Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 21 June 2018 at 10.00 am
County Hall

Membership

Chairman -
Deputy Chairman -

Councillors:	Kevin Bulmer	Dr Simon Clarke	Laura Price
	Mark Cherry	Mike Fox-Davies	Alison Rooke
			Arash Fatemian
District Councillors:	Nigel Champken-Woods	Neil Owen	Monica Lovatt
	Sean Gaul	Susanna Pressel	
Co-optees:	Dr Alan Cohen	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *20 September 2018*

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 Email:
Policy & Performance Officer	-	*Samantha Shepherd Tel: 07789 088173* *Email: Samantha.shepherd@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
Chief Executive

June 2018

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. ELECTION OF CHAIRMAN

To elect a Chairman for the 2018/19 Council year. Members are advised that the Constitution for the Committee stipulates that the Chairman is to be drawn from the Oxfordshire County Council members of the Joint Committee.

2. ELECTION OF DEPUTY CHAIRMAN

To elect a Deputy Chairman for the 2018/19 Council year. Members are advised that the Constitution stipulates that the Deputy Chairman is to be drawn from the District Councillors serving on the Joint Committee.

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 19 April 2018 (**JHO5**) and to receive information arising from them.

For ease of reference when considering any Matters Arising from the last meeting, an actions list for 19 April 2018 meeting is attached for information.

6. Speaking to or Petitioning the Committee

7. Forward Plan (Pages 19 - 22)

10:15

The Committee’s Forward Plan is attached at **JHO7** for consideration.

8. Update on Oxfordshire Winter Plans 2017/18 (Pages 23 - 50)

10:20

At the time the Oxfordshire Winter Plans were presented to the Committee in November 2017, Members asked to review their subsequent effectiveness. The attached report (**JHO8)** from the Oxfordshire Clinical Commissioning Group (OCCG) includes information on the success of some of the new initiatives, for example flu jabs for Social Care staff, to learn where the system should be investing in the future.

9. OCCG key and current issues

11:35

OCCG will give an oral update report on key issues and will outline any current and upcoming areas of work.

10. Care Quality Commission (CQC) Local System Review (Pages 51 - 58)

12:15

Representatives from the Oxfordshire Clinical Commissioning Group, the County Council, Oxford Health Foundation Trust and the Oxford University Hospitals NHS Foundation Trust will report on the following issues (**JHO10)**:

- How ‘innovation’ is being interpreted and used in the Oxfordshire system to address the CQC findings;
- How learning from best practice is being incorporated into the work in Oxfordshire;
- The work being undertaken to address the housing and workforce issues within the system; and
- A proposed evaluation framework for actions arising from the system review to assess the impact on service users and patients, to aid scrutiny by the Committee.

13:00 LUNCH

recycled paper

11. Healthwatch Oxfordshire (Pages 59 - 62)

13:45

Rosalind Pearce, Chief Executive Officer will be present to report on the views and latest activities of Healthwatch Oxfordshire (**JHO11**). She will present a short video which has been co-produced by the Luther Street Medical Practice Patient Participation Group (PPG), Healthwatch Oxfordshire and the Luther Street Medical Practice staff on the work of the PPG of the Medical Centre.

12. Update on implementation of recommendations from the Oxfordshire Health Inequalities Commission (Pages 63 - 70)

14:00

A request was made on 16 November 2017 that progress be reported to this Committee every 6 months to ensure Health Inequalities remains a priority. A report is attached which will review progress of the Health & Wellbeing Board with the Health Improvement Commission's recommendations (**JHO12**).

13. Stroke Rehabilitation Services - Pilot Report (Pages 71 - 78)

14:45

Oxford Health will report back on the performance, outcomes and next steps following the Stroke Rehabilitation Services Pilot. It includes information on the plans to provide intensive care at home, on the County Council therapy services, and the plans for expanding the ESD services. It also seeks further evidence about issues about the Services highlighted by Healthwatch Oxfordshire (**JHO13).**

14. Transition of Learning Disability Services (Pages 79 - 88)

15:30

The OCCG will give an update the Committee on the transition of Learning Disability services from Southern Health to Oxford Health which took place in July 2017 (**JHO14**).

15. Chairman's Report (Pages 89 - 94)

16:15

The Chairman's report is attached (**JHO15**).

16. Dates of Future Meetings

Please find below the dates of future meetings of this Committee for your diaries:

All will take place on a Thursday and start at 10am (with a pre-meet at 9:15am):

20 September 2018
29 November 2018
7 February 2019
4 April 2019
20 June 2019
19 September 2019
21 November 2019
6 February 2020

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.

This page is intentionally left blank

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 April 2018 commencing at 10.00 am and finishing at 3.00 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair District Councillor Monica Lovatt (Deputy Chairman) Councillor Kevin Bulmer Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Laura Price Councillor Alison Rooke District Councillor Andrew McHugh District Councillor Neil Owen District Councillor Susanna Pressel Councillor Glynis Phillips (In place of Councillor Mark Cherry)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle
Other Members in Attendance:	County Councillor Jenny Hannaby (for Agenda Item 8)
Whole of meeting	Strategic Director of People; J. Dean and S. Shepherd (Resources)

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.

10/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Cllr Glynis Phillips attended for Cllr Mark Cherry and an apology was received from Anne Wilkinson.

11/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest submitted.

12/18 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 8 February 2018 were approved and signed as a correct record subject to the following corrections:

- Page 4, Minute 7/18, penultimate paragraph – correction of 'Nuffield Hospital' to 'Nuffield Health Centre';
- Page 5, Minute 7/18, references to 'consultation' in paragraphs 4 and 5 to be amended to 'engagement' – and in paragraph 5, the reference to the 'final' version of the Plan to read 'first' version;
- Page 6, Minute 7/18, paragraph 2 – reference to the National Association of GPs' to read 'British Medical Association'; and
- Page 6, Minute 7/18, penultimate sentence, to amend the word 're-registered' to 'allocated'.

There were no matters arising.

