting. He stated that this was the best means possible of being able to release resources to assist people in their own homes via community services and ASC, and to unlock potential investment in primary care. Questions to be answered centred around how to release the resource in patient care? What sort of contractual and work place models exist to do it? What are the issues around moving staff from acute to EMU's? All these answers would be included in the next stage of the Transformation Plan. When the formal consultation was launched there would be permanent change to consult upon. Mr Bell assured the Committee that there would be a united front, adding that the biggest issue was that of staffing – and that staff could be deployed under the new Transformation Plan.

The Committee were in favour of the principles of the reconfiguration programme, but felt that the OUH were no yet in a position to carry it out. It was aware also that the GPs were also in favour, but the way they were organised at present made it impossible due to lack of resources .It was understood that the forthcoming Transformation Plan consultation would have a knock on effect. However, if the consultation was delayed until after the OCC election, there would be no decision made for a year. It also recognised the difficulty in recruiting carers and asked who would be responsible to be with patients at home during the night? Mr Brennan responded that it had been a challenge, but to date 47 carers had been recruited, predominantly from the retail sector.

A member asked what would be the effect of bed closures on the Nuffield Orthopaedic Centre? Mr Brennan explained that this was an evolving programme and needed a reasonable conclusion. Paul Roblin stated his view that the redeployment of existing hospital staff into the community based model was not practicable. Lily O'Connor commented that patients could be looked after in their own home and that the Plan was individual patient-based. Those patients who expressed an anxiety about it would not be placed into the service. However, many patients did ask for outreach into their own home. She reassured all that this would be set up, planned, recorded and monitored in the Liaison Hub.

A member asked where the care home providers for the Banbury area would come from as in Banbury, 5 doctors had left one surgery alone and it took 2-3 weeks to set up a GP appointment. Mr Brennan commented that if the care provider had closed down then that was an issue for OCC. Beds were provided at Chipping Norton Hospital. Paul Roblin commented that there was no question that the GP service was in crisis. He did not believe, however, that this was linked to hospital configuration and hospital beds.

A member asked about travel time once home care had been introduced. Paul Brennan explained that the Liaison Hub would still run at the JR, and the SHDS service would operate from bases in the north and south of the county to enable staff to do the work at home.

A question was asked about Out of Hours cover and medical nursing care services. Lily O'Connor responded that this would continue 7 days a week and there was no expectation that others would take the service. It had been found that packages of care had been reduced. It was expected that patients cared for at home would be more mobile and mortality would be lower. They would reach independence sooner or they might not even need the service any more.

The Committee asked what would be the impact of launching a consultation if 50% of stage 2 had already been implemented. Paul Brennan responded that one further change was essential to make in the following week and then a series of changes would be made later this year and early next year.

A member of the Committee suggested that success at stage 2 would be good evidence to include within the Transformation Plan consultation next year. An added benefit of this would be that it could then be articulated more clearly to the public. Paul Brennan agreed that this was a good point and if this was the view of the Committee, it could be an advantage of engagement. To consult on stage 2 now would only serve to confuse the public.

David Smith commented that if the Committee stipulated that there must be full consultation now, the OCCG would have to write the consultation document for submission to the OCCG Board in November. This would run into, and overlap the main Transformation Plan consultation which was scheduled to begin on 4 January 2017.

Paul Brennan was asked if consultation was required now would it stall all the good work already taking place? He agreed that it would, and services would be sat with empty beds. He suggested that, as a compromise, the Trust would agree to a short period of consultation. Paul Roblin expressed the view that this would divert attention from delivery of the full provision and that the STP already contained a large element of what had been discussed.

Dr Price put forward the view that to delay would be a problem for patients and carers.

In considering the way ahead the Committee **AGREED** (unanimously) that OUH's plans for acute bed and service reconfiguration constituted a substantial service change that required consultation.

To this end, it was **AGREED** with OUH that the scope of the 'Rebalancing the System' pilot be extended to incorporate this proposal and that no changes would therefore be made that were irreversible. The pilot outcomes would be used as evidence to support the transformation consultation in January 2017. Should the Transformation Plan consultation be delayed further, the OCCG would hold a 12

week consultation on this proposal, starting in January 2017, to fully understand the impact on providers, partners, patients, the public and staff.

..... in the Chair

Date of signing .....

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HOSC Forward Plan – November 2016			
Meeting Date	**Item Title**	**Details and Purpose**	**Organisation**
February 2017	Health and Care Transformation Consultation Part 1	• Committee formally receives and scrutinises the health and care consultation proposals • A deadline for the formal response from the Committee is advised by the CCG	Whole System – (Stuart Bell, Transformation Board Chairman)
February 2017	Quality of Care in Care Homes	• The quality and availability of care in care homes, e.g. oral health, infection control, flu jabs for staff and residents, medical support, access to GPs, etc.	OCC/OCCG/PHE
February 2017	OUH Emergency Departments	• Plans for addressing pressures on A&E departments in the JR and Horton • CQC inspection outcome	OUH
February 2017	Strategy for Primary Care	• Strategy for ensuring the sustainability of primary care, as agreed by the CCG in January	OCCG
February 2017 (FOR INFO)	Health Inequalities Commission Report	• Report of the Health Inequalities Commission – ready Autumn 2016	OCCG
April 2017	Transformation proposals	• Decision from CCG Board on future model for o critical care facilities; o stroke care; o changes to bed numbers in order to move to an outpatient (ambulatory) model of care o maternity services	Whole System – (Stuart Bell, Transformation Board Chairman)
April 2017	Health Inequalities Commission Report	• Report of the Health Inequalities Commission and Health and Wellbeing Board's response	Whole system & HWBB
April 2017	Obesity prevention	• Impacts of national obesity strategy • Local activities focused on encouraging healthy weight	OCC & Districts
April 2017 (tbc)	Health and Social Care Integration Plan	• Oxfordshire's plan for health and social care integration to be ready by March 2017 and implemented by 2020	OCCG/OCC

June 2017	Health and Care Transformation Consultation Part 2	• Committee formally receives and scrutinises the health and care consultation proposals • A deadline for the formal response from the Committee is advised by the CCG	Whole System – (Stuart Bell, Transformation Board Chairman)
September 2017	Transformation proposals	• Decision from CCG Board on future model for o Acute services; o Community Hospitals	Whole System – (Stuart Bell, Transformation Board Chairman)
Future Items			
	Better Care Fund Update	• Implementation Update on the Better Care Fund	OCCG
	NHS Workforce – Recruitment and Retention	• Raised as a potential area – most likely has been covered through Transformation work stream updates	Whole System
	Health and Wellbeing Board	• How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration? • Is there effective governance in place to deliver this? • How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for greater integration?	Whole System
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • Requested at June 2016 meeting	NHS England

1 Introduction

This report summarises:

1. Healthwatch Oxfordshire's recent patient and public voices pertaining to the Health and Overview Scrutiny Committee's agenda for November as described in the Forward Plan
2. The key activities and areas dealt with by Healthwatch Oxfordshire (HWO) since the last board meeting in September 2016.

2 HOSC Forward Plan – November 2016

Over the past three years Healthwatch Oxfordshire has commissioned, funded through our Voluntary Sector Project Fund or produced in house 24 reports ranging from highlighting hurdles vulnerable migrants and refugees face in accessing GP services to views and experiences of using Minor Injuries Units in Oxfordshire. Our outreach programme, together with people contacting us directly by telephone or email, offers us the chance to listen to individual's experiences of health and social care services in Oxfordshire. Below is a summary of what we have heard and found out and reported on specifically relating to each proposed HOSC agenda item for November 2016.

2.1 Travel and transport access to hospitals

We hear most often:

Time to travel to John Radcliffe, Nuffield Orthopaedic Centre and Churchill hospitals from outside of Oxford is a major bugbear of patients attending outpatient appointments and for visitors to inpatient departments at the hospitals. The difficulty of finding a parking space, together with the cost these are frustrations voiced often across the county.

Patient parking pantomime experience:

> *Nuffield Orthopaedic Centre - finding parking is an absolute nightmare. Lady drove around for an hour looking for a space without success. Nurses were coming out and tapping on people's car windows to confirm attendance for appointments. People had partners running to reserve spaces by standing in them. Patient finally parked in a disabled slot as she was on crutches.*

We have recently heard that volunteer drivers – who take patients into hospital appointments who otherwise might not have made the journey – are experiencing difficulties with the parking permit system and the frequent long waiting time. Drivers we have spoken to and heard from voluntary organisations supporting them, are beginning to wonder whether it is worth doing and is making it harder to recruit volunteer drivers.

Sometimes, where patients live and where the services are that they can access makes no sense to them. For example, access to mental health services in the south east of the county was raised by a patient - having to travel into Abingdon or Oxford for support when they lived a few miles away from Reading seemed silly to the person.

The good news is:

- ✓ When people complain, they are listened to and even have had parking fees refunded
- ✓ Hospital transport generally delivers to appointments – even if one must book well in advance
- ✓ People are using the Minor Injuries Units rather than go to A&E at the JR

2.2 Primary care transformation

Most of what we have heard when out at public events regarding primary care has been about GPs. Information gained from our various reports; particularly Minor Injuries Units, refugees' experiences, Asian women, Icknield Community College, our Access to GPs survey report in 2014, Gypsy and Traveller community experience, mothers' experience of post and ante-natal community services, My Life My Choice report on GP provision for people with learning disabilities and students use of local health services.

The overriding message is that the care provided is good and people feel listened to by professionals. Identified needs include: improved support to address barriers such as language and cultural awareness; tailor services to meet the needs of communities including longer GP appointments, better waiting areas; professionals need ongoing training for them to respond to different communities with confidence and appropriately.

Icknield Community college students' comments:

Most students agreed that their practice waiting rooms were not very young person-friendly. "Old fashioned", "Dull", "Needs updating with bright colourful decorations", "depressing" and "quiet" were among the comments. Students recommended re-arranging the seats in clusters rather than around the walls would make the waiting room less formal and more sociable and the introduction of sofas would get people chatting to each other. Having nice pictures or drawings would be more up-lifting for someone that is sick rather posters showing ill health and deterioration was also a point agreed on by the students.

A recent common complaint re GPs is getting an appointment with a sense that receptionists are blocking access to GPs, asking too many personal questions *'they are not health professionals, why should they decide whether I need to see my doctor'* and *'I don't want to speak about medical stuff to receptionist I might know them, they live down the road…'*.

If this is the direction of travel for patients wanting to make an appointment with their doctor, i.e. a form of triage delivered by the receptionist, there needs to be a clear message to all patients why receptionists are asking questions, confidence built into the patient community that receptionists are trusted and operate within the same boundaries of confidentiality as other staff at the surgery and better training for and use of script by receptionists. The recent QCQ report on one surgery in Oxfordshire that uses a call back system 'phone consultation system' thus the receptionist is making a judgement on whether an appointment or telephone consultation is required was recommended to 'provide appropriate written guidance or prompts for reception staff to ensure they have access to information that will enable them to safely prioritise patients with an urgent need'.

Our report on MIUs identified reasons for people using it including referral by GP, out of hours and for one patient they had struggled into JR A&E waited over four hours and returned home to go to the MIU.

Regarding consultations on Primary Care Transformation, it is our opinion that there is more work to be done with GPs and community based professionals to 'come on board' – they should be a key and trusted mouthpiece for changes in primary care, thus building confidence in changes to services that will affect many NHS service users.

2.3 Health Inequalities Commission Report

At the board's meeting in November, Richard Lohman, Health Inequalities Commissioner and a member of the Healthwatch Oxfordshire Board, will give a presentation of the Commission's findings. This will be in public so giving an opportunity for the Board to hear from members of the public and for the Commissioner to respond. Healthwatch Oxfordshire will review the findings and publicise our response.

It is worth noting that several organisations that had been supported by Healthwatch Oxfordshire to conduct research into their community's experience of health and social care services in Oxfordshire made presentations to the Commission.

2.4 Care in private care homes

Healthwatch Oxfordshire receives few contacts from the public about care homes. This is an area of social care and health that we are looking to develop in 2017. In 2016 Healthwatch did attempt to engage with all care home managers in the county to understand what the issues were facing them. In the end, we managed to talk to four managers and the common points raised are summarised as:

1. They were reluctant, even stopped, taking people funded by the local authorities as the payment was not enough to provide 24-hour care or a quality service
2. CQC inspections:
   - are a snap shot often not the 'full picture'
   - did not treat all care homes equally as those rated Good did not receive the level of ongoing support as those rated 'Requires Improvement'; the perception is that Good homes are subsidising poorer ones
3. Staff recruitment and retention – none of the four homes spoken to had difficulty in recruitment, using word of mouth and targeted recruitment. However, retaining staff was a problem particularly with other care homes 'poaching' staff. Training was an important element to retention.

3 Healthwatch Oxfordshire Activity September – October 2016

3.1 Health Transformation

Over the past few months Healthwatch has been actively engaged local health transformation programmes:

- Oxfordshire Health Transformation – attending 'Big Conversation' events, Transformation Board, meeting with the OCCG communications and engagement teams
- Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP – Leadership Group (Healthwatch Oxfordshire represent the Healthwatchs in the BOB STP area). In July 2016 HWO made a Freedom of Information request for the draft plan because the NHS is reviewing it in secret, and now await the outcome of our appeal as this request was rejected.

3.2 Local matters in which we have been actively engaged with include:

Horton General Hospital – obstetric service, which was suspended temporarily at the beginning of October on safety grounds. The Oxfordshire University Hospitals Trust has given assurances that it will continue to attempt to recruit suitable obstetricians, and we

hope that this situation can be resolved as soon as possible. As I write the trust has announced that the closure will remain in place until March 2017, at the earliest. We will continue to monitor the situation closely.

Deer Park Surgery, Witney which will be closing at the end of March 2017. Healthwatch Oxfordshire voiced its concerns. As well as giving radio and television interviews with BBC Oxford, we are attending meetings with the practice's patient participation group, the Health Overseeing and Scrutiny Committee and the Oxfordshire Clinical Commissioning Group. Healthwatch Oxfordshire is concerned first and foremost that patients, particularly vulnerable patients, must be supported to transfer surgeries and so have continuity of care. While we are also concerned about the impact on other GP surgeries in Witney, we understand that they indicated to the clinical commissioning group that they could take additional patients subject to support from the CCG in respect of recruitment of doctors and premises. We will continue to monitor this.

The transfer of patients is planned for January onwards, to give GP surgeries time to plan and resource for additional patients. However, we aware that this is causing concern to some patients, particularly the elderly, and we have asked the CCG for more frequent and clear communication with patients can be achieved over the next three months.

4 Outreach programme

July, August and September are particularly busy months for Healthwatch staff as they reach out to members of the public to listen to individuals' experiences of health and social care services. By attending local events such as fetes and fairs, play days, Banbury Canal Day, Patient Participation Group days across the county, we can reach a wide population. During these months, we spoke to over 220 individuals and seven different voluntary and community organisations.

5 We heard

Since April 2016 we have been reporting monthly 'This month we heard' on our website. We have now produced our first Quarterly Update, targeted at members and officers of local authorities, health and social care commissioning bodies and service delivery organisations across the county.

Since April we have spoken to at least 400 individuals and 16 organisations about their experiences of health and social care services in Oxfordshire. Monthly reports can be viewed on our web site www.healthwatchoxfordshire.co.uk

The main recurring themes we have been hearing included:

- Too little support and long waiting times for people with mental health problems
- Long waiting times and access to make an appointment with a GP
- Praise for many individual GP surgeries
- Long waits for some hospital outpatient services such as cardiology
- Poor communications from hospitals

A hard copy of the full update is attached. It is also available on our web site and here

Quarterly update Autumn 2016Final.p

6 Projects

6.1 **Refugee Resource** is looking at access to primary care services of refugees and asylum seekers. The report 'Primary health care services for refugees, asylum-seekers and vulnerable migrants in Oxford city: A study on the experiences of service users and service providers' was published on 16th September 2016. The report, which was produced with the support of Healthwatch Oxfordshire, explored the primary healthcare needs of asylum-seekers, migrants and refugees in the city of Oxford, as there was anecdotal evidence that this group was among those facing the greatest barriers in accessing services. This group, one of the most marginalised and disadvantaged in society, also tends to live in the most deprived areas. The study found that, with a few exceptions, most of the refugees, asylum-seekers and vulnerable migrants interviewed have had positive experiences of accessing primary health care in the UK. Most were very appreciative of the treatment received and the compassion and sensitivity shown by health care professionals toward them. Nevertheless, they face a range of linguistic, cultural and administrative barriers to accessing appropriate care.

The health care professionals involved in the study were all committed to delivering an equitable service for this patient group, and were clearly doing all they could to provide an exemplary service. Nevertheless, they also faced many challenges in meeting the needs of this group who can present with complex health issues related to their experiences of war, torture, exile and loss, as well as the challenges of adjusting to a new life in the UK, often with little or no English.

Because of the findings of this report, Refugee Resource has made several recommendations for the providers and commissioners of primary care services, including:

- Recognising that the health needs of this group is a key inequality issue that requires specific support and resources;
- Making funding available to allow those GP surgeries which see many migrants to offer an enhanced service with longer appointment times;
- Making interpreters more readily available;
- Carrying out awareness-raising/training among healthcare professionals to increase their understanding of the experiences and primary health care needs of this patient group;
- Outreach work in communities with high numbers of refugees, asylum-seekers and migrants to orient them to primary health care services.

6.2 **Cruse Oxfordshire** - a project assessing experiences of bereavement services in the north of Oxfordshire. The report was published on 1st November. The report findings are themed and focus on the need for bereavement services in Banbury and surrounds:

- **Information** on services for bereaved people needs to be timely, accurate, widely available and comprehensive.
- **Access to services**: this information should enable bereaved people to access the appropriate service for them, through an assessment process and sign-posting.
- **Capacity to respond to need**: people who have been bereaved need a rapid response from the service they choose which means the services need to have capacity, in terms of both people and accessible local venues.

Healthwatch Oxfordshire is keen that the service providers begin to work together to improve access to services through better awareness and coordination.

7 Projects reports in development

Project reports by Oxford Against Cutting, dealing with female genital mutilation, and Oxford Parent and Infant Project (OXPIP) will be published by the end of 2016. These will be the last of the Healthwatch Oxfordshire supported voluntary sector reports because of the budget cuts for 2016/17 we are no longer able to fund research by local community and voluntary organisations.

8 Future

The coming months will see Healthwatch Oxfordshire:

Reflect on and respond to the Health Inequalities Commission Report

Continue to actively contribute to the health transformation agenda, focusing on ensuring that the patient and public voice has an opportunity to be heard and to help explain matters to the public in plain English

Develop our activity around social care particularly around the upcoming changes in home care and day care services

Plan to trial a targeted approach to Healthwatch Oxfordshire activity across a single geographic community

Continue to develop our engagement with patient participation groups and locality forums and respond to what we are hearing about the concerns facing patients accessing GP services

Continue to raise our profile across the county

Plan our annual conference for the voluntary sector to be held on 7th February 2017 focussing on health and social care transformation in Oxfordshire

healthwatch Oxfordshire

Activity update, April to October 2016

What do we do?

Healthwatch Oxfordshire was set up on April 1 2013, as a result of the Health and Social Care Act 2012. Healthwatch Oxfordshire sits alongside 151 other local Healthwatch across the country.

Healthwatch Oxfordshire hears what children, young people and adults have to say about health and social care services, whether that is praise, criticism or ideas for improvement. We strengthen the collective voice of patients and the public, so that service providers and commissioners listen to what they have to say.

We then hold them to account on how they use the information we provide to shape, inform and influence service delivery and design.

Outreach

Healthwatch Oxfordshire maintains a busy programme of attending events across the county, ranging from community play days, markets, conferences, and even a football match at the Kassam Stadium, home of Oxford United, where we were able to speak to men about their health concerns.

Reaching people

Since April we have spoken to at least 400 individuals and 16 organisations about their experiences of health and social care services in Oxfordshire.

The main recurring themes we have been hearing included:

- Support and waiting times for people with mental health problems
- Waiting times and access to make an appointment with a GP
- Praise for many individual GP surgeries
- Long waits for some hospital outpatient services such as cardiology
- Poor communications from hospitals

Contact us

By phone: 01865 520 520

By email: hello @healthwatchoxfordshire.co.uk

Online
www.healthwatchoxfordshire.co.uk/share-your-experiences

Write to us:

Healthwatch Oxfordshire

The Old Dairy, High Cogges Farm

High Cogges, Witney OX29 6UN

Facebook: www.facebook.com/HealthwatchOxfordshire

Twitter: @healthwatchOxon

healthwatch Oxfordshire

Reports

Healthwatch Oxfordshire researches and writes reports on current issues in the local health and care services, and also supports other organisations to do the same.

So far this year, we have published reports on:

Experiences of using Minor Injuries Units in Oxfordshire. This report found that in general people were happy with the service they received from these units and were using them appropriately. However, we recommended that better signposting was needed to raise awareness of these units.

Gypsy and Traveller Community Experiences of Healthcare in Oxfordshire. seAp was awarded a grant from Healthwatch Oxfordshire to carry out a project looking into how members of the Gypsy and Traveller community in Oxfordshire access health services, and their experiences of the NHS. The project also looked at the experiences of the health professionals who treat and support the travellers to understand better the issues from their perspective.

Primary health care services for refugees, asylum-seekers and vulnerable migrants in Oxford city. This report was produced with the support of Healthwatch Oxfordshire, and explored the primary healthcare needs of asylum-seekers, migrants and refugees in the city of Oxford, as there was anecdotal evidence that this group, were among those facing the greatest barriers in accessing services. This group, one of the most marginalised and disadvantaged in society, also tends to live in the most deprived areas.

All reports are available online at http://healthwatchoxfordshire.co.uk/

Annual report

Healthwatch Oxfordshire's annual report was published in June and outlines our activities for the financial year 2015/16.

The report highlights how we have contributed to improvements in local health and social care services, through the publication of reports on **Dignity In Care**, and **Improving Discharges from Hospital**.

The full report is available on our website or we can send you a paper copy on request.

Join our mailing list

www.healthwatchoxfordshire.co.uk/join-our-mailing-list

Looking ahead

We have a workplan in place to enable us to fulfil our mission and work towards our vision, we will:

* Find out about local people's experiences of using local health and social care services.
* Use information about local people's experiences to provide independent and informed advice to relevant local and national organisations about how local services need to change.
* Help to hold those in charge of local health and social care services publicly to account for their agreement to improve services, and to formulate policy and strategy, in line with our advice.
* Provide advice and information to individuals about access to local care services.

Forthcoming work is planned to include a project to assess the affect on services of cuts by Oxfordshire County Council. We sit on the Health And Wellbeing Board, Health Improvement Board, Transformation Board, and Townlands Stakeholder Reference Group.

In addition to reporting to the Health Overseeing and Scrutiny Committee, we will continue to act as the Healthwatch Thames Valley representative on the BOB STP Leaders Group and NHS Thames Valley Priorities Committee, and CQC Quality Surveillance Group.

Oxfordshire
Clinical Commissioning Group

A report for Health Overview and Scrutiny Committee

Primary care in Oxfordshire

October 2016

1. Purpose

The purpose of this paper is to provide an overview of general practice in Oxfordshire and to note the work that is being undertaken to ensure sustainability of General Practice. A summary of recent changes to General practices is also provided.

2. Background

The GP Forward View published by NHS England in April 2016 reiterated the importance of general practice at the heart of the NHS. It emphasised that, with a growing and aging population with complex and multiple health conditions, a personal and population-orientated primary care is central to any country's health system.

Oxfordshire currently has around 600 GPs and 300 other clinical staff working in 72[1] general practices, with a total of around 720 000 patients on their collective lists. Practices are grouped into six localities (City, North, Northeast, South East, South West, and West). They, along with the majority of the rest of healthcare in Oxfordshire, are commissioned by Oxfordshire Clinical Commissioning Group (OCCG), of which all 72 practices are members. These practices are contracted to be open to their patients from 8am to 6.30pm. Outside these hours we currently contract Oxford Health Foundation Trust to deliver out of hours services.

Primary care is largely commissioned on a 'practice list' basis, which means that GPs receive an annual amount of money for serving their registered patient list. A smaller proportion of practice funding is linked to specific outcomes and initiatives, for example the Quality Outcomes Framework, enhanced services and local improvement schemes. The vast majority of practices are run as partnerships, receiving commissioning income and premises reimbursement from the NHS and employing their own staff.

Whilst GP practices are independent contractors, the vast majority of Oxfordshire practices are also members of one of four GP federations. These federations provide patient services at scale (e.g. local urgent care hubs, home visiting and care navigator services). GPs are often also contracted to support the provision of a broader range of health services, such as the county-wide out-of-hours service, and medical support for community hospitals and care homes.

[1] *CCG data 1 Oct 2016*

Oxfordshire CCG took on delegated responsibility for the commissioning of general medical services from NHS England on 1st April 2016. However other primary care services still commissioned by NHS England are also key to the delivery of primary care to the population of Oxfordshire. They include[2] 118 pharmacies, 81 high street dental practices and 67 high street opticians.

3. Primary care delivery in Oxfordshire

3.1. GP Access survey

The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices[3]. The most recent data collection is based on the July 2016 GPPS publication. This combines two waves of fieldwork, from July to September 2015 and January to March 2016, providing practice-level data. In Oxfordshire CCG, 20,571 questionnaires were sent out, and 8,718 were returned completed. Feedback was positive from patients with Oxfordshire CCGs results being better than the national average in all but one of the domains.

Survey questions	% who answered	CCG result	National result
Overall, How would you describe your experience of your GP surgery?	very good / fairly good	90%	85%
Generally how easy is it to get through to someone at your GP surgery by phone?	very easy / fairly easy	79%	70%
How helpful was the receptionist?	very helpful / fairly helpful	88%	87%
Last time you wanted to see or speak to a GP or nurse from your GP surgery, were you able to get an appointment to see or speak to someone?	yes / yes, but I had to call back closer to or on the day	89%	85%
How convenient was the appointment you were able to get?	very convenient / fairly convenient	93%	92%
How would you describe your experience of making an appointment	very good / fairly good	80%	73%
How do you feel about how long you normally have to wait to be seen?	they didn't wait too long	57%	58%
Did you have confidence and trust in the GP you saw or spoke to?	Yes definitely / Yes, to some extent	97%	95%
Did you have confidence and trust in the nurse you saw or spoke to?	Yes definitely / Yes, to some extent	98%	97%
How satisfied are you with the hours that your GP is open?	very satisfied / fairly satisfied	77%	76%

[2] NHS E data Oct 2016

[3] Ipsos MORI administers the survey on behalf of NHS England and more information can be found at https://gp-patient.co.uk/

3.2. Quality and outcome framework (QOF)

The QOF was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. The objective of the QOF is to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients. The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice. This Quality and Outcomes Framework (QOF) publication[4] provides data for the reporting year 1 April 2015 to 31 March 2016.

Oxfordshire GP practices achieve better quality for their patients compare to the national average.

	Oxfordshire CCG average	England average
Total achievement	97.5%	95.3%
Clinical domains totals	97.7%	95.2%
Public Health domains totals	98.2%	98.3%

3.3. Compliance with Care Quality Commission (CQC) Standards

Registration with the CQC means that a GP practice is making a legal declaration that they meet all the CQC standards of quality and safety. Once a practice is registered, the CQC has a duty to monitor and inspect the service to make sure the practice is compliant with these standards. Where a practice is non-compliant the CQC has a range of sanctions, including withdrawing registration. The role of the CQC is to ensure that practices in England provide people with safe, effective and high-quality care, and to encourage them to make improvements. The CCG works closely with the local CQC representative to share intelligence and promote best practice.

The table below compares England performance with Oxfordshire performance. (Up to 30 September 2016)

Rating	England		Oxfordshire CCG		
	No of practices*	%	No of practices*	%	% difference
Outstanding	180/4827	4%	3/44	7%	+3%
Good	4013/4827	83%	35/44	79.5%	-3.5%
Requires Improvement	500/4827	10%	6/44	13.5%	+3.5%
Inadequate	134/4827	3%	0/44	0%	- 3%

*No of practices with rating over the number of practices inspected

[4] http://content.digital.nhs.uk/catalogue/PUB22266

4. Pressures on primary care

There has been much identified nationally about the pressures on General Practice and the sustainability of the current model going forward[5] . Oxfordshire practices offer about 4 million appointments each year which may be delivered as face-to-face, telephone, or home visit consultations, by GPs, nurses, and other clinical staff. This accounts for about 70% of patient contacts with healthcare in Oxfordshire. This number is currently increasing at the rate of about 4% a year and is likely to increase further as a result of a growing and aging population. The practices are responsible for the majority of urgent appointments, prescribing, long-term condition (such as diabetes or asthma) care, end-of-life care, continuity of care, and co-ordination of care for complex patients. As such, they face challenges common to general practices across the UK, including:

- Increasing need from patients requesting same-day access for urgent care, who are generally low-intensity patients;
- Increasing need from complex, frail, or elderly patients who require continuity and co-ordination of care, who are generally high-intensity patients;
- Worsening practice sustainability due to rising costs, difficulty in recruiting or retaining staff, need to update premises and other infrastructure, and retirement of older GPs;
- Proliferation of patient contacts and multiple patient records across various organisations (general practice, hospital, mental health services, community health services, social care, and so on), leading to delays and gaps in communication, and greater difficulty in understanding and co-ordinating how care is delivered to the patient.