13/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following members of the public addressing the Committee immediately prior to Committee discussion on the item itself:

Agenda Item 8
Cllr Jenny Hannaby
Jane Febers and Helen Wigginton, senior officers of the Royal College of Nursing with responsibility for members in Oxfordshire, Buckinghamshire and Milton

14/18 FORWARD PLAN

(Agenda No. 5)

The Chairman assured the Committee that the meeting between the Chairman of Health & Wellbeing Board/Health Improvement Partnership Board/Oxfordshire Joint Health Overview & Scrutiny Committee had been postponed. However, it was hoped that it would take place in early May.

The Chairman confirmed that priority would be given to scrutiny of the Health & Wellbeing Board's reorganisation by this Committee at either the June 2018 or the September 2018 meeting.

15/18 HEALTHWATCH OXFORDSHIRE
(Agenda No. 6)

George Smith, Chairman, presented the report from Healthwatch Oxfordshire on their views and latest activities (HWO6).

Professor Smith was asked what, in HWO's view, were the NHS Trusts highlighted in the report doing differently or better than Oxfordshire. He responded that changes to locally based domiciliary services had been done very well elsewhere. For example, domiciliary care workers had been given additional training to help recognise deterioration or concerns needing assessment. These care workers were then more integrated with nursing teams who could respond where concerns were flagged.

A member asked if there was evidence of improved health and wellbeing as a result of the integration of health and social care in areas showcased by CQC. Professor Smith responded that social prescribing incorporated others from a wide spectrum, for example, those who were lonely. He highlighted a recent venture where volunteers were giving companionship to older people in the Mendips area. This venture had resulted in a 20% reduction in health and care costs, together with an improvement in the quality of life for the older person.

The Chairman thanked Professor Smith for the report pointing out that the CQC was pleased with the way health and social care integration was proceeding with the Action Plan.

The Committee **AGREED** to thank HWO for the report and Professor Smith for his attendance.

16/18 CARE QUALITY COMMISSION LOCAL SYSTEM REVIEW
(Agenda No. 7)

The Committee considered a summary report (JHO7) by the Oxfordshire system leaders in relation to the CQC Local System Review. It summarised the outcome of the Review, its recommendations and the high – level Action Plan developed by system leaders in response to those recommendations, as well as setting out the proposed governance for ensuring the delivery of required actions. This Committee was asked to note the progress made and to provide any comments or observations that it may assist in assuring delivery of the agreed Action Plan.

The Committee welcomed the following representatives to the meeting:

- Stuart Bell CBE, Chief Executive, Oxford Health Foundation Trust (OH);
- Dr Tony Berendt, Medical Director, Oxford University Hospitals Foundation Trust (OUH);
- Lou Patten, Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG)
- Kate Terroni – Director of Adult Services, Oxfordshire County Council (OCC).

Kate Terroni, in giving a presentation to Committee, began by giving a recap on the CQC's approach to the review, which was to look at the Health and Social Care systems as a whole and how people and patients moved through the pathways. She stated that one of the main messages of the report was the absence of a single vision in Oxfordshire and the need to set clear strategies where it was required to avoid fragmentation and duplication.

She then gave an update on the actions included in the Action Plan, which, she stressed, were a very real opportunity to bring all the organisations together under one umbrella. To this end, the Oxfordshire Health & Wellbeing Board (HWBB) had agreed to call a special meeting on 10 May 2018 to consider a governance review of the Board which would formally pull together the efforts and powers of all organisations to give a much more unified view of the health and social care systems, which would be easier to scrutinise and hold to account. She stressed that the governance review would indicate that it would be a different way of moving forward.

The Chairman stated that the Committee would like to see actual results before it could be deemed successful and asked that this be borne in mind during the discussions.

Lou Patten stated that the aim of the Action Plan was to bring people together and to be as productive as possible in its delivery via the Integrated Care Delivery Board, which would be accountable for the areas of transformation. She added that an example of the new leadership was that of two assurance meetings which had taken place this year when NHS England and NHS Improvement had brought the entire system together in order to have a regulations conversation regarding performance. Going forward this very positive type of meeting would now be employed as a system. The aim was to empower the patients situated at the front end of the service line, rather than that of the organisation itself. An example of this was the focus on those patients who were in a hospital bed who did not need to be there. By focusing on gathering a group of 'doers' in a room to problem solve, they had started to create a 'freeing up' of the system which would assist with the patient flow. She further reported that a Winter Plan review had taken place which gave opportunities to learn externally. This would be brought to the next meeting of this Committee.

Kate Terroni also gave the following examples of 'mini' teams comprising representatives from all organisations looking at capacity over the whole system and how to respond:

- A single approach to target reporting;
- A workforce group looking at commissioning; and
- More joint posts, for example, a joint care homes commissioner

Lou Patten added that, as part of this new approach, future consultations would concentrate on developing spaces that brought together the social and health care needs for patients in each area of Oxfordshire.

Stuart Bell commented that there was also a need to ensure that Oxfordshire learned broadly from the experiences of other systems outside of Oxfordshire. He referred to the impetus given to giving a stronger central role to provider services within the

HWBB. He also made reference to the challenges Oxfordshire was facing in recruitment and retaining staff and with the availability of housing. An important part of the local system review was to address how to make the best use of people already living in Oxfordshire. He pointed out some good work undertaken on 'stranded' patients, which would make a real difference to frail older people.