5. Investment for a Sustainable and Transformational Primary Care

In 2016/17 the CCG allocated an additional £4M to support a sustainable primary care The CCG six localities were asked to submit proposals for spend against the £4million allocation to support a sustainable and transformational primary care. Following a review of the financial recovery plan by the extra ordinary CCG Board held on 25 August 2016, the following investment in primary care for 2016/17 was agreed in line with the business case presented to the Oxfordshire Primary Care Commissioning committee (OPCCC) in August 2016. Full year funding will be available for 2017/18.

Scheme	Locality	Budget for October 16 – March 17
Home visiting service	North, North East, South West, West	£407,403
Care Navigator and Social prescribers	Oxford City	£145,763
Practice Sustainability and working at scale scheme	Oxford City	£472,193
Guaranteed access to	South East	£182,000

[5] The Kings Fund, Understanding pressures in general practice. May 2016

routine appointments		
Enhanced long term conditions management	South West	£36,000
Improving GP access	South West	£125,702
Increase in appointments from hubs	North, North East, West	£354,844
	Total	£1,723,905

6. General Practice Access Fund (GPAF)

As a result of a successful application to the Prime Ministers Challenge Fund in March 2015, the CCG has been invited to be an early participant in the Access Fund. The GP Access Fund will fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

The new national requirements include

- weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.
- a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

The CCG is working with practices and Federations to ensure delivery of extended access for the population. There will be mixed delivery models across the CCG with some additional appointments provided at locality level possibly through an access hub or out of hours service and some will be provided through practices although not necessarily the patient's own practice. Patients will not necessarily see their own doctor. The patient's own practice will book the extended hour appointment at the practice/hub offering the service. Some services will be in place from 1 November 2016 with full service delivery by 31 January 2017.

7. Vulnerable Practices

Quality and primary care team leads are working closely with 11 practices currently assessed as vulnerable either due to recruitment difficulties, CQC inspection at requires improvement or quality issues. Funding from the national team has been provided for 'expert' practice management support, away days for the practice to explore new ways of working, training sessions with staff and facilitation costs. From 1 November 2016

the vulnerable practice scheme is being replaced by the General Practice Resilience Programme.

8. GP Fellowship Scheme

The first GP Fellow has been appointed and will start in November 2016. The appointee will work in practices requiring support on a series of 6-monthly placements as well as working with a federation for service redesign.

9. Patient Voice on future plans for primary care

The CCG has a Primary Care Patient Advisory Group (PAG) which has a patient representative as chair; links from each of the localities and also a representative from Healthwatch. The Primary care PAG met regularly with the Head of Primary care and Localities for the CCG. It has recently been asked to comment on the care closer to home strategy, the draft visions and outcomes for primary care in Oxfordshire and how patients could be supported to self-care where appropriate.

10. Oxfordshire Practice changes

10.1. Merger of Victoria House Surgery and Langford Medical Practice, **Bicester** The merger of these two practices was affected on 1 October 2016 and the new practice has been named Alchester Medical Group. The practice has confirmed that services will continue to be delivered from both the Victoria House and the Langford premises for the time being. Any changes to longer term location of care will be made following the outcome of the NHS England Estates & Technology Transformation Fund process where a bid for a new site has been put forward.

10.2. North Bicester Surgery: Following a decision by the practice to terminate its contract, the practice closed on 30 September 2016 and the patient list has been dispersed to neighbouring practices. At the beginning of September it appeared that less than half the patients had re-registered with an alternative practice. As a result the remaining patients were contacted again urging them to re-register as soon as possible (see Appendix 1)

10.3. Deer Park Medical Practice, Witney: Following an open procurement process which resulted in no provider offering services even at a premium price, Deer Park Medical Practice will close on 31 March 2017 and its patient list dispersed. The CCG is working with the practice and its patients to ensure that the list dispersal is managed in a safe way over the next six months. We will also be working with other practices in Witney to help minimise any impact on services delivered in those practice.

Re-tendering was considered, but, given the lack of response to this procurement it was considered that a further process was not likely to produce a different result. No local practices had bid for the contract and there was no option for a merger with another practice. In the absence of any other alternative, the only available option was to close

the practice and to ‘disperse’ the patient list (this is asking patients to register with another practice who are still accepting patients). Ahead of the decision, other local practices were consulted on a confidential basis to confirm that there would be sufficient capacity to absorb the patients in a safe and managed way.

The PPG has been very unhappy with the lack of engagement and consultation on the closure and list dispersal. There has been coverage in the Witney Gazette, Oxford Mail and a petition has been started to halt the closure. The CCG has met with the PPG and explained the reasons for not engaging / informing them sooner and the reasons behind the closure. The reasons relate to the ‘commercial in confidence’ nature of the procurement process. The CCG has also presented to the West Oxfordshire District Council Economic Overview and Scrutiny Committee and its subsequent working party on the Deer Park closure. Examples of the CCG communications to patients and stakeholders can be found in Appendix 2 and 3.

10.4. Kennington Health Centre

The GPs at Kennington Health Centre have had difficulty in recruiting permanent new doctors due to a national shortage of GPs and the high workload in the practice. There are also continued increases in the work expected from GPs and the complexity of running the business side of the surgery which increase the pressure on GP partners further.

While the doctors at the surgery remain very committed to providing high quality patient care, they have reluctantly given notice to Oxfordshire Clinical Commissioning Group (OCCG) to terminate their contract to provide medical services at the surgery as they feel unable to continue to maintain the current workload.

The GPs want to continue to provide medical care to their patients without having to run the business side of the practice. This will enable the GPs to concentrate on providing clinical work while the administrative and business roles are undertaken by another provider. The GP partners have written to patients to reassure them it will be business as usual at the surgery, and that patients will continue to receive support, advice and a high level of care from doctors and all practice staff over the coming months while an option for the future is sought.

OCCG is looking at a range of options on ways to continue providing GP services at the surgery; as part of this it has started discussions with nearby practices about one of them delivering services from the Kennington Health Centre site. This option could allow current GPs at the practice to focus exclusively on providing patient care.

OCCG and practice GPs have met with the surgery’s patient participation group (PPG) whose members recognise the way health services are delivered at the practice needs to change. They will be kept fully informed on developments over the coming months. The PPG have also inputted to the letter sent to all patients of the practice.

10.5. Horsefair Surgery
The partner GPs at Horsefair Surgery in Banbury are now in the final stages of arranging a new partnership arrangement with a commercial company. This means the practice will be able to continue providing services to patient's long term despite going through a difficult stage of being unable to recruit to posts left vacant as a result of retirement and ill health.

However the partners at Horsefair consider that continuing to provide a service across two sites would put the practice at risk. They have therefore requested approval to close the branch surgery at Middleton Cheney. As a result, the CCG has asked the practice to engage with patients to ensure the impact is clearly understood and arrangements are put in place to ensure everyone has access to GP services either at Horsefair's main surgery or another local practice.

10.6. Oak Tree Health Centre, Didcot: The practice has applied to reduce its practice boundary in order to ensure that it has capacity to absorb planned growth close to the practice. This was agreed, subject to formal agreement between practices in the locality about how the anticipated growth will be shared which has now been received.

10.7. A sustainable primary care in Banbury
Banbury practices have been especially affected by difficulty in recruitment over the last 6 months and as a result many have GP vacancies. One practice has its list closed to new patients, two practices are on the CCG vulnerable practices list, two practices have applied to the CCG to close their lists and one has requested reducing its boundary. All practices are reporting recruitment of GPs is extremely difficult and are looking at other ways to skill mix. The large amount of housing development is also having pressure on the practices in Banbury.

The CCG has been working with the practices to understand these pressures and develop novel ways of assisting the practices. One of the areas that is hugely time heavy is patients moving between practices. It has been agreed that Banbury patients should be encouraged not to change practices and we are supporting a process whereby inter practice transfers will only happen in exceptional circumstances. These might include the patient moving house or relationship issues with the practice. This action was proposed by the North Locality GPs as a means to avoid the need to close the lists of a further two practices and better equalise pressure and risk. The Banbury Health Centre non registered patients will continue to offer some flexibility.

11 Next steps

Primary care is being considered as part of the Oxfordshire Healthcare transformation programme. It is likely that the model of delivery will have to change in order to provide a sustainable primary care that can continue serving the population into the future. New models of delivery are likely to be through better skill mix and through alternatives to face to face appointments where appropriate. The changes will be part of the Oxfordshire Healthcare Transformation Programme.

Julie Dandridge
Deputy Director. Head of Primary care and Localities

Diane Hedges
Chief Operating Officer / Deputy Chief Executive

1 November 2016

Appendix 1

Dr Andrew Gibson
Surgery
Dr Brendan McDonald
Dr Anna Watkinson

Julie Ford - Practice Manager

North Bicester

Bure Park
Bicester
Oxon OX26 3HA

Tel: 01869 323600
Fax: 01869 323300

Date

Title Firstname Surname
Address 1
Address 2
Town
County – Postcode

Dear Patient,

URGENT: Your doctor's surgery is closing. Please register with a new doctor now:

We wrote to you on 22 July 2016 to inform you that North Bicester Surgery is permanently closing on Friday 30 September. You will not be able to contact anyone at the surgery after this time.

According to our records you have not yet registered with another GP Practice. It is important that you now register elsewhere, so if you become ill, you are registered with a GP practice and can be seen quickly.

If you do not register with another practice by 30 September 2016, then your medical record will be held by NHS England until you register with a new practice. Please note that if you transfer after this date, the transfer of your medical records may take longer.

There are four other GP practices in Bicester, ready to welcome new patients, including;

- The Health Centre, Coker Close, Bicester. Tel: 01869 249 333
- Langford Medical Practice, Nightingale Place, Bicester. Tel: 01869 245 665
- Montgomery House Surgery, Piggy Lane, Bicester. Tel: 01869 249 222
- Victoria House Surgery, Buckingham Road, Bicester. Tel: 01869 248585.

Registering with a new GP practice is simple. You can visit the practice of your choice and complete a form. You will need to bring a form of identification with you, such as a passport or

driving licence. You can collect a registration form from North Bicester Surgery and complete it before handing it in at your new chosen practice.

To find out more about GP practices in your area visit the NHS Choices website at www.nhs.uk If you need further support in finding a practice, contact the Patient Services Team at Oxfordshire Clinical Commissioning Group on 0800 052 6088.

If you have recently registered with another practice, please ignore this letter, your records will be transferred as soon as possible to your chosen practice.

The decision to close the practice has not been taken lightly and we would like to thank you, our patients, for the loyalty you have shown us and the good relationships we have built with you over the years.

We are working with Oxfordshire Clinical Commissioning Group (the OCCG) to help support all of our patients during this period of change.

We thank you for your support and wish you well for the future.

Yours faithfully

Dr Andrew Gibson Dr Brendan McDonald Dr Anna Watkinson

Partners of North Bicester Surgery

North Bicester Surgery
Information about Surgery Closure

Why is North Bicester closing?
The practice has had to take this action as a result of the continued decrease in national funding which still has a further five years of cuts to run. The three doctors have spent the last two years exploring all options for the future but on the advice of their accountant have decided that changes in the national GP contract have made the practice financially unviable and unable to recruit new doctors.

When is North Bicester Surgery closing?
North Bicester Surgery is closing on 30 September 2016.
You will continue to receive full medical care while you remain registered at the surgery.

Will I need to register at a new practice?
Yes. North Bicester Surgery will continue to provide medical care until it closes on 30 September 2016. You can register at a new practice at any time. *You will not be automatically registered at a new surgery.*

Choosing a new GP practice
There are four other GP practices in Bicester. They are aware that patients from North Bicester Surgery will be looking to register with a new GP practice and are ready to welcome new patients.

The Health Centre Coker Close Bicester, Oxfordshire, OX26 6AT Tel: 01869 249333	**Victoria House Surgery** 119 Buckingham Road Bicester, Oxfordshire, OX26 3EU Tel: 01869 248585
Montgomery-House Surgery Piggy Lane Bicester, Oxfordshire, OX26 6HT Tel: 01869 249222	**Langford Medical Practice** 9 Nightingale Place Bicester, Oxfordshire, OX26 6XX Tel: 01869 245665

How to find out about alternative GP practices
To find out about the closest GP practices in your area you can visit the NHS Choices website where you will find more information on these practices. Bicester Library can help patients who don't have online access and family and friends can offer advice too. If you need further support in finding a practice, you can contact the Patient Services Team at Oxfordshire Clinical Commissioning Group on 0800 052 6088.

How to register at a new GP practice.
You will need to complete a form to register at a new practice. You will need to visit the practice to collect and complete this form.

What will happen to my records and paperwork?
Your medical records will automatically transfer to your new surgery when you register.

Hospital and Out Patient arrangements.
Please remember to tell any hospitals you visit that that you have a new GP so that letters are correctly addressed.

What happens if I forget to register at a new surgery?
If you forget to register at a new surgery you will no longer have a GP after the 30 September 2016. Your records will be returned to a central register until called for by your new surgery when you do register.

What will happen to North Bicester Surgery staff?
Staff at North Bicester Surgery will be made redundant on the 30 September 2016. The surgery will work with all their staff to assist them; some have already secured new positions. The doctors are either retiring or pursuing other interests

What role does the NHS take in assisting the closure of Bicester Surgery?
North Bicester Surgery will work with Oxfordshire Clinical Commissioning Group (OCCG) and NHS England South (South Central) to ensure the smooth transfer of patient care and records and help patients with locating and choosing an alternative practice to move to. If you have any questions regarding the closure of North Bicester Surgery you can contact the Patient Services Team, Oxfordshire Clinical Commissioning Group on 0800 052 6088.

Appendix 2 – Briefing sent to Councillors and on CCG website

Update on Deer Park Medical Practice, Witney

Following an unsuccessful procurement process Deer Park Medical Practice will close on 31 March 2017 and its patient list dispersed. Oxfordshire Clinical Commissioning Group (OCCG) will work with the practice and its patients to ensure that the list dispersal is managed in a safe and orderly way over the next six months. We will also be working with other practices in Witney to help minimise any impact on services delivered in those practices.

All efforts have been made to secure services at Deer Park Medical Centre. The contract with Virgin Care to provide GP services at Deer Park Medical Centre, Witney, was due to expire in November 2016. OCCG and NHS England (NHSE) went through a procurement process for a new contract in March 2016. The contract value was offered at a significantly higher price than that paid to other practices in Oxfordshire as it was recognised that as an Alternative Provider Medical Services (APMS) type contract there was a shorter payback time due to a defined contract length (General Medical Services – GMS contracts are contracts in perpetuity). However, following evaluation, OCGG and NHSE was not able to award a contract.