Questions, comments and issues from members of the Committee included the following:

- With regards to transformation, the role of the community hospital needed to be brought to the fore to help address staff morale. Lou Patten stated that there was no sense in consulting on the buildings themselves, but on what was needed in each locality;

- A member stressed the importance of using plain English;

- In response to a request for more of a focus on where the innovation was in the system review, Kate Terroni responded that at this stage it was deemed helpful to focus on how to model health and social care differently and to the best advantage, such as the creation of Wellbeing Teams in each locality; or looking at care-worker routes to make them more effective; or looking at support from voluntary sector partners. She undertook to present what was innovative to a future meeting. Conversations were taking place with other authorities, for example with Shropshire and Frome. Lou Patten added that part of the process at the scoping stage was to look at what was happening elsewhere. This practice was being embedded as a thread throughout. The Chairman suggested that this Committee could focus on how innovation was being interpreted and used in the Oxfordshire system;

- A member asked why the possibility of having an in-house, domiciliary care service was not mentioned in the Action Plan. Lou Patten agreed that this would prove to be very effective. Kate Terroni reported that an options appraisal was currently being developed for a small, flexible health-care service. These were due for completion in June/July;

- In response to a question asking why carers were not recognised in the report and asking if the Action Plan adequately tackled the shortfall in carers required, Kate Terroni stated that it was believed that 60k people provided informal care in Oxfordshire, and of those, 7k were known to OCC. In the recent past a decision had been taken for GPs to allocate carer's grants as a single approach. Since then, carers had been offered the ability to self-assess their eligibility. She added that the value of carers was both enormous and essential and the question which needed to be asked was whether to support carers more;

- A member commented that that a 'stranded 'patient was not a good term. Lou Patten responded that she had a sympathy with this comment but stated that it was a national term which was used to categorise patients in

order to give a better understanding, a baseline for performance and information on any constraints within the system;

- In response to a question about how far the organisations had gone in their work towards a vision to have a fully integrated health and social care system for the benefit of Oxfordshire residents, Kate Terroni stated that it was almost there. The vision was due to be considered at the 10 May 2018 special meeting of the HWBB for sign off. The next strategy was to look at where the systems were and where they needed to be. Again, in response to a question as to whether all the organisations were acting differently in relation to this, Lou Patten stated that it was all about open and honest challenge. Conversations had taken place with all providers and commissioners;

- It was the view of a Committee member that any innovation monies would be needed first in the communities, as community services needed to be improved before the provision of bed.; and asking how this would be financed as to date there had been no mention of a pooled budgets? Lou Patten responded that funding for community health services for local patients were set by a funding formula. Oxfordshire was one of the lowest funded counties because it was seen as both healthy and wealthy in comparison to other areas. Discussion had indicated that £30m would be top sliced which meant that there would be a struggle to work with that sum reasonably. There would be a need to be as efficient as possible within the available resources. It was hoped that there would be more productivity and efficiencies within the overlap in service locations. Kate Terroni stated that one of the first pooled budgets for £350m was pooled across the OCCG and OCC (as referenced throughout the report). There was a challenge each year to make it more meaningful and each year there was important decision making made by people in joint posts;

- In response to a question regarding what, in their view, was missing from the report, Kate Terroni stated that it was key worker housing. However, Cherwell DC and Oxford City were looking collectively at how this could be tackled. Stewart Bell added that OH and OUH were looking at sites in order to assist. He echoed the need to work with the district councils on affordable housing;

- A member pointed out that more liaison was required with the district councils to ensure that they were bidding for sufficient housing. It had been shown as part of the Growth Deal that Oxford City Council had put in a claim for 98 affordable houses, Cherwell District Council for 82, South Oxfordshire District Council for 6 and Vale of White Horse for 6. Lou Patten undertook to take this up with the key providers across the system;

- With reference to a question regarding IT capability, Kate Terroni stated that an IT person would be placed in an inter-operability function. There was also a need to look outside of Oxfordshire for ideas, for example, at how North East Lancashire had achieved the bulk of provision on the same

IT system. Stuart Bell commented that progress was being made on the interactivity of GPs, Mental Health practitioners and with the communities;

- In response to a question about how the system review would sit alongside DTOC statistics, Kate Terroni stated that this time a year ago the statistics sat at 180-200 as compared to 88 compared to that week which stood at 98. If one was to take the longer view, it was heading in the right direction;

- With reference to a question about what principles system leaders would work together by, Lou Patten stated that would be governed by regulations and a set of working principles which would provide both a check and challenge to each other. There would be a tangibility about it. She reminded the Committee that this would not be the first time that leaders had gone through contracts together as previously they were NHS England assured. Stewart Bell stated that Lou Patten and himself were already doing it at Buckinghamshire – which proved it could be done;

- In response to a view expressed by a Committee member that currently there were fewer health and social care providers, Kate Terroni stated that the fragility of the Health Care market could not be underplayed. She assured the Committee that officers would be acutely aware of the situation in the rest of the market when doing the appraisal. She added that the hourly rate was £19.40 per hour and, with the addition of more precept by the Better Care Fund, it was now set at £20.40. Since this had been set there had been no health care providers exiting the market. The option appraisal was currently being prepared – adding that there was a value in having a form of in-house provision;

- A member expressed a view that there needed to be a significant culture change to make this venture work. Lou Patten responded that it was about knowing and understanding the motivation of clinicians, nurses, carers etc and then making it tangible and in the best interests of the patients. For example, clinicians had expressed a wish to take patient care out to place based locations and to work out the best solutions for their clients, such as frail people.

- At the close of the discussion all were thanked for their attendance and for responding to questions.

Dr McWilliam reminded the Committee that this was a review that was specifically looking at social and health care systems working and it was the Committee's decision as to whether it wanted to scrutinise the Health & Wellbeing Board's efforts to look at it in its totality.

It was **AGREED** that:

(a) a framework be provided to the Committee indicating how it was envisaged a framework would be provided and how each outcome would have a positive impact on users and carers; how it would be picked up by the Health & Wellbeing Board; and what the broad timing was for each expectation; and

(b) this piece of work to include the following three distinctive areas which would be useful for this Committee to pick up:

- what was the innovative aspect of each outcome;
- how plans for housing and workforce were to be incorporated; and
- how was Oxfordshire incorporating best practice from other areas in the plans.

17/18 OCCG: KEY AND CURRENT ISSUES

(Agenda No. 8)

Prior to discussion on this item the Committee was addressed by the following people:

Jane Febers and Helen Wigginton – regional officers responsible for members of the Royal College of Nursing (RCN) in Oxfordshire, Milton Keynes and Buckinghamshire.

Jane Febers gave a brief resume for the information of the Committee on the work of the RCN in support of nurses, health care assistants and students in a range of health care settings. The RCN aimed to improve the working life of staff by a number of means:

- by offering its members free confidential advice;
- by supporting and protecting a diversity programme, providing the tools to protect against discrimination in the workforce;
- by lobbying governments to improve the quality of patient care and providing advice to parliamentary select committees - the NCT had no ties to any political party;
- by attending UK conferences; and
- by engaging in national research.

They concluded by stating that their members in Oxfordshire had very real and valid concerns with regard to future plans for health and social care and morale was low.

Veronica Treacher spoke with regard to the transformation of, and evolution of the NCO's believing it to be an 'americanisation' of the NHS. She expressed her concerns that the recommendations relating to structural shifts rarely hit the headlines and that they required scrupulous scrutiny in order to understand the implications of what was about to happen. She added that, in her view, it would cause uncertainty in the future leading to an instability in the market, for example with GP practices proving uneconomical to run.

OCCG had been invited to give an update on its key issues and upcoming areas of work. This included:

- An update on the West Oxfordshire Place based Plan
- An update on the Transformation Programme
- Integrated Care Systems

Lou Patten, Chief Executive and Catherine Mountford, Director of Governance, OCCG attended for this item and presented the report JHO8.

West Oxfordshire Place based Plan

Lou Patten reported that she had met with patients and public engagement bodies who were keen to work with the OCCG and to engage with patients in order to make it a more inclusive way forward. This she had found to be very helpful.

A local member for West Oxfordshire stated that the local communities in west Oxfordshire would like to see an impetus on GP services in the west to work in collaboration with each other in order to reach some kind of GP representation in the locality. She suggested that a portion of the any funding available could be given to each practice to accommodate extra patients and to collaborate with other practices. Lou Patten responded that one of the key lessons learned at the meeting with the PPG was the confusion about the fundamental truth that GP practices are individual businesses which hold a contract with the NHS to deliver services. She added that the OCCG could not require individual practices to collaborate, but she believed that they could work together in a more 'linked' manner, in order to, for example, share burdens. Moreover, the CCG Governing Body had considered a discussion paper about provider collaboration and it had been made a clear intention and high priority for the future. This enabled NHS providers who were not already doing so, to work together. In Witney GPs were already working together collectively.

The Chairman, on behalf of the Committee stated that all patients registered at Deer Park Surgery had now been allocated to another practice and the Committee was happy to draw a line under the matter.

Transformation Programme

With regard to the Transformation Programme, Lou Patten reassured the Committee that it would not be treated as a countywide approach, but as a locality one. Her hope was that by describing a local approach it would promote a different type of public participation. She made reference to the address made by the representatives from the RCN earlier (declaring her interest as a registered nurse herself and on a RCN Board herself) stating that their voices needed to be as loud whether speaking with a locality voice or with a county-wide voice. She was asked if the OCCG recognised the concerns outlined to which she responded that she had not heard from OUH or OH, both of whom were very empathetic and challenges had been mainly around workforce issues.

A member commented on how pleased she was to see the plans for three free-standing units. Lou Patten was asked about the plans for Wantage Midwifery Unit which had been temporarily closed for 19 months, and, in the absence of a stage 2 consultation, would there be a consultation about its closure, as this would constitute a substantial change. She stated that it was her understanding that it was the inpatient beds that were temporarily closed and that the Midwife Led Unit MLU had continued to stay open. She added that there would still be an opportunity to deliver babies at the site in the form of an MLU. A local member referred to the presence of

legionella found at Wantage hospital, commenting also that more and more new homes were being built in the area, thus causing a greater stress on GP services. She added that answers were required quickly. Lou Patten responded that she could not give answers at this stage as to whether inpatient beds at Wantage Hospital would remain open or closed and appreciated that work on the programme had to be completed as speedily as possible. She added that with regard to community hospitals, there was a need to look at local populations first before doing anything, together with the demographics of the people living there including their health and social care needs and how, for example, to support frail people. After that, the OCCG would describe how it would look to people. There would be a commitment to maintain buildings whilst this work took place, as far as it was possible. A member responded that pressure was required on the OUH to ensure that the Maternity Department at the Horton Hospital, which was in a state of temporary closure, was not allowed to deteriorate in the meantime.

In response to a question about the timescale of the Plan, Catherine Mountford replied that all the engagement and consultation activities would also be online. When asked whether finances had been protected for primary care, she responded if discussions centred on countywide services, this would require consideration. A member commented that in the past, resources for intermediate care beds had not been distributed on a geographical basis, adding that if local needs were to be looked at, then there was a need to look at the provisions for local bed care also. Lou Patten responded that if it was looked at in this way, there would be challenges around both workforce availability and affordability. There would be a need for community hospitals to work in a network capacity across Oxfordshire, as efficiently as possible.

Lou Patten was asked how much capital was required for community beds to be externally commissioned. She responded that one of the conversations that was needed was around issues relating to the workforce and the buildings.

At the end of the discussion, the Chairman, speaking on behalf of the Committee, welcomed the new approach, pointing out that HOSC had already accepted other recommendations subject to a number of caveats. He thanked Lou Patten and Catherine Mountford for the report and asked Lou Patten to report back to Committee based on what Committee requested at the time.

Integrated Care Systems

Lou Patten gave a presentation on Integrated Care Systems, which included some reflection and learning from the Buckinghamshire experience.

The Chairman then opened the meeting out to questions from members.

A member commented on the good diabetic care a member of her family had received from a local pharmacist.

Lou Patten was asked if this was a move to the ‘quasi unpicking’ of the marketing of care, in place of payment by results. She replied that payment by results comprised of a list of services with prices, some proving to be a false economy. Rather it would

be about asking how much money was in the bank and how it could be used in the most effective way.

A member asked what protectors would be in place to prevent failed aspects infiltrating into how the NHS was managed, adding a view that whilst in pursuit of innovation, aspects of health and social care may crumble, due to there being no construct. Lou Patten referred to the integrated way of working in Torbay where health providers conducted discussions with teams in the wider community teams. This had resulted in greater job satisfaction for staff and more people applying for jobs. She stated further that she was keen to accelerate the aspect of more people being looked after independently at home and fewer people going into care homes.