The decision not to award the contract was taken at the Oxfordshire Primary Care Commissioning Committee which is responsible for primary care issues. Following delegation of responsibility from NHS E for primary medical services and in line with national requirements, the CCG Board does not make decisions on primary care.

Following discussions between the provider Virgin Care, OCCG and NHSE, the contract has been extended for a limited period until 31 March 2017. This will allow time for patients to choose and register with a new GP practice and to allow the three remaining GP practices in Witney which have offered to take on the care of the Deer Park Medical Centre patients, to put arrangements in place to accommodate them.

OCCG and NHSE considered re-tendering, but, given the poor response to this procurement it was considered that a further process was not likely to produce a different result. No local practices had bid for the contract and there was no option for a merger with another practice. In the absence of any other alternative, the only available option was to close the practice and to ‘disperse’ the patient list (this is asking patients to register with another practice which is still accepting patients). Ahead of the decision, other local practices were consulted on a confidential basis to confirm that there would be sufficient capacity to absorb the patients in a safe and managed way

The particular challenges to the sustainability of small practices are well documented e.g. in the Nuffield Trust report *Securing the Future of General Practice* the need to develop larger-scale organisations is identified as a pressing priority for primary care. In Oxfordshire, it is noticeable that the number of smaller practices is declining steadily as they have either merged with other practices or closed over the past few years.

OCCG and NHSE have met with the practice patient participation group and will continue to meet with them over the next six months. A letter has been sent to patients registered at the Deer Park Medical Centre to update them on the current situation.

A letter to patients reassures them that the practice will remain open until the end of March 2017 and they do not need to take any action at the moment. A further letter will be sent to patients early in the New Year with more detailed information about registering with a new practice.

For further information please contact Julie Dandridge, Deputy Director Delivery and Localities, Head of Primary Care at Oxfordshire Clinical Commissioning Group julie.dandridge@oxfordshireccg.nhs.uk or call 01865 336861.

Appendix 3 – letter sent to patients of Deer Park Medical Centre

Oxfordshire
Clinical Commissioning Group

To all patients of the Deer Park
Medical Centre, Witney

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

Telephone: 01865 336800

22nd September 2016

Dear Patient,

Re. Future of the Deer Park Surgery

As you may be aware, the contract to provide GP services at Deer Park Medical Practice was recently put out to tender as it was due to expire. Unfortunately, despite prolonged negotiations no contract was awarded and having considered all possible alternatives Oxfordshire Clinical Commissioning Group (CCG), supported by NHS England, have decided to close the practice. We understand that this decision will be distressing to patients of Deer Park, but we feel that this is the only realistic option available.

Please note that you do not need to do anything at this stage. We have recently agreed with Virgin Care that the current contract can be extended until **31st March 2017** in order to ensure that all patients have plenty of time to choose and register with another practice. This will also enable other local practices to be fully prepared for receiving new patients when Deer Park closes. This means that you can continue to be seen by your GP at the Deer Park surgery where services will continue as usual.

We will be writing to you again in **January 2017** to provide you with more detailed information about other local practices and how to register with them. During this period of change, Oxfordshire CCG and NHS England will continue to work with the Deer Park practice and the Patient Participation Group to support all of our patients, including

providing you with all the information, advice and support that you will need to find an alternative practice and, when you move practice, ensuring the smooth transfer of your care and your patient records.

Oxfordshire CCG is also working closely with the three other GP practices in Witney, all of whom have confirmed they are very keen to take on new patients. The Windrush Medical Practice, Nuffield Health Centre and Cogges Surgery have all confirmed they will have plenty of capacity to welcome new patients.

Although there is no immediate need for you to change practices, if you would like to find about the closest GP practices in your area you can visit the NHS Choices website via http://www.nhs.uk/Service-Search/GP/LocationSearch/4 to find a list of practices and contact details. Alternatively, you can contact the **Patient Services Team** on **0800 052 6088** who will be able to give you information about GP practices closest to where you live and will also be able to answer any questions you have regarding the closure of Deer Park Medical.

If you would like to discuss this with a patient representative from your practice, the Chair of the Deer Park Patient Participation Group, Mrs Brenda Churchill, can be contacted on 01993 704752.

Yours faithfully

Diane Hedges

Director of Delivery & Localities

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: Thursday 17 November 2016

Title of Paper: Update on the Oxfordshire Transformation Programme

Purpose: To provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on the Oxfordshire Transformation Programme

Senior Responsible Officer: David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group

1. Introduction

The following paper provides an update on progress of the Oxfordshire Transformation Programme.

2. Background

The NHS in Oxfordshire performs well compared to other parts of the country. However, like the rest of the country, the current health and social care system faces a number of challenges.

Changes in people's health and longer life expectancy mean that the county's health services are facing demand on a scale not seen before. In addition, those people living in Oxfordshire's most deprived communities often experience more ill health and worse outcomes than people living in more affluent areas. We are also facing real challenges recruiting high quality NHS staff and maintaining high quality estates and facilities.

While the amount of money received for the NHS locally is increasing year on year, the cost of delivering services is growing at a faster rate. The local NHS needs to be able to cope with the significant increase in activity within the budget available.

The Oxfordshire Transformation Programme is taking a collaborative 'whole system'[1] approach which recognises the interdependencies between primary, community and acute care.[2]

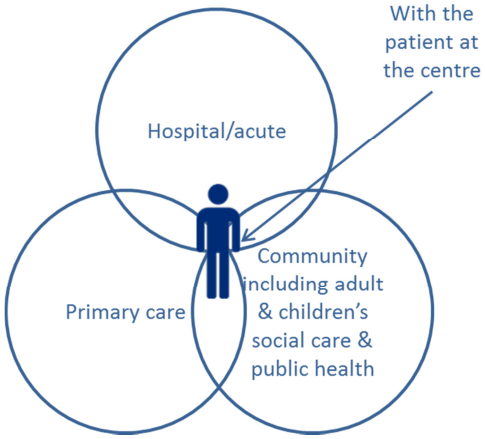

Figure 1 - **Diagram showing the whole system scope of the Transformation Programme**

To support this, six clinical workstreams and five enabling workstreams were established to engage partners from across the health and care system in considering change.

[1] Oxfordshire Transformation Board membership includes local NHS organisations, Oxfordshire County Council, Healthwatch and patient representative.

[2]The programme does not, however, include NHS England services commissioned under **national contracts** such as high street dental practices, high street opticians with a contract to provide NHS general ophthalmic services, or community pharmacy services. (Although it *does* include any locally commissioned services from community pharmacy and opticians.)

Clinicial Workstreams

- Integrated Frail Older People and Urgent and Emergency Care for the adult population
- Mental Health, Learning Disabilities and Autism
- Elective (planned) care
- Maternity Services
- Children and Young People's services
- Primary Care

Enabling Workstreams

- Public Health / Prevention
- Quality
- Finance and Activity
- Supporting functions (e.g. Information Management and Technology (IM&T), workforce, estates)
- Consultation and Engagement

Each of the clincial workstreams have proposed a vision for how services can be improved and have developed plans to turn the vision into reality. In several cases, they have already started to make improvements.

There are two areas where the Transformation Programme's proposals could result in signficant service change:

1. Acute Hospital Services

Changes are proposed in four areas:

- Urgent and Emergency Care, including:
  - emergency and critical care facilities
  - stroke care
  - changes to bed numbers in order to move to an ambulatory[3] model of care
- Planned Care (Elective Care, Diagnostics and Outpatients)
- Maternity Services
- Children's Services

2. Community Hospital Services

The Transformation Programme is developing new models of care in community settings that are expected to result in:

- More people being supported in their own homes and less reliance on inpatient beds in supporting rehabilitation after treatment;
- More consistent urgent care in local settings.

These changes are likely to impact on what services are required in community hospitals in the future. It is therefore expected that some of the options for delivering those changes will result in specific proposals for change in relation to the community hospital infrastructure across Oxfordshire.

[3] **Ambulatory care** is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation. This care can include advanced medical technology and procedures. **Ambulatory care** means patients are treated without the need for a hospital admission or an overnight stay in hospital

In June this year, Oxfordshire's NHS also embarked on 'The Big Health and Care Conversation', via a series of county wide events; discussion groups; focus groups; meetings and a public survey. The NHS asked the public's views on how care can be delivered differently while still providing the best care, the best health outcomes and the best value for people living in the county.

We have used various methods to engage with patients and the public to raise awareness of the case for change and to get them involved in the development of proposals to help transform the way health is delivered in the county. A detailed report on the engagement undertaken including key themes is available on the Oxfordshire Transformation Programme Website: www.oxonhealthcaretransformation.nhs.uk

Highlights of activity undertaken are outlined below:

- 6th June 2016 stakeholder event - official launch of the public engagement (over 100 people attended).
- Big Health and Care Conversation Roadshows held in Banbury, Oxford, Wallingford, Bicester, Witney, Wantage, Abingdon and Henley (over 400 people attended).
- Smaller displays were set up in Thame, Farringdon and Didcot.
- Online and hard copy survey (over 200 responses).
- Online survey undertaken with Oxford University Hospital NHS Foundation Trust foundation trust members in the north of the county, South Northamptonshire and South Warwickshire specifically around services at the Horton General Hospital (233 responses).
- Two options development workshop for community hospitals.
- Presentations and feedback at stakeholder meetings incl.: Age UK, Carers Oxfordshire, 6 x OCCG Public Locality Forums, Community Groups.
- MP, County and District Councillor briefings / feedback sessions.
- Dissemination of the 'case for change' leaflet across Oxfordshire.
- Receiving and responding to over 200 letters.
- On-going media programme to promote the case for change including proactive briefings and advertising of events.
- Two focus groups on maternity (Oxford & Banbury).
- Four focus groups with students in Henley, Abingdon and Witney to explore prevention / self-care / primary and urgent care.
- A session with the CCG's primary care patient advisory group.
- On-going meetings / briefing and feedback sessions with community and patient groups.
- On-going outreach with hard to reach groups.

3. Public Consultation on Oxfordshire Transformation Proposals

Given the challenges outlined above, proposals will include substantial changes not just in how care is delivered, but in the number and location of sites from which it can be provided; while ensuring services are safe, of high quality, affordable and can be staffed appropriately.

We are reviewing the in-patient beds we have in the community and in our hospitals, with a balance to be made between having high quality specialist services all on one hospital site and what facilities are provided from the eight community hospitals across Oxfordshire. Similarly, we are looking at how maternity services can be delivered safely and sustainably across the county.

We are going through a process of assurance before we can go to public consultation. Our draft proposals are now being reviewed by the Thames Valley Clinical Senate to ensure the clinical care we are proposing is supported by evidence of good practice, is viable for the long-term and provides good outcomes for people. We also have to go through the NHS England Assurance Process for proposed service change. Following this the Board of Oxfordshire CCG have to determine if we have undertaken sufficient engagement and have a robust business case to support consultation.

The Secretary of State set out four key tests for service change within the revised Operating Framework for 2010-11, which are designed to build confidence in the NHS with staff, patients and communities. For service reconfiguration proposals it must be demonstrated that there is:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

In the event we and NHS England are confident we have undertaken sufficient preparation the public consultation on a set of proposals for changes to health services in Oxfordshire is planned to start [4] at the beginning of January 2017. However the consultation will now be in two parts.

The first part will focus on those areas where there are the most pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have been made) or where the proposed changes have been piloted.

This includes:

- **Critical care facilities**
- **Stroke care**
- **Changes to bed numbers** in order to move to an ambulatory model of care (see footnote 3 above)
- **Maternity services**: including Obstetrics, Special Care Baby Unit (SCBU) and configuration of midwife led units in the north[5].

Also included will be proposed changes to the delivery of **Planned Care** services at the Horton General Hospital (including elective care, diagnostics and outpatients). These proposals have the potential to significantly improve the services available to patients in north Oxfordshire.

[4] The start date is dependent on the NHS England Assurance Process
[5] Some options could impact on emergency gynaecology surgery at the Horton General Hospital

The second part, which is hoped will take place later in May 2017, will focus on proposed options for the reconfiguration of other services in two groups:

Acute Services:

- Emergency Care in Oxfordshire;
- Children's Services including the current processes for assessment and the provision of in-patient paediatric beds.

Community Hospitals:

This will include all current service to be provided in community hospitals, including the future configuration of midwife led units in south Oxfordshire.

Further work and engagement with our GP Practices to develop options has been undertaken over the past few months and it has become clear that our proposals for community based care will benefit from continued development with a wide range of stakeholders prior to us launching a public consultation on any service change. Over the coming months more engagement with local groups across the county will be undertaken as well as further options development work with public and patients. We would invite the HOSC to advise us how they would like to be involved in this work.

Due to the risk of Legionella inpatient beds at Wantage Community Hospital will remain temporarily closed irrespective of the expected delay to the consultation on community hospital services. Regular legionella readings continue to be taken and the risks have not changed. To remedy the legionella issues would cost in excess of £300k and until we are confident of the future model of care and the role of Wantage Community Hospital, this expenditure may not be a good use of public funds. Maternity and physiotherapy continue to operate at the hospital.

A plan for the public consultation is currently being drafted and this will be shared with NHS England. The draft plan is attached at the end of this paper in Appendix 1 and views from HOSC members are invited.

No decisions have been made and will not be taken until the public consultations have been completed and final proposals are put to Oxfordshire CCG Board.

Appendix 1

NHS
Oxfordshire
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Oxfordshire Transformation Programme:

Health & Care Consultation Plan

DRAFT

Authors	Ally Green & Sarah Adair, Heads of Communications & Engagement
Status	V1 V2 – 1/11/2016
Approved by: Date	
Distribution	

1. Introduction

This consultation plan sets out the approach to be taken by Oxfordshire Clinical Commissioning Group (OCCG) in consulting with the public and stakeholders about changes to health services proposed in the Oxfordshire Transformation Plan.

2. Background

The NHS in Oxfordshire performs well compared to other parts of the country. However, like the rest of the country, the current health and social care system faces a number of challenges.

Changes in people's health and longer life expectancy mean that the county's health services are facing demand on a scale not seen before. In addition, those people living in Oxfordshire's most deprived communities often experience more ill health and worse outcomes than people living in more affluent areas. We are also facing real challenges recruiting high quality NHS staff and maintaining high quality estates and facilities.

While the amount of money received for the NHS locally is increasing year on year, the cost of delivering services is growing at a faster rate. The local NHS needs to be able to cope with the significant increase in activity within the budget available.

The Oxfordshire Transformation Programme was established to bring NHS partners together to address these concerns and ensure that the people of Oxfordshire have the very best standards of care across the county. So far, the Transformation Programme has carried out a clinical review of services across the county with a particular focus on:

- Maternity and children's services
- Learning disability, mental health and autism services
- Specialist advice and diagnostics (outpatient services and planned operations)
- Urgent and community services
- Primary care

In June this year, Oxfordshire's NHS also embarked on 'The Big Health and Care Conversation', via a series of county wide events; discussion groups; focus groups; meetings and a public survey. The NHS asked the public's views on how care can be delivered differently while still providing the best care, the best health outcomes and the best value for people living in the county.