A member stated that she would be interested to see what kind of rigorous protections would be put in place to stop the over-reliance on particular providers, and called for solutions to be embedded into the integrations. Lou Patten responded that this was a valid point and agreed that there was a need to reduce the overlap in care.

Lou Patten confirmed that she would still hold responsibility for a statutory organisation, and would remain accountable to the NHS, but she would be empowered to work together with other organisations. She added that there was a way to go before ensuring that all people understand that.

Both were thanked for their attendance for this item and for the presentation.

18/18 RESPONSE TO THE IRP - CONSULTANT-LED MATERNITY SERVICES AT HORTON

(Agenda No. 9)

Prior to consideration of this item, the Chairman made reference to the recent IRP judgement which directed the OCCG to consult the public again with regard to the maternity service at the Horton Hospital. He thanked members of the Committee and all who campaigned for the ‘real, tangible change’ which had been achieved.

The Committee considered proposals from this Council and the OCCG to address the IRP recommendations on the permanent closure of consultant-led maternity services at the Horton General Hospital (JHO9). A requirement of the recommendations was for Oxfordshire to form a new joint health scrutiny committee with Northamptonshire and Warwickshire County Councils.

Lou Patten and Catherine Mountford (OCCG); and Sue Whitehead and Glenn Watson (OCC) attended for this item.

Following a discussion the Committee **AGREED** to:

(a) note the IRP recommendations;
(b) note the requirements to form a new joint health scrutiny committee in response to the IRP recommendations, to be focused on consultant-led maternity services at the Horton General Hospital;

(c) request Oxfordshire County Council's Director of Law & Governance, in consultation with the Chairman and Deputy Chairman, to seek to negotiate the terms of reference for a new joint committee to be focused on consultant-led maternity services at the Horton General Hospital, to include a membership that is agreeable to all three Councils, for approval by the respective full Councils;
(d) (nem con) in respect of (c) above, to include within the Terms of Reference that this committee be for the purpose stated only; and that the power of referral to the Secretary of State should sit with the new Committee only;
(e) (nem con) it was this Committee's view that a conversation between paediatrics and obstetrics was required as both services were inter-dependent ie. obstetrics require neo-natal services.

19/18 OXFORD HEALTH (OH) QUALITY ACCOUNT

(Agenda No. 10)

The Committee was asked to scrutinise the key priorities contained in the Oxford Health Foundation Trust's (OH) Quality Account.

Due to time limitations as a consequence of the large amount of business on the Agenda, and the need for Health Officers to be at a meeting elsewhere, the Chairman requested, and it was **AGREED** that the Quality Account be circulated to members of the Committee for their comment and then collated for the Trust.

20/18 OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (OUH) - QUALITY ACCOUNT

(Agenda No. 11)

Dr Tony Berendt and Dr Clare Dollery (OUH) attended for this item. Dr Dollery gave a presentation.

The Chairman thanked Drs Berendt and Dollery for the presentation and opened the meeting out for questions and comment.

A member referred to a very useful presentation which had been given by OUH on cancer pathways and the One Stop Shop at the Churchill Hospital at the last meeting and asked if the priority to reduce the 62 days for referral to treatment could be met. Dr Berendt stated that it was hard to measure performance in this area. He added that the one stop shop may prove to be of overall benefit to the patient as recorded in performance targets relating to patient pathway, but it could not apply to forensic methods.

Also with regard to cancer pathways a member asked whether there were any areas identified where performance blockages had occurred. Dr Berendt responded that Board papers included integrated performance reports, not service by service breakdowns. Blockages were identified pathway by pathway but it had been recognised that there was a need to introduce changes which would identify blockages between pathways which required addressing.

Stemming from a request made at the last meeting, a member asked if every ward in the hospital now had a mental health champion who was identifiable to carers coming in with a patient with mental health needs. Dr Berendt responded that he needed to come back to the Committee on this matter. He added however that a supply teaching programme, which included patient mental health issues had now been completed. Dr Berendt was requested to return to members with information on whether a champion was available in every ward at all times. Dr Dollery responded that the immediate purpose was for them to be readily available.

A member asked if the Trust was seeking different quality measures, given that the CQC had been specially critical with regard to end of life care quality of care (ie the whole of the patient experience and process) and would it affect the Quality report. Dr Dollery responded that the Trust was very mindful of the CQC system and one of its aims was to take on one of the goals from the CQC report and to ensure that each pathway included pre and post pathways. Dr Berendt added that there was a certain amount of work which had to be carried out on this aspect. For example, end of life care was very internally directed and there was a need to adopt a better joined-up system. There would be greater emphasis on conducting conversations externally on how to become more responsive, as there was now a higher volume of care available to patients who wanted to die out of hospital. Dr Berendt added however that currently there was a statutory requirement to have a separate quality account, but, as the system moved on, it may be possible to adopt a joint account which would be more effective.

With regard to a question asking if the Trust was content with the way the patient complaint system operated, Dr Dollery reported that efforts had been made to improve the system this year, but there was still a considerable way to go in this area. She added that timeliness was crucial as it was important to the Trust that patients were aware that it was listening. On a positive note Dr Dollery reported that there had been fewer complaints last year. Currently there was not a quality priority for complaints, but the Trust would continue to learn from them. A member asked if there was scope to improve the process of making a complaint further, to which Dr Dollery agreed there was.

The Chairman summarised the points to be made by this Committee, as identified above, and requested Drs Berendt and Dollery to return to members of the Committee with their priority areas as they were finalised.

Drs Berendt and Dollery were thanked for their attendance and presentation to the Committee.

21/18 HOSC & HEALTH 'WAYS OF WORKING' WORKSHOP REPORT AND DRAFT PRINCIPLES

(Agenda No. 12)

Prior to consideration of this item, the Committee was addressed by Liz Peretz speaking on behalf of ‘Keep our NHS Public’. She spoke against the protocol and the establishment of the HOSC Planning Group on the following grounds:

- HOSC had been set up as an independent voice with the power to call in any service leader. She asked if this access to senior officers would be compromised;
- HOSC should decide on its own agenda, not those bodies whom it was scrutinising; and
- It was her view that meeting in private would negate the public's essential ability to challenge with regard to any service change.