We have used various methods to engage with patients and the public to raise awareness of the case for change and to get them involved in the development of proposals to help transform the way health is delivered in the county. A detailed report on the engagement undertaken including key themes is available on the

Oxfordshire Transformation Programme Website:
www.oxonhealthcaretransformation.nhs.uk

Given the challenges outlined above, the Oxfordshire Transformation Plan proposes substantial changes not just in how care is delivered, but in the number and location of sites from which it can be provided; while ensuring services are safe, of high quality, affordable and can be staffed appropriately.

The Oxfordshire Transformation Plan has also been developed to address the challenges ahead for the local health services as set out in the five Year Forward View and forms a substantial part of Oxfordshire's contribution to the Buckinghamshire, Oxfordshire and west Berkshire Sustainability and Transformation Plan.

The public consultation on a set of proposals for changes to health services in Oxfordshire is planned to start [6] at the beginning of January 2017. However the consultation will now be in two parts.

The first, which we anticipate will start in January, will look at options for the future delivery of some hospital services including maternity (obstetric and midwife-led in the north and west Oxfordshire), stroke and critical care. It will also review the number of hospital beds that have been temporarily closed, across the Oxford University Hospitals Foundation Trust (OUHFT) hospital sites in Banbury and Oxford, as part of the initiative to reduce delayed transfers of care[7] in Oxfordshire and provide care in a different way.

The second, which is hoped will take place after May 2017, will focus on the provision of emergency departments in Oxfordshire and the proposed options for the reconfiguration of other services provided from our community hospital sites and the development of more local models of urgent care integrated with primary care in the county. This means care will be provided on an outpatient or day basis including diagnosis, observation, consultation, treatment / intervention and rehabilitation services and support; unless treatment in hospital is the best place for a patient at the time. The premise being that 'the best bed is your own bed'.

Further work and engagement with Oxfordshire GP Practices to develop options has been undertaken over the past few months and it has become clear that proposals for community based care will benefit from continued development with a wide range of stakeholders prior to launching a public consultation on any service change. Over the coming months more engagement with local groups across the county will be undertaken as well as further options development work with public and patients.

[6] The start date is dependent on the NHS England Assurance Process
[7] When a patient is well enough to leave a hospital but for a variety of reasons is unable to

The population affected by these proposals are largely in Oxfordshire but for services based at the Horton Hospital, this plan recognises the need to engage with the communities living in south Northamptonshire and south Warwickshire.

A detailed action plan and identification of stakeholders and key audiences underpins this plan.

3. Consultation Principles

Our consultation will meet the following principles, which are based on previous consultations across Oxfordshire and on NHS England guidelines. They are:

1. We are committed to engaging as widely and deeply as possible, and will encourage those who have attended our events to continue to be engaged in our work. We will listen to them and take account of their views.

2. Our leaders will always talk to communities at an early stage to explain our proposals for change as deeply, openly and frankly as they can. They will accommodate local views and contributions, where they will contribute to a better service.

3. We will carry out a full assessment of the likely impact of any changes on communities from a health inequalities point of view, using evidence-based analysis and anecdotal feedback. Any gaps in engagement identified through this process will be filled by means of targeted engagement, such as through focus groups or similar.

4. Engagement events will be held in a variety of areas chosen for their contrasting geography and demography, as well as supplemented by other work to ensure the full geographic and demographic diversity of Oxfordshire (and any neighbouring areas it impacts on) is covered by representative events.

5. We will be open and transparent and will continue to hold meetings in public venues wherever practicable and with an open invitation to the public to attend (recognising that on occasion some management of numbers may be necessary for health and safety reasons).

6. We will make documents public and respond promptly and openly to requests for information. We will make our public-facing documents and presentations accessible, in different formats as required and present them in clear, simple language with proposed changes clearly explained, including what opportunity people have to influence those changes.

7. Our consultation will ask clear questions and provide an opportunity for involvement in the design of new services, so that patient views and experience can be considered alongside clinical input.

8. The programme will make a careful note of specific, individual concerns raised and either follow up with individuals or groups directly, or report back on action taken to resolve them at future events and in future reporting, before key decisions are made.

4. Aims

NHS organisations have a duty to involve patients and the public in:

- Planning the provision of services.
- The development and consideration of proposals for changes in the way those services are provided.
- Decisions to be made by the NHS organisation affecting the operation of services.

Involving patients and the public early on in options development will also help to demonstrate point four of the Secretary of State's four key tests for service reconfiguration set out in the revised Operating Framework for 2010/11: *strengthened public and patient engagement*.

Notwithstanding statutory obligations, involving and engaging will help to:

- Create understanding of the need for change and the case for developing new models of care to transform health and social care services in Oxfordshire.
- Better inform the development of new models of care.
- Enable the Transformation Programme to work in partnership with the public to ensure the successful implementation of any service change projects.

Alongside this, the following aims will apply to the consultation itself:

- Ensure the process, scope and scale of the consultation is of a sufficient level to demonstrate all Clinical Commissioning Group (CCG), NHS England (NHSE), legal and statutory assurance tests have been met.
- Achieve and provide evidence of deep engagement using a range of methods to do this with communities and diverse groups across Oxfordshire and providing a comprehensive log of engagement.
- Meet equality assessments and ensure materials are accessible on request. Ensure that the final decision is developed through genuine engagement and involvement.

5. Stakeholders

OCCG has many stakeholders; in order to ensure consultation activities are tailored around individual stakeholder needs, we will analyse the various audiences. We will do this by identifying groups and / or individuals for each stakeholder as appropriate,

undertaking analysis of the stakeholder's needs so we can understand who we need to communicate with and how.

Below shows the categories for our stakeholders:

- Public (e.g. patients, carers, community and minority groups)
- Internal stakeholders (Oxfordshire CCG member practices and staff)
- Commissioners (e.g. Oxfordshire County Council, NHS England)
- Local Providers (e.g. Oxford Health Foundation Trust, Oxford University Hospitals Foundation Trust, GP federations, pharmacists, independent and voluntary providers such as Age UK and MIND).
- Public Sector Partners (e.g. Oxfordshire County Council, district councils)
- Voluntary & Community Organisations (e.g. Oxfordshire Community and Voluntary Action, Oxfordshire Rural Community Council)
- Professional (e.g. Local Medical Committee, Local Pharmaceutical Committee)
- Political Partners (e.g. MPs, Councillors from parish, district and county councils)
- Scrutiny (e.g. Healthwatch, Oxfordshire Joint Health Overview and Scrutiny Committee, Health and Wellbeing Board)
- Media as a conduit to the public (e.g. Oxford Mail, BBC, Banbury Guardian)

6. Governance and transparency

In line with our principle to be 'open and transparent', we will:

- Offer the same level of information to people attending our events and/or who ask to be given updates.
- Put as much information as we can on the website showing the clinical and demographic evidence behind the need for change and for the planned proposals.
- Put meeting papers and other key decision documents on the website.
- Provide regular updates to everyone in the local health and social care system about progress and next steps in the programme.
- Enable our clinicians and other key programme decision-makers to have a wide-ranging discussion in suitable forums which enable challenge and debate.

The consultation and communications for the programme will be run by the communications team in the CCG with support from advisers, and will:

- Fit within the overall governance arrangements of the programme, providing regular updates to the appropriate meetings of the programme, the CCG and its partner organisations.
- Meet regularly with communications colleagues from across Oxfordshire and cross-border health and social care systems, including the relevant local authorities and provider organisations (including hospitals) and update them on progress.
- Work with Healthwatch and the Locality Forums and wider community representatives to ensure that the patient's voice is heard in discussions and decisions.
- Be accountable to the Transformation Programme Board and provide regular updates to it, as well as to NHS England and other key stakeholders such as government ministers and MPs.
- Be staffed by the programme team, including support and attendance at consultation events but draw on advice, support and some resource from local Trust teams.
- Draw on and manage outsourced resources e.g. for focus groups, design, print and distribution.
- Ensure that consultation responses are thoroughly considered and are included as a formal part of the decision-making process.

7. Materials

The materials to be developed to support the consultation are:

- Core consultation document
- Easy Read summary of the consultation document
- Frequently asked questions (FAQs) and answers
- Poster advertising the consultation
- Website
- Survey for use online and hard copy.

The core product will be the Consultation Document which will be developed to encourage maximum participation in the process, as follows:

- A core narrative, associated messages, with FAQs, will be developed with input from clinicians, Healthwatch, Patient representatives and other advisers as appropriate and used to generate key content for the consultation, including the main document.
- The document, and all other materials, will be written as clearly, simply and in as compelling a way as possible, avoiding jargon and ensuring stakeholder readability.

- All core materials will be tested for accessibility with lay members of the Transformation Board (chief executive of Healthwatch and the nominated representative Chair of Locality Forums) and there will be a summary version available.
- Copies of the full document will be distributed to community settings and stakeholder groups across Oxfordshire and cross-border areas as appropriate.
- There will be hard copies of the main document and/or summary posted out to areas defined as relevant to the programme, in recognition that not everyone wanting to respond will be able to do so online.
- There will be special versions – such as audio, translated, large print or braille versions – made available on request.
- Graphics and video material may be used to make the concepts and information more accessible to audiences.
- The branding from the 'Big Health and Care Conversation' will be developed for the consultation to demonstrate the connection and will be used to clearly identify the consultation materials.

8. Means of communication

A number of different communication methods will be used to target all relevant stakeholders as well as patients and voluntary organisations as required. This can include but is not limited to:

Website:

- The consultation document and associated materials will be published on a dedicated section of the CCG website.
- This will be branded and will host:
    - General information about the programme including context, background, maps and charts
    - Meeting papers including actions and minutes of key meetings.
    - Clinical evidence and data used to inform proposals.
    - Previous relevant documents and data relating to the programme.
    - The consultation document and easy-read summary document.
    - The consultation questionnaire available to print out and via link to Talking Health.
    - Web links will be provided to partner organisations to publicise the consultation on their websites.

News Media:

- News media will be kept informed with press releases and interviews provided as appropriate.

- Media enquiries will be handles as swiftly and accurately as possible, with inaccuracies challenged and rebutted, based on a set of agreed and updates FAQs.
- Local newspaper adverts may be considered as a way of providing information about events.

Social Media:

- Facebook and Twitter will be used to reinforce and bolster other channels as appropriate and monitored for relevant feedback.

Other:

- Regular information will be shared with members of Talking Health and Locality Forums (for onward distribution to PPGs).
- Partner and key stakeholder newsletters will publish information about the consultation.
- Information will be sent directly to members of:
    - Oxford Health Foundation Trust, Oxford University Hospitals Foundation Trust and Healthwatch
    - Voluntary and Community Sector Organisations
    - Relevant advocacy groups

9. Key Messages

Oxfordshire CCG has already agreed and set out its corporate vision and objectives and its core values in *Oxfordshire Clinical Commissioning Groups' Strategy for 2014/15 -2018/9*. These have been developed into key messages which underpin all of its communications and engagement activities.

The high level key messages for OCCG are as follows:

- Oxfordshire Clinical Commissioning Group plans and buys health services on behalf of everyone living in Oxfordshire. To do this successfully we need to work with local people, Oxfordshire GPs, hospital clinicians and other partners (including local government and the voluntary sector).

- We are committed to:
  - putting patients' needs first
  - working with the people of Oxfordshire to develop quality health services fit for the future
  - working with GPs, hospital clinicians and other partners to tackle health inequalities
  - giving you a chance to have your say on the health priorities which matter to you.

- We believe you can make a difference to the way in which our health services are delivered.

The above messages are supplemented by the following for the Transformation Programme:

- Although most patients currently receive good care in Oxfordshire, achieving the best standards of care for everyone is becoming increasingly difficult.
- Pressure on services is increasing, particularly where demand is more highly concentrated among older people – our plans for health services are being driven by clinicians who see patients every day and see how services could be improved.
- Fundamentally it's about improving quality and reducing inequality of health and care services – there is currently too much variation in the care that is provided across Oxfordshire.
- We need to help prevent people getting avoidable diseases by supporting healthier lifestyles – the people in Oxfordshire need to be a partner in this or we will not succeed.
- We want to work with local people to shape the future of health and social care and develop local solutions in response to local needs.
- The challenges we face will inevitably mean difficult choices will need to be made – we encourage people to share their views and comment on the options during the consultation.
- No decisions have been made and will not be taken until the public consultations have been completed and final proposals are put to Oxfordshire Clinical Commissioning Group's Board.

10. Response handling

The CCG will handle all queries and responses swiftly, efficiently and in a coordinated way so that people know their views are being heard and are being handled appropriately.

- We will establish systems to ensure questions and responses are logged.
- We will publicise the freepost address and generic email address for responses.
- As well as all formal responses to the consultation, we will bring together any questions that are directed through the Freedom of Information route in the CCG.
- We will maintain the stakeholder database ensuring it is updated regularly and can be relied upon to be accurate.

- We will not be overly proscriptive about when responses are made and will make clear to anyone enquiring of us or wanting to respond, where reasonable, we will always seek to accommodate wherever practicable responses or questions outside formal channels set up by us.

11. Feedback

We will commission independent support to thoroughly and comprehensively analyse all responses to the consultation, explain our analysis, and explain how we have taken into account all views given to us as part of the on-going future development of the programme.

- We will commission an independent analysis of the responses and writing of the report of the consultation.
- We will publish our consultation report which will include the analysis.
- We will make clear how the consultation feedback has been used to inform our decision making.
- We will regularly report back to those who have expressed an interest in the consultation to keep them informed about activity and progress.

12. Equalities & impact

The consultation will take account of equality legislation around protected characteristics. The protected characteristics set out in the Equality Act 2010 are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex; sexual orientation.

We will therefore:

- Undertake an Equality Impact Assessment, with the objective of ensuring the potential impact of any plans on protected groups has been assessed.
- Use the Equality Impact Assessment to identify any groups such as those who do not have English as their first language who have not been fully engaged with and commission focus groups to proactively ensure any such groups do in fact provide feedback to the programme, even if this is not in the form of formal consultation responses.
- Employ similar methods to ensure the voices of other groups that may be seldom heard are included.

Similarly the programme will identify those impacted by the proposed changes and ensure they are supported to have their voice heard.

13. Staff engagement

It will be important to reach out to health and care staff across Oxfordshire so they are aware of, and can get involved in, the consultation. A commitment has been made by NHS provider organisation to undertake engagement with their staff, however the programme will provide briefing materials on the consultation and information to local trust and other partner organisation communications teams so they can then lead the staff engagement process from within their individual organisations. This could (if appropriate for the organisation) include template materials and content which trusts can easily use to encourage participation by, for example, placing on websites, sending out via email and using at staff events.

We will also ensure hard copy materials are available at relevant staff sites and digitally on appropriate websites and intranets.

14. Spokespeople

The programme and consultation will depend for its effectiveness on dedicated, articulate, well briefed spokespeople/presenters who will:

- Be predominantly clinicians, drawn from across the health economy, with an emphasis on primary care;
- Be supported where possible by lay personnel;
- Be drawn from across Oxfordshire, with the proviso that if the emphasis is on consultation in one part of the county, they will be drawn predominantly from that locality;
- Lead on responding to key stakeholders, both individually and in groups;
- Lead on media interviews and related media activities;
- Be supported by the communications team in terms of materials, briefings, media advice and presentation training where needed, to ensure their explanations and presentations are clear, easy to follow, and understood.

15. Engagement and events during consultation

A number of events will be held to ensure that

- There has been pre-consultation on the proposals, in addition to earlier consultation and engagement, so that any plans then consulted on have been informed by engagement with the public, patients, and key stakeholder groups.
- The consultation itself can be shaped by early feedback, for example on format and language.

- During consultation, as many responses as possible are encouraged from the communities and populations potentially most affected by the plans.
- The wider context of any specific local proposals is considered.

These events will comprise:

- Large, system-wide events in key locations before, during and after consultation.
- Smaller mobile events – or 'drop-ins' – in each locality affected most directly by the local proposals relevant to them.

16. Engagement and Events

A full programme of events and activity will be published at the start of the consultation along with the consultation document and questionnaire. Below is a summary of the methods of consultation to be used:

Consultation Method	Implementation assumptions
General publicity – advertising in local media, posters and postcards, support on social media, as well as via NHS organisations and established stakeholder channels such as Healthwatch and local voluntary group networks	• Information about consultation and public events available in GP and hospital waiting rooms and receptions, libraries, town hall and other civic and community centres. • Publicity in local papers to promote specific local events. • Website, questionnaire and freepost address advertised widely to drive responses.
Public meetings – an effective way of engaging with wide range of interested parties in the local health economy as well as patients and the general public. Also clear demonstration of public accountability.	• Any invitation received to attend a public meeting (whether campaign group or community group) to be considered and, wherever possible, accepted.
Drop in sessions – to provide an opportunity for detailed conversations with the public, local commissioners and the acute trusts about their specific priorities and interests.	• Drop-in events held in areas most affected by proposals. • Include static and interactive elements including the ability to fill in the consultation questionnaire. • Events will take place at a variety of times, during the day, evening and weekends.

Focus groups will be held to target identified seldom heard groups in conjunction with the Equalities Impact Assessment work.	• Focus groups during consultation, with numbers and frequency to be confirmed, in part depending on the Equality Impact Assessment.
Online – Information about the Transformation Programme, the pre-consultation engagement and the business case together with the consultation document and questionnaire will be available online.	• Advertised directly to members of Talking Health. • Included in all publicity to encourage participation even if not attending a meeting or event.

17. Risks and Mitigation

The main communications risks have been identified as follows:

Communications risk	Mitigation
Clinical engagement, leading to incorrect information about the impact of changes at the Horton	Local clinicians have been involved and informed of challenges and options for change. Oxford University Hospitals Foundation Trust staff engagement at the Horton General Hospital. The case for permanent relocation will be described in terms of patient and clinician benefits. Clinical leaders to provide support.
Inadequate information causes undue concern among patients/public/stakeholders	Patient representatives involvement in developing supporting materials to ensure they are clear, consistent and comprehensive. Ensure the issues most likely to excite local opinion – money and transport are adequately covered within the case for change and the communications material.

Buckinghamshire, Oxfordshire and Berkshire West (BOB)

Sustainability & Transformation Plan (STP)

November 2016

Ian Cave, STP Programme Director
ian.cave@oxfordshireccg.nhs.uk

Progress Report November 2016
Our ambition and plans
NHS England process
Financial position
Governance
Progress updates
Next steps

Our ambition

Prevent ill health, with a particular focus on obesity to reduce demand for services over the medium to long term.

Standardise access to urgent care so a range of well-informed clinicians can safely diagnose and prescribe treatment while minimising the number of duplicated consultations a patient receives. This will release GP time so they can work together at scale, become more integrated with community services operating out of community hubs and focus on people with more complex conditions. GPs will also be able to call on an increased number of home carers to enable more people to be cared for in their own homes rather than being sent to hospital.

Improve our workforce offer and increase staff retention by working with Trusts and Health Education England to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.

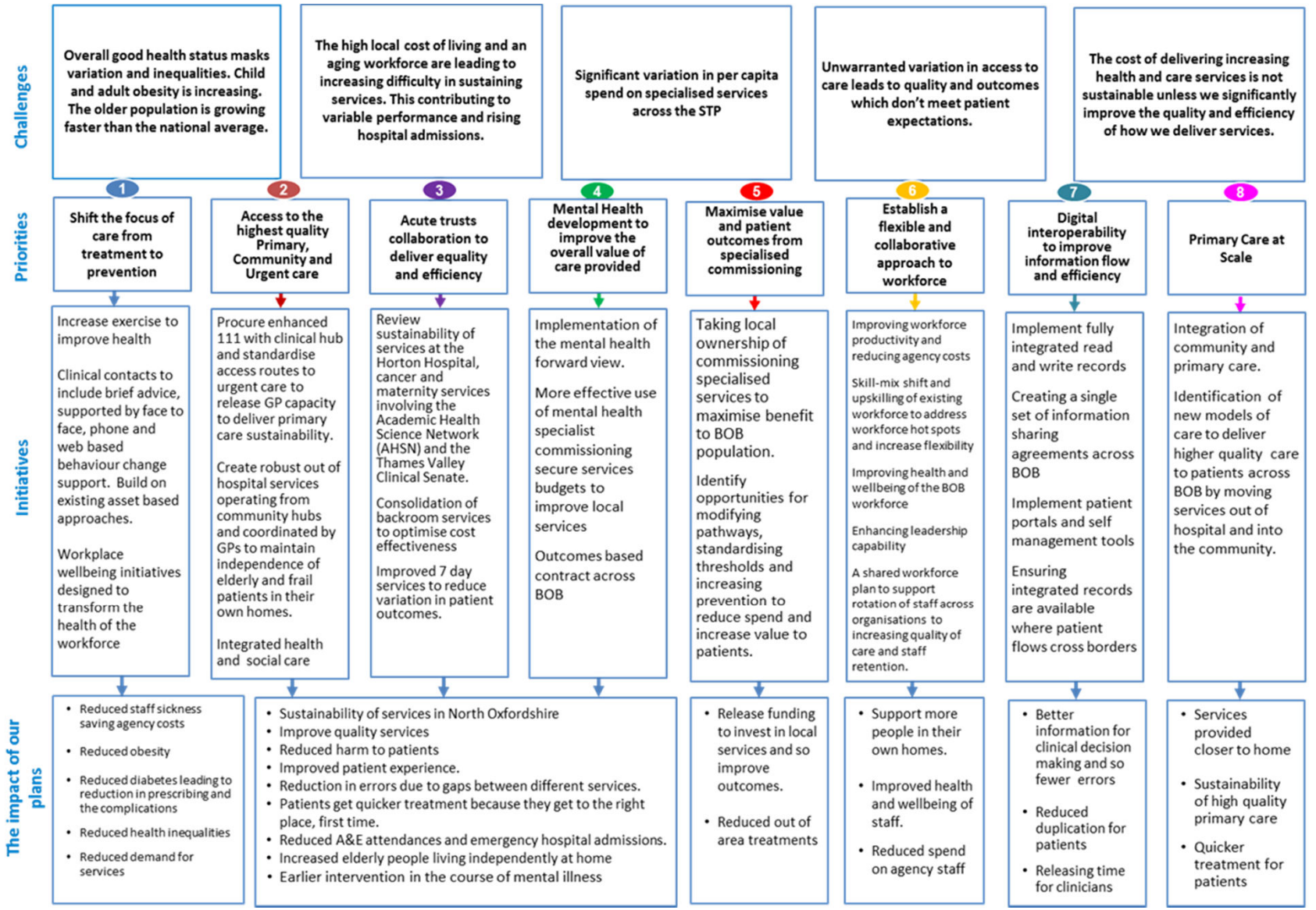
Provide digital solutions for self-care, virtual consultations and interoperability to increase patients' access to information and reduce duplication and travel.

Increase efficiency by commissioning, where appropriate, at scale across the BOB geography. For example, by co-commissioning specialised services with NHS England to identify alternative pathways of care.

Centralise back office functions to deliver savings by procuring at scale for example using the Shelford Group framework.

Undertake meaningful engagement and consultation activity on services, such as those at the Horton Hospital in Banbury to help inform decisions on the commissioning of future services.

Plan on a page



For example in Oxfordshire

Shifting the focus of care from treatment to prevention

Utilising technology to help patients manage their conditions and to enable self-referrals and promote self-care e.g. physiotherapy, podiatry

Urgent care

Ambulatory ‘by default’ as the model of care, i.e. without needing an overnight stay
A hyper-acute stroke service delivering the best outcomes

Acute care

Horton Hospital sustainability (Emergency & Urgent Care, Obstetrics and Paediatrics).
Significantly improve planned care services available in North Oxfordshire.

Primary care

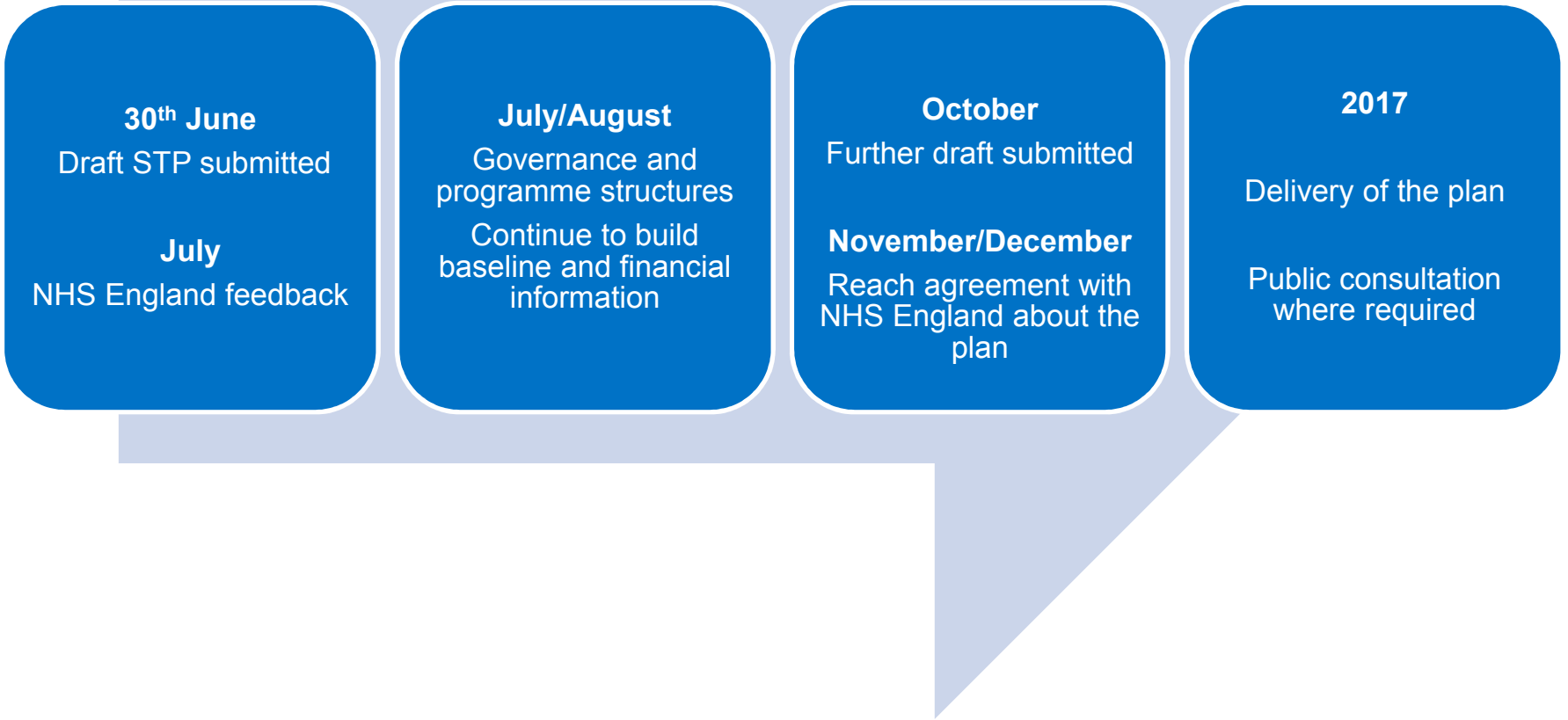
Develop a wider skill mix to allow GPs to operate “at the top of their license”
Primary care neighbourhoods connected to locality hubs
Widen long term condition support with more clinics in the community supported by a local diagnostic service

Developing new models of care

Create robust out of hospital services operating from the community integrated with Primary and Social care

NHS England process

Public and clinical engagement



Our financial position

2016/17 £2.55bn funding across Buckinghamshire, Oxfordshire and Berkshire West.