She urged the Committee not to throw away the 'real voice' of the Committee and to make it into a 'non-democratic' Committee. She pointed out that transparency and the ability to carry out independent scrutiny would be lost.

The Chairman, in response to the points made in the address, stated that the protocol had been devised in mind of the principles contained in the IRP recommendations in relation to the ways of working that had led to the Deer Park referral. He stressed that this did not negate the scrutiny function or detract from the power of referral. Rather, the Committee would be better informed and could therefore plan for an issue in a better way, rather than having issues introduced to the Committee at a late date. He added that he was a big advocate for conducting business in the public domain as far as possible. However, when it came to planning, the Committee needed to hold flexible, informal meetings where no decisions were made.

Cllr Laura Price stated that in her view this document was an 'enhanced version of the toolkit', meetings for which were held behind closed doors. She added that the Committee was in danger of confusing what was a formal and an informal meeting, particularly when thinking about whether proposals constituted a substantial change of service.

The Chairman then proposed, and was duly seconded, that the Planning Group be held in public session. This was lost by 3 votes to 7. The Chairman than proposed, and was duly seconded, to formally adopt the recommendations contained in the report.

The Committee **AGREED** to:

(a) note the progress made against addressing the IRP recommendation and the Committee's agreements made on 8 February 2018;
(b) agree the draft protocol outlined in Appendix A of this report; and
(c) (by 8 votes to 3) establish a Planning Group and to request the HOSC support officers to negotiate its terms of reference in order to ensure the Group meets to inform the next meeting of this Committee.

22/18 CHAIRMAN'S REPORT
(Agenda No. 13)

The Committee considered the Chairman's report (JHO13) which included an update on social care liaison.

Cllr Price agreed to join the MSK Task & Finish Group. The Chairman confirmed that all physiotherapy services were included in the Terms of Reference for the Group.

It was requested that the progress in relation to the implementation of the new Healthshare service be added to the Forward Plan in light of concerns expressed by Healthwatch Oxfordshire (HWO).

A member suggested that a HWO representative could be a better patient representative on the MSK Group, rather than an individual patient. The Chairman stated that the Task & Finish Group was in trial stage and it was his preference that it be left as a broad definition of an individual patient, but to include 'or a HWO representative'.

The Committee **AGREED t**o note the Chairman's report.

.... in the Chair

Date of signing ....

This page is intentionally left blank

HOSC Actions from 19th April 2018

Item no	Item	Action	Lead
14/18	Forward Plan	Ensure the review of the Winter Plan appears on the agenda for the June meeting of HOSC	Sam Shepherd
14/18	Forward Plan	Ensure Quality Accounts from primary care are considered by the Committee next year	Sam Shepherd
14/18	Forward Plan	To scrutinise the reorganisation of the Health and Wellbeing Board (June or Sept 2018)	Sam Shepherd
15/18	Healthwatch Report	Track the progress of the roll out of social prescribing	George Smith (HWO)
16/18	CQC Local System Review	to request the Director for Adult Services to devise a framework, for agreement by this Committee, which informed on how the Health & Wellbeing Board would be evaluating each outcome arising from the system review , and its impact on service users and patients; in order to aid scrutiny by HOSC. The framework to include a clear timeframe of when these benefits would be realised.	Kate Terroni (OCC)
16/18	CQC Local System Review	Report back to the committee on: 1. How innovation is being interpreted and used in the Oxfordshire system 2. What work is being undertaken to address the housing and workforce issues in the system 3. How learning from best practice examples elsewhere in the country is being incorporated in the work in Oxfordshire.	Kate Terroni (OCC)
17/18	CCG Update	HOSC to receive a report going to the CCG's Primary Care Commissioning Committee on the detailed response to NHSE-commissioned review of the CCG's engagement on West Oxfordshire Locality Plan.	Catherine Mountford (OCCG)
17/18	CCG Update	HOSC to receive information on the spend in primary care across Oxfordshire. To be scoped with the Chairman	Catherine Montford (OCCG)/ Cllr Arash Fatemian (HOSC)
17/18	CCG Update	Gain assurances from OUH that the maternity building(s) at the Horton General Hospital will be maintained throughout the period of time to respond to the IRP recommendations.	Lou Patten (OCCG)
17/18	CCG Update	HOSC to receive a report back on the outcome of Phase One of the Transformation Programme; specifically on the progress and situation regarding bed numbers.	Catherine Mountford (OCCG)
17/18	CCG Update	Work with HOSC to develop evaluation	Lou Patten

		parameters for Integrated Care System for Oxfordshire	(OCCG)
18/18	IRP Response	In consultation with the Chairman and Deputy Chairman: seek to negotiate the terms of reference for a new joint committee to be focused on consultant-led maternity services at the Horton General Hospital, to include a membership that is agreeable to all three Councils, for approval by the relevant full Councils. This committee should be time-limited in nature.	Nick Graham (OCC)
19/18	OH Quality Account	Quality Account for OH to be circulated to the committee via email for comment.	Jane Kershaw (OH) and Sam Shepherd (OCC)
19/18	OH Quality Account	Dr Berendt to report back to the Committee on action taken to identify a staff member acting as mental health champion on each ward.	Dr Tony Berendt (OUH)
20/18	OUH Quality Account	Detailed breakdown of the performance of individual cancer specialisms on Referral to treatment Times	Dr Claire Dollery (OUH)
20/18	OUH Quality Account	Share the detail of the final set of future priorities for the Quality Account 2018/19	Dr Claire Dollery (OUH)
21/18	Ways of working	Circulate the HOSC Protocol to the Health and Wellbeing Board	Sam Shepherd/ Julie Dean (OCC)
22/18	Chairman's report	MSK Task and Finish Group should scrutinise all aspects of the new contract and Health Share should be listed as an 'additional attendee' not as a member of the group as they may require scrutiny.	Sam Shepherd (OCC)