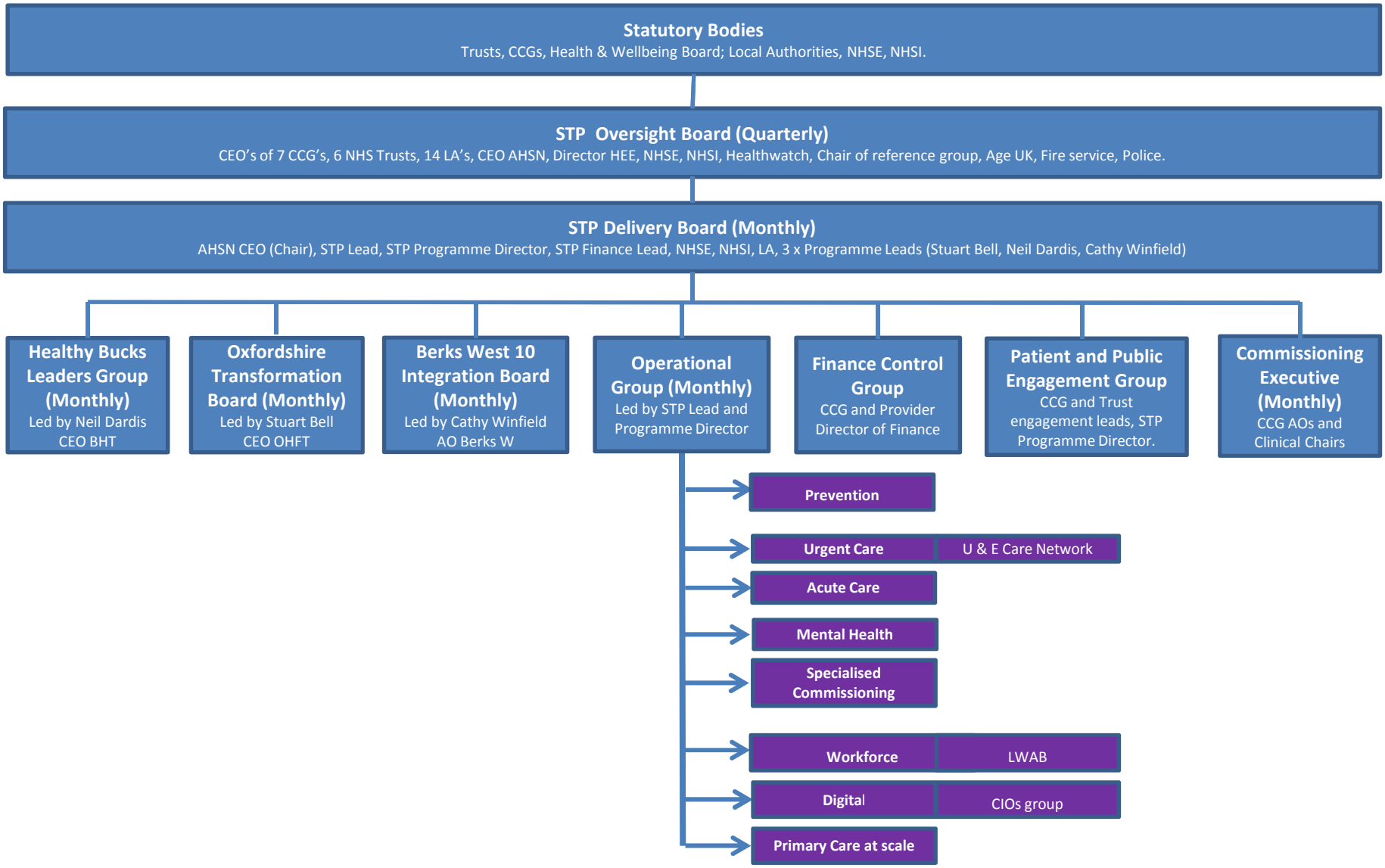
2020/21 £2.87bn funding across Buckinghamshire, Oxfordshire and Berkshire West (12% increase) ***but*** our expenditure is growing at a faster rate than the increase in our funding

If we do nothing different, rising costs, inflation and demand on the NHS will lead to a **gap of £479m** by the end of 2020/21. But we expect our plans to create a relatively small surplus of £11m.

Closing the gap

Efficiency savings	Asking organisations providing NHS services to become 2% more efficient each year	£213m
Delivering services in different and more cost effective ways	Local transformational changes and finding better ways to reduce growth in the need for services	£88m
Maximising the benefits of working at scale	Working at scale across the BOB area to transform services	£83m
National Sustainability and Transformation Funding	Using additional national transformational funding, which has been allocated for use in our area in 2020/21.	£106m

STP governance



Programme updates

Financial Gap	Greater clarity on financial position and BOB wide schemes.
Specialised Commissioning	Joint Director across NHS England and STPs.
Joint Commissioning Executive	Consideration as part of the Memorandum of Understanding
Programme Management	Project charters agreed for all STP projects.
Communications and engagement	Strategy in place, building on local engagement.
Berkshire West	Development of Accountable Care System proposition.
Buckinghamshire	Engagement about development of community hubs.
Oxfordshire	Case for change submitted to clinical senate and pre-consultation Business Case in draft.

Next steps – our priorities

- Strengthen engagement with patients and the public, clinicians, staff, local authorities, voluntary organisations and other key stakeholders to shape our plans and to ensure that they are implemented in partnership
- Agree a Memorandum of Understanding to enhance system wide collaboration and delivery
- Develop a risk sharing agreement across NHS organisations to ensure financial balance across the STP.
- Build on existing system leadership to achieve collective accountability to deliver the proposals at pace
- Ensure sufficient resourcing to drive delivery of our plans
- Review estates and capital plans so they are deliverable within local and national constraints
- Further development of business cases to access national sources of revenue and capital funding to enable delivery of our plans.

Community Nursing Service Review 2015/16

AIM: To develop a model for community nursing in Oxfordshire that is an integral part of a multi-disciplinary out-of-hospital care team, sustainable and fit for purpose within available resources.

Background

A review of Oxfordshire's community nursing service was undertaken during 2015, primarily following concerns around the service's ability to adequately respond to the growing demands being placed upon it. These demands were coming from an increasingly frailer older population and more complex patients with multiple long term conditions. Furthermore, the service provider, Oxford Health NHS Foundation Trust (OHFT), was experiencing higher than average levels of sick leave and staff attrition rates.

OHFT has been working with Oxfordshire Clinical Commissioning Group (OCCG) to ensure the service is able to manage current demand and that it is fit for the future, supporting Oxfordshire's Care Closer to Home Strategy. With regard to current service provision, in a recent CQC inspection undertaken in June 2016, the Trust was awarded an overall rating of 'Good' indicating services are being provided in an effective, caring, responsive and well-led way but 'required improvement' to be safe. http://www.cqc.org.uk/provider/RNU

The Review

The community nursing review set out to agree the vision for community nursing in Oxfordshire to fully support care closer to home and agree a patient centred model that would;

- help to address the current concerns regarding the service
- be safely and effectively delivered within available resources to maximise patient outcomes and experience
- ensure co-ordinated care in tandem with Primary Care
- have a beneficial system impact
- be an integral part of the Integrated Locality Team model
- improve the interface with other community services and reduce duplication of effort
- improve working practices between District and Practice Nursing Teams to enable greater partnership working.

A modelling exercise was subsequently undertaken in order to understand how improved efficiencies and patient outcomes could be achieved within available resources. This modelling exercise was undertaken by Newton Europe with full staff involvement so as to understand the issues from their perspective and to engage them in the change process.

Key Recommendations from Newton Europe

- Improve internal productivity through increased use of standardised care pathways
- Fewer, larger teams with regular standardised interface with primary care, and reduced travel time (neighbourhood teams supporting GP clusters)
- Skill mix review against each new team's standardised caseload to maximise effectiveness and efficiency;
    - Increase Band 6 District Nurse (DN) with specialist practitioner qualification (to treat increasing cohort of complex/unstable patients)

    - Appropriate administrative support in each new team (to maximise patient-facing clinical time)
    - Band 4 Assistant Practitioners to deliver non-complex care (to maximise overall clinical capacity
- Development of Care Notes and its interface with primary care electronic health records to maximise ease of clinical communication and reduce low value tasks

There are a number of further actions that OHFT have/are in the process of implementing (see table below) regardless of the wider joint actions highlighted above:

	Efficiency	**Current baseline**	**Implementation approach**	**Indicative date for delivery**
1	Streamline handovers	Newton Europe identified average handover time is 34 minutes; aim is to standardise and reduce to 25 minutes	County-wide	Roll out to teams by **end April 2016** Embedding May onwards and audit as part of Community Nursing Quality Assurance Tool (CNQAT)
2	Reduce travel time: start from home and reduce unnecessary return trips to base	Newton Europe modelling suggests release of approximately 75 minutes per team / day	Phased	1 pilot site in place in each locality by end March 2016 Roll out complete **end August 2016**
3	Implement use of mobile electronic health record	EMIS (Egton Medical Information Sytem) Template being trialled in Chipping Norton: Carenotes app being trialled in MH teams for Trust prior to Trust-wide roll-out	Phased	TBC; pending technical configuration date, but **asap in FY17**
4	Extend use of standardised care pathways to maximise outcomes and efficiency	Venous leg ulcer pathway in place: early intervention leg wound care pathway under development; mixed aetiology wound pathway identified as next priority	Phased	Roll out complete **end December 2016** for early intervention leg wound pathway
5	Embed DN Duty Desk, and optimise rapid response across DN and MDT integrated locality hub teams	In place in SW and W GP localities	Evaluate and refine current implementation; then roll out to all localities	Evaluation completed end **March 2016**, county-wide roll-out completed by **September 2016**
6	Review each DN team caseload to ensure appropriate and timely discharge	Teams in North have started weekly caseload reviews with Band 7 Clinical Development Leads (CDLs). Other CDLs beginning implementation with their teams	County-wide	**End March 2016**

Locality Approach

However, the key challenge from the review was to put into place neighbourhood teams supporting GP clusters, and for community services to support primary care in a flexible way that would enable all services to manage future trends/demands in a more integrated way.

As such, each locality now has a multi-stakeholder Locality Community Services Group with the overall purpose of:
Working to the remit of the letter from OCCG's Clinical Chair (dated 4/3/2016) to OHFT's CEO (see letter to OHFT's CEO from OCCG's Chair – attached) to:

- *Agree a patient centred model for locality community services that will:*
    - *Be safely and effectively delivered within the available resources to maximise patient outcomes and experience*
    - *Ensure co-ordinated care in tandem with Primary Care*
    - *Have a beneficial system impact*
- *Identify the collective community based out of hospital resource available to the locality*
- *Identify the GP practice clusters for the locality and supporting cluster teams*
- *Consider the relationships and interfaces with all community and primary care services to ensure duplication is reduced and patient experience is improved*
- *Consider how the working practices could develop to enable greater partnership working in the interest of patient care*
- *Encourage innovation and new ideas in order to provide effective care in the most efficient way, building capacity within the system.*

Each group, whilst working to the stated overall purpose, have agreed their own locality outcomes according to their specific needs, challenges and priorities and will be responsible for evaluating these. Whilst action plans and timescales are also being developed by each locality group the key date for evaluating the effectiveness of this approach is December 2016.

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Health Overview and Scrutiny Committee – 17 November 2016

Chairman's Report

Liaison meetings

The Chairman attended the following meetings with representatives from health and social care organisations between June and September 2016:

- 9 September – Local Councillors, Bicester
  A briefing on the progress of the transfer of patients to other surgeries and a discussion about health planning for a growing Bicester and future use of the North Bicester Surgery building.

- 27 September - Oxford University Hospitals Trust
  A briefing on the issue of Obstetrics at the Horton Hospital and the acute bed and service reconfiguration proposal scheduled for discussion at HOSC on 30 September.

- 29 September –Healthwatch Oxfordshire
  An introductory meeting with Rosalind Pearce, Executive Director of Healthwatch Oxfordshire.

- 12 October –Patient Participation Group, Deer Park Medical Centre
  A meeting with the Patient Participation Group to discuss the best way to inform and communicate with patients about transferring to alternative practices before the Centre closes in March 2017. Approximately 3,700 of 4,300 patients registered at the practice are expected to transfer to other Witney surgeries. 8% live outside Witney and will transfer to more local surgeries.

- 2 November – Oxford University Hospitals Trust
  A visit with other members of the Committee to the Discharge Liaison Hub at the John Radcliffe Hospital.

- 3 November - Oxfordshire Clinical Commissioning Group
  A briefing on emerging issues in primary care services.

- 9 November – Kings Fund Annual Conference 2016
  A conference to explore key challenges for the health and care system and share learning on the essential actions needed guarantee that the system can be both sustained and transformed.

Feedback on HOSC visit to the Discharge Liaison Hub

On 2nd November the Chairman and Deputy Chairman visited the Discharge Liaison Hub at the John Radcliffe Hospital to see first-hand how the discharge of patients, many of whom are frail with complex needs, is coordinated and managed by a multi-disciplinary team.

Lily O'Connor, Divisional Head of Nursing and Governance - Medicine, Rehabilitation and Cardiac Nurse Division, Oxford University Hospitals Trust provided an overview of the functions of the Liaison Hub, its multi-disciplinary team and the patients they see:

The Liaison Hub

Oxford University Hospitals Trust employs social workers (who are supervised by Oxfordshire County Council's Adult Social Care), therapists, nurses, discharge coordinators and an administrator to staff the Hub. They are currently managing the needs of 65 patients in Hub beds located in nursing homes across Oxfordshire. This number has increased from 55 beds to manage additional pressure over the Autumn/Winter. Assessments for Continuing Healthcare have also recently started for people in Hub beds, although many patients are not usually eligible for this type of NHS funded care, so the Hub team ensures that assessments for adult social care run alongside this and a package of care can be put in place without delay. Patients can stay in Hub beds for up to 6-8 weeks whilst they are assessed for longer term care.

Many of the patients dealt with through the Hub are stable, but require further assessment to determine their discharge destination. For these patients, a stay in an acute bed can do more harm than good and a Hub bed can facilitate a more accurate assessment, as well as improving the patient's perception of a care home.

The Acute Ambulatory Unit (AAU)

The Chairman and Deputy Chairman were shown around the Acute Ambulatory Unit, situated next to the Hub office – Hub patients are seen here as outpatients if their needs escalate, as evidenced by the few hospital beds and numerous patient chairs and trolleys in the Unit. The focus is on prompt assessment, sending the patient back to their nursing home with 'Acute Hospital at Home' to follow up if required.

Acute Hospital at Home

This service is relatively new and has not yet been trialled to pick up patients in their own home before they are assessed by the hospital. Initial evidence is indicating that patients recover twice as fast with this acute wrap around care compared with a stay in hospital.

Clinical Coordination Centre (CCC)

The Chairman and Deputy Chairman also met staff in the Clinical Coordination Centre, attached to the Acute Ambulatory ward. GPs can call the centre directly and speak to a consultant physician who is a member of the Hub / Acute Ambulatory ward to get advice and support with assessing a patient. Risk is shared between the GP and the consultant so that unnecessary admissions to hospital are avoided. The Centre also monitors patients in departments across the hospital and those arriving with the Ambulance Service to identify prompt discharge routes.

The Chairman is keen to arrange another visit for more HOSC members to attend, sometime next year.

Cllr Yvonne Constance
Chairman of Oxfordshire Joint Health Overview and Scrutiny Committee

Oxford University Hospitals NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee Meeting

Thursday 17 November 2016

Title	**Update on the temporary suspension of obstetric services at Horton General Hospital**

Mr Paul Brennan
Deputy Chief Executive/Director of Clinical Services
Oxford University Hospitals NHS Trust

Summary

1.	This paper provides an update to the HOSC on the review of the readiness to lift temporary suspension of obstetric and neonatal services at Horton General Hospital, on the grounds of patient safety. Following a review of the progress in recruiting obstetric doctors it was decided to retain the Midwifery Led Unit at the Horton General Hospital until 5 March 2017
2.	A further round of recruitment initiatives is being pursued, and the position will be reviewed again in Mid December 2016, to determine whether it is safe to lift the temporary suspension and reopen to Obstetric care in March 2017.