HOSC Forward Plan – June 2018

The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The “PICK” methodology can help scrutiny committees consider which topics to select or reject. This is:

Public interest	➢ Is the topic of concern to the public? ➢ Is this a “high profile” topic for specific local communities? ➢ Is there or has there been a high level of user dissatisfaction with the service or bad press? ➢ Has the topic has been identified by members/officers as a key issue?
Impact	➢ Will scrutiny lead to improvements for the people of Oxfordshire? ➢ Will scrutiny lead to increased value for money? ➢ Could this make a big difference to the way services are delivered or resource used?
Council performance	➢ Does the topic support the achievement of corporate priorities? ➢ Are the Council and/or other organisations not performing well in this area? ➢ Do we understand why our performance is poor compared to others? ➢ Are we performing well, but spending too much resource on this?
Keep in context	➢ Has new government guidance or legislation been released that will require a significant change to services? ➢ Has the issue been raised by the external auditor/ regulator? ➢ Are any inspections planned in the near future?

Meeting Date	Item Title	Details and Purpose	Organisation
September 2018	DPH Report	• An Annual Report is a statutory duty of Director’s of Public Health and it is a duty of the County Council to publish the report. • The Director of Public Health for Oxfordshire will present his Annual Report for 2017/18.	DPH

Updated: 11 June 2018

Meeting Date	Item Title	Details and Purpose	Organisation
September	New Governance of the Health and Wellbeing Board	• The reorganisation of the Health and Wellbeing Board	
April 2019	Quality Reports	• Quality Reports from: Oxford University Hospitals, Oxford Health and SCAS on the progress against their high level priorities. • Formal response from HOSC required on the final draft accounts	OH/OUH/SCAS/Federations
June 2019	HWBB Annual Report	An annual report to HOSC on the activity of the HWBB, covering: • Activity of the Board over the financial year 2018/19 in pursuit of the Health and Wellbeing Strategy • How it performed against its aims and objectives during that period, including an overview of performance for all the sub-partnerships of the Board (e.g. HIB/Children's Trust & Integrated Systems Delivery Board). • Report to include assessment of how revised governance arrangements are working • Plans for 2019/20.	
Future Items			
	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns. • Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure
	Health visiting services	• Impact of changes to children's centres on provision of health visiting service • Scrutiny of newly commissioned service	PH & OH & CEF

Updated: 11 June 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		• 0-5 health visiting services	
	GP appointments	• Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored	CCG
	Anaesthetist training at the Horton General Hospital	•	OUH
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
	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
	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities	
	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell)	
	School Health Nurses	• The impact of school health nurses in secondary schools and future service plans • This is being recommissioned by PH by March 2018	PH, OH
	Health support for children and young people with SEND	• How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care? • Linked to outcomes of SEND Local Area Inspection	OH, OUH
	Priorities in Health –	• How the CCG manages competing priorities –	CCG

Meeting Date	Item Title	Details and Purpose	Organisation
	Lavender Statements	Thames Valley Priorities Forum	
	Commissioning intentions	• Committee scrutinises the CCG Commissioning Intentions	CCG

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21 June 2018

Title of Paper: Update Oxfordshire Health & Social Care System Winter Plan 2017/18

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with evaluation on the delivery of the Oxfordshire Winter Plan 2017/18. Partners in the system include:

- GP Federations
- Oxfordshire County Council
- Oxford Health NHS Foundation NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group
- South Central Ambulance Services NHS Foundation Trust
- Age UK and the very wide range of social care and third sector providers

Senior Responsible Officer: Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group

Update on Oxfordshire Winter Plans 2017/18

1. Introduction

In November 2017 a paper on the Oxfordshire health and social care system wide winter plans was presented to JHOSC. This document is an evaluation report of that plan.

Key priorities for the health and social care system are:

- Pathways and flow – how patients access and move through services
- Managing demand – ensuring the right services are available at the right time
- Achievement of the Accident & Emergency (A&E) four hour target – people attending A&E to be seen, treated and either discharged or admitted within four hours
- Delayed transfers of care – reducing the numbers of medically fit patients delayed in hospital
- Workforce – recruitment, development and retention of staff
- Ensuring Primary Care capacity and resilience
- Securing value for money

In line with the recently published Kings Fund report it has been widely acknowledged that the winter of 2017/18 saw the NHS in England experience extreme – and possibly unprecedented – pressures. Health Secretary Jeremy Hunt himself admitted that the pressures on the system meant it *"probably was the worst ever"* winter for the health service.

NHS England Chief Executive Simon Stevens said at the Nuffield Trust Health Policy Summit that February 2018 was probably the *"most pressurised month the NHS has seen in its nearly 70-year history"*. This report notes that substantially more patients attended A&E – roughly 5.8 million in the winter months in 2017/18, compared to just under 5.6 million the year before – an increase of 5%. Over the past five years A&E attendances in the winter months have grown by 13%.

In line with this, urgent care activity across the Oxfordshire system has continued to increase often above planned levels and as such has placed significant challenges on the system to manage patient care safely and in a timely way.

This report is presented as three stages of a potential patient journey – hospital avoidance, in hospital and out of hospital.

2. Hospital avoidance

Our hospital avoidance plans and services have helped us to support patients to remain in their own home and avoid hospital attendance or admission. This included a range of services listed below.

2.1 TV Integrated Urgent Care (IUC) 111

The Urgent and Emergency Care Review led by Sir Bruce Keogh proposed a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. Put simply

"If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week"

The NHS England Integrated Urgent Care (IUC) vision has two fundamental parts:

- For those people with urgent but non-life threatening care needs we should provide a highly responsive, effective and personalised service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

In line with this South Central Ambulance NHS Foundation Trust (SCAS) formed an alliance with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust (OHFT) and Buckinghamshire Healthcare NHS Trust to deliver a newly commissioned IUC Service which went live from 5 September 2017 across Thames Valley.