1. Introduction

In line with the decisions taken by the Trust Board on 31 August 2016 the Obstetric Unit at the Horton General Hospital [HGH] was redesignated as a Midwifery Led Unit, on a temporary basis, at 8am on the 3 October 2016. This paper provides an update on the recruitment position, on the basis of which the Trust has decided to maintain the Midwifery Led Unit [MLU] status until March 2017 subject to further review in December 2016.

2. Recruitment

The latest recruitment round for Trust Grade doctors resulted in eight applications and four doctors being shortlisted and invited for interview. Unfortunately, two of the four doctors did not attend the interview and following interviews, one doctor was offered the post. That doctor has accepted, and will start in February 2017.

The Trust will have four doctors out of nine in post by mid to late November 2016, with a further doctor taking up post in February 2017. The four doctors are the two remaining Clinical Research Fellows and two new appointments, one commenced on the 28 October 2016 and the second is planned to commence on the 17 November 2016. A further advert was placed in the British Medical Journal [BMJ] on the 7 October 2016 with a closing date of the 28 October 2016. Three doctors have been shortlisted and interviews are being held the week commencing the 7 November 2016.

There is a linked recruitment challenge in relation to special care nurses; the minimum, establishment needed to operate the unit is twelve. An advert for Special Care Nurses closed on 26 October 2016 and three applicants have been shortlisted.

3. Conclusion

Based on the current Obstetric Trust grade doctor position, the Trust decided to retain the temporary arrangements for the provision of a Midwifery Led Unit at the Horton General Hospital until 5 March 2017, on the grounds of patient safety.

The position will be reviewed again in Mid December 2016, to decide on whether it is feasible to reopen Obstetric services on 5 March 2017 or to continue to operate as a Midwifery Led Unit beyond 5 March 2017.

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NHS England South Central: Integrating pharmacy into primary care

Strategic Direction

NHS England has announced a £42million Pharmacy Integration Fund (PhIF) to support pharmacy to transform how it operates across the NHS for the benefit of patients over the next two years, as set out in the Five Year Forward View, for the NHS.

The PhIF has been created through the community pharmacy review that is led by the Department of Health as part of the package of proposals under consideration to transform the way pharmacy and community pharmacy services are commissioned from 2016/17 and beyond. A joint letter from the Department of Health and NHS England announced a consultation which completed on 24 March 2016, to consider how the fund should be used. Stakeholder engagement continues and it is anticipated that further consultation will take place over the next five years. The PhIF is the responsibility of NHS England and is separate to any negotiations related to the Community Pharmacy Contractual Framework (CPCF). It will be used to validate and inform any future developments of the CPCF going forward. NHS England is the national commissioner for community pharmacy services and the role of the organisation is to ensure the NHS provides safe, effective, high quality patient care and services within community pharmacy and to ensure the NHS lives within its means.

NHS England intends to use the recommendations of an Independent Review of Community Pharmacy Clinical Services, commissioned by the Chief Pharmaceutical Officer, to inform its approach to commissioning NHS Pharmacy Services, within the agreed contractual framework, once the review recommendations have been properly considered.

The review is examining the evidence base of the clinical elements of the current Community Pharmacy Contractual Framework and other clinical services. It will make recommendations for commissioning models and clinical pharmacy services aimed at ensuring community pharmacy is better integrated with primary care and making for greater use of community pharmacy and pharmacists.

The Independent review is chaired by Richard Murray of the King's Fund and was commissioned by the Chief Pharmaceutical Officer in April 2016 following the opportunity presented by the publication of the Five Year Forward View in October 2014 and the General Practice Forward View in April 2016, both of which set out proposals for the future of the NHS based around the new models of care. The review is due to be completed by the end of 2016.

The need for an in-depth pharmacy review was determined by the present context in which pharmacy operates:

- The changing patient and population needs for healthcare, in particular the demands of an ageing population with multiple long term conditions.
- Emerging models of pharmaceutical care provision from the UK and internationally.
- The evidence of sub-optimal outcomes from medicines in primary care settings.
- The need to improve value through integration of pharmacy and clinical pharmaceutical skills into patient pathways and the emerging new care models.

The Pharmacy Integration Fund will support community pharmacy as it develops new pharmacy clinical services, working practices and digital platforms to meet the public's expectations for a modern NHS community pharmacy service. NHS England is not asking community pharmacy to do more, but rather to work together over the next five years to develop how things can be done differently. The profession will have to change and as the national commissioner and corporate body of the NHS, NHS England will be working closely with them to support and enable this process.

The aim of the PhIF is to support the development of clinical pharmacy practice in a wider range of primary care settings, resulting in more integrated and effective NHS primary care for patients. In particular, the fund will drive the greater use of community pharmacists and pharmacy technicians in new, integrated care models, in line with calls from commentators within the sector to make better use of the pharmacy skill set. This will improve access for patients, relieve the pressure on GPs and accident and emergency departments, ensure best use of medicines, drive better value, improve patient outcomes and contribute to delivering a seven day health and care service.

Public Health

Public Health England is developing a 'value proposition' to inform the local commissioning of community pharmacy services by local authorities, while NICE is expected to publish a guideline in 2018 about the role of community pharmacy in promoting health and well being. This work is separate to the PhIF but will inform the future local commissioning of services for public health services from community pharmacy.

An independent review of community pharmacy clinical services, which was commissioned by the Chief Pharmaceutical Officer of England, Dr Keith Ridge, will be used to determine how the fund will be spent over the next two years. The review is due to report by the end of the year.

Funding
The joint letter from the Department of Health and NHS England shared details of the £42m Fund to be used over the next two years.

Through the business planning process, NHS England has identified the need to achieve efficiency savings that has impacted on all transformation and new care models programmes. Some of the PhIF has been set aside to achieve those efficiency savings in the first year in line with all other NHS England funding streams.

For 2016/17, NHS England has allocated £2m to roll out two initiatives to integrate pharmacy into urgent care: a national urgent medicines supply pilot as a referral from NHS 111; and work to improve access to pharmacy minor illness services via NHS 111.

For 2017/18, £40m will be used to fund a range of workforce developments for pharmacists and pharmacy technicians working in a range of settings to better integrate pharmacy into NHS primary care services. Work continues with organisations involved in indemnity insurance to ensure pharmacy professionals have access to the insurance they need to enable them to adopt new ways of working. The Fund will also continue to support the national urgent care pilot and commission an evaluation.

Although some schemes that are funded by the Pharmacy Integration Fund have been announced for 2016-18, other will be funded in consultation with stakeholders once the Chief Pharmaceutical Officer's Independent Review has been published. The Independent Review of Community Pharmacy Clinical Services is planned to report at the end of 2016 and this will inform how the Fund will be used to invest in shaping the integration of community pharmacy clinical services.

There has been a commitment to use up to 5% of the PhIF for evaluation of any programmes of work supported by the Fund and following consultation this will also be available to support evaluation where the integration and transformation of clinical pharmacy is underway led by local teams as part of Sustainability and Transformation Plans.

Ongoing planning and engagement with stakeholders will help to shape and determine the further deployment of the Fund beyond 2018. A pharmacy integration stakeholder reference group will be established in 2017 to ensure engagement with a wide range of stakeholders. This will be in addition to the two task and finish groups that have already been established for care homes and integrated urgent care. The work on urgent care will also be reported through to the Pharmacy Reference Group for the Keeping People Well and Stable work stream of the NHS England Out of Hospital Urgent Care programme.

The governance of the Fund is overseen by an NHS England Pharmacy Integration Oversight Group that includes representation from CCGs, NHS England regions,

General Practice, Patients and Carers, Department of health, Health Education England and Public Health England.

Pharmacy priorities
The initial priorities for the fund in 2016-18 are;

- Deployment of clinical pharmacists and pharmacy services in community and primary care settings including groups of GP practices, care homes and urgent care settings such as NHS 111.
- Development of infrastructure through the development of the pharmacy professional workforce, accelerating digital integration and establishing the principles of medicines optimisation for patient-centred care.

Workforce Development
Health Education England (HEE) is producing a workforce plan for pharmacy professionals for March 2017 that covers the whole health care system. This will be bringing together the work they have already done for secondary care with a fresh piece of work to develop a plan for primary care. This combined plan will inform future investment in developing staff pre and post registration.

The following initial workforce development has already been commissioned through the Fund to develop the post-registration pharmacy workforce:

- April 2017-March 2018: Educational grants for community pharmacists to undertake post-graduate clinical pharmacy certificate training that potentially can lead to a clinical pharmacy diploma for 1,000 community pharmacy-based pharmacy professionals.
- April 2017-March 2018: Pharmacy technician clinical leadership programme
- April 2017-March 2018: Training and development for 150 pharmacists working in care homes – to include independent prescribing qualification.
- Training and development for 120 pharmacists working in integrated urgent care clinical hubs including NHS 111 and GP Out of Hours – to include independent prescribing qualification.

Urgent Care
Pilot studies to evaluate the role of the clinical pharmacist working within the NHS 111 contact centre have been undertaken. This together with the NHS 111 Phase 2 Learning and Development programme have shown that pharmacists can add value to the clinical skill mix working within the Clinical IUC hub, completing calls and providing self-care advice across calls that involve the use of medicines. The following areas of development have been identified;

- Development of pharmacists into IUC Clinical Hubs to roll out with the IUC clinical hub development. The role within the hub will be evaluated to identify the impact on referral rates and patient outcomes.

NHS England wants to further integrate community pharmacy into the NHS' national urgent care system and develop a national pharmacy urgent care programme. This will be piloted in two work streams to run from December 2016 to April 2018.

Urgent Medicines Supply Service:

- Tested as a national pilot, it will be a direct referral from NHS 111 to community pharmacies. This will speed up access to urgently needed repeat prescriptions because they will no longer need a GP out of hours appointment and route patients away from A&E who might attend looking for urgent medication.
- This will be evaluated to inform the development of a national service.

Urgent minor illness care:

- This will develop an evidence-based, clinical and cost-effective approach to how community pharmacists and their teams contribute to urgent care in the NHS, in particular making the referral of people with minor ailments from NHS 111 to community pharmacy much more robust. This will make support for people with minor ailments a core part of NHS pharmacy practice and pharmacy an integral part of the NHS' urgent care system.
- This will reduce waiting times and free up GP's who it is estimated spend approximately 40% of their time advising patients with minor illnesses.

Clinical pharmacists in general practice and care homes
As a result of new ways of working in general practice, 500 pharmacists are currently working in GP practices and care homes, reducing both the pressure on general practice and accident and emergency admissions. Now NHS England wants to extend this type of innovation into community pharmacy using the PhIF as the catalyst for transformation.

The roll out of clinical pharmacists in General Practice is set to start from April 2017. There are other models already in place in parts of England. The intention is to work with the NHS England Primary Care Transformation team to look at other models and use the PhIF to undertake a more detailed evaluation during the roll out.

The following areas for care homes have been identified for development:

- Mapping the range of services provided by community pharmacies to care homes and how they are commissioned.
- Deployment of pharmacy professionals into care homes and evaluation of the models of integrated clinical pharmacy that achieve the best outcomes for patients.

Digital
NHS Digital has responsibility for delivering the Medicines Digital Strategy. Pharmacy Integration through digital technologies is key to achieving efficiencies and

modernising community pharmacy to link it to the rest of the health care system. The following priorities will be supported by the PhIF:

- Developing the adoption of messaging and transfer of care data to community pharmacy from NHS 111 and hospital care settings and the sending of a post event message from community pharmacy to other care settings
- Supporting the uptake of NHS Mail2 by community pharmacies
- Supporting the uptake of the Electronic Prescription Service tracker by NHS 111 and IUC clinical hubs

The review is examining the evidence base of the clinical elements of the current Community Pharmacy Contractual Framework and other clinical services and will make recommendations for commissioning models and clinical pharmacy services aimed at ensuring community pharmacy is better integrated with primary care.

Pharmacy Access Scheme

The Government believes efficiencies can be made within community pharmacy without compromising the quality of services or public access to them. The Department of Health's new Pharmacy Access Scheme provides sufficient funding to protect pharmacies identified as essential, in more rural and isolated areas where there are fewer pharmacies with higher health needs and ensure accessible NHS pharmacy services across England. In addition, the new digital platforms will increase rather than decrease convenience for patients. Analysis shows that 40% of community pharmacies are now located in clusters of three or more, within a ten minute walk of each other, which are not providing value for money for the NHS.

NHS England will be publishing details of the implementation of the pharmacy access scheme, quality payments and market entry rules in December 2016. Our local team in South Central will be working with contractors to offer support and ensure everyone is prepared for the changes.

The Pharmacy Access Scheme will run from 1 December 2016 to 31 March 2018. Qualifying pharmacies will receive an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding in December 2016.

A list of those pharmacies identified as eligible for the Pharmacy Access Scheme has been published by the Department of Health. This is subject to review. A further briefing will be shared in December by the NHS England South, South Central team, which will contain further details on the implementation of the pharmacy access scheme and confirm those pharmacies that are part of the scheme in South Central (Berkshire, Buckinghamshire, Oxfordshire, Bath, Gloucestershire, Swindon and Wiltshire).

The scheme will be paid for from the funding for the community pharmacy contractual framework (CPCF). The PhAS will be an additional monthly payment

made to all small and medium sized pharmacies that are a mile or more from another pharmacy. These payments will mean that those pharmacies make a smaller efficiency saving than other pharmacies, 1% in 2016/17 and 3% in 2017/18. Pharmacies dispensing the largest prescription volumes (the top 25%) will not qualify for the scheme – these pharmacies are large businesses which are expected to continue to be viable.

Quality Payments

A quality payments scheme will be introduced for the first time. Up to £75m will be available in 2017/18 and will reward quality of service provided, so that we can target improvement in people's health nationwide. This will also mean the public will see how well their local pharmacy is delivering care. The Quality Scheme provides the opportunity for a pharmacy to publish its patient satisfaction survey and to list its nationally and locally commissioned services which is a huge step forward for the profession. What is not paid out in quality payments will be paid out in other fees and allowances. To qualify for a payment, pharmacies will have to meet four gateway criteria;

1. Provision of at least one advanced specified service
2. NHS Choices entry up to date
3. Ability for staff to send and receive NHS mail and
4. Ongoing utilisation of the Electronic Prescription Service.

Pharmacies passing more than one of a list of gateway criteria, will receive a payment. There are two review points for payment in 2017; end of April and end of November. Further information is available on the Department of Health website in 'Community Pharmacy in 2016/17 and beyond: Final Package'. Further guidance on the Quality Payment Scheme will be published in December 2016.

Market entry

The Department of Health are proposing to make regulations which provide some protection for two pharmacies that choose to consolidate on a single existing site, where this does not create a gap in provision. Subject to Ministerial and Parliamentary approvals, the aim is for the changes to come into force in December 2016.

For further information, please contact

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