For the first month of the service SCAS achieved call answer performance of 94.46% for the TV area as a whole, with Oxon delivering 94.34% answered within 60 seconds. The abandonment rate (patients who hang up before their call is answered) was below that national requirement of 5%.

Performance against targets fell during the winter period in part due to increased demand and patient acuity levels exacerbated by a rise in staff sickness and a requirement to support a high level of national contingency measures.

SCAS received additional funding of £100k to provide additional clinical resource. Half of this funding was used for clinicians who were sourced through their private provider delivery partner. This clinical resource was focussed on enhanced clinical assessment for A&E dispositions and 999 ambulance referrals. However it must be noted that in times of extreme pressure with call waiting to be answered, these clinicians were deployed to call answer duties. The remaining funding was used on IT equipment to enable an additional GP to work within the IUC Service. This GP was only able to provide one session for the Oxfordshire area.

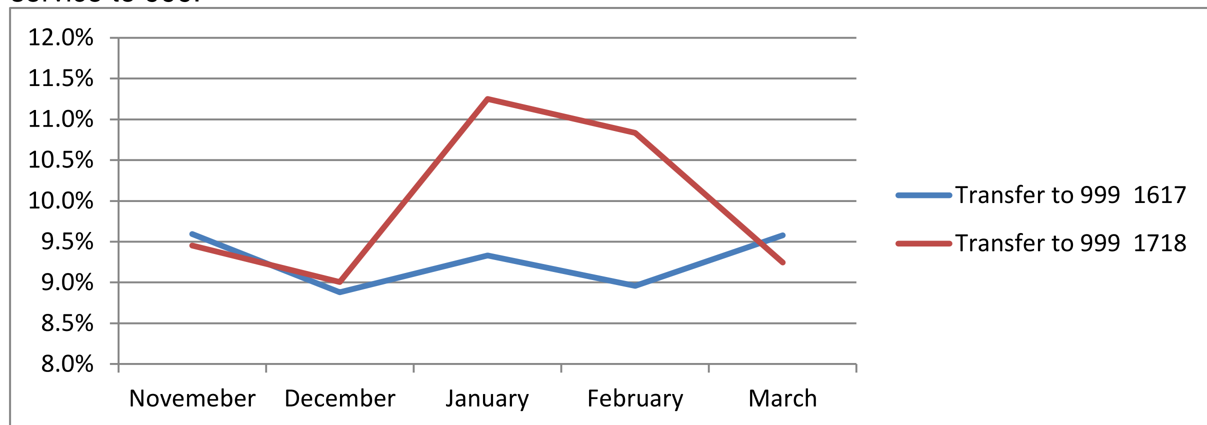
		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
	IUC Performance indicators	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**
NCI-2	Abandoned calls (target <5%)	0.67%	7.53%	2.58%	1.55%	5.04%
NCI-4	Call waiting time (target 95% < 60 seconds)	93.14%	64.84%	81.85%	83.98%	64.54%
NCI-9	Transfer to 999 (target <10%)	9.45%	9.01%	11.25%	10.83%	9.25%
NCI-10	Attend Accident and A&E Type 1 & 2 (target <5%)	5.36%	4.66%	6.53%	6.33%	6.16%

The Thames Valley IUC contractual target for 999 referrals is 10%. As can been seen from the table above, January and February were in excess of this for Oxon. These months were due to demand levels and associated winter symptom acuity but also it must be noted that NHS England, made changes to the denominator metric for this target. This changed from

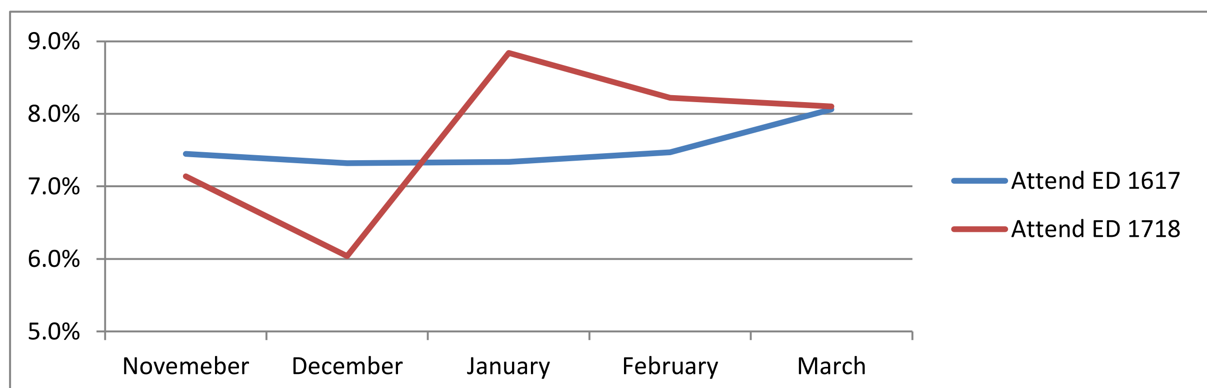
measuring the transfer rate from calls answered to calls triaged. The service tracks nationally at circa 2% lower than the national average of around 12%. Nationally this demonstrated many services being in excess of 12%. The table above clearly demonstrates an improved picture for March 2018 and this continued throughout April and May 2018. This is due to symptom acuity reducing and also more importantly to a new mandated NHSE initiative for all Category 3 and 4 (not life threatening 999 calls) ambulance disposition calls to be held in a queue for clinical validation by a clinician (GP as well as clinicians) to validate the appropriateness of an ambulance referral prior to transferring to the ambulance service. At the outset of this initiative, NHSE guidance stated that these calls can be held for up to 15 minutes, this has now been extended to 30 minutes.

A&E type 1&2 dispositions (emergencies), as can be seen above, are in excess of the 5% target, however, the IUC clinicians and the GPs are reviewing A&E referrals and a similar process for A&E dispositions is being implemented to reduce this referral rate. SCAS has implemented technological changes to the Adastra clinical record management system that is used and will enhance this further to demonstrate improvements to support the local health care economy.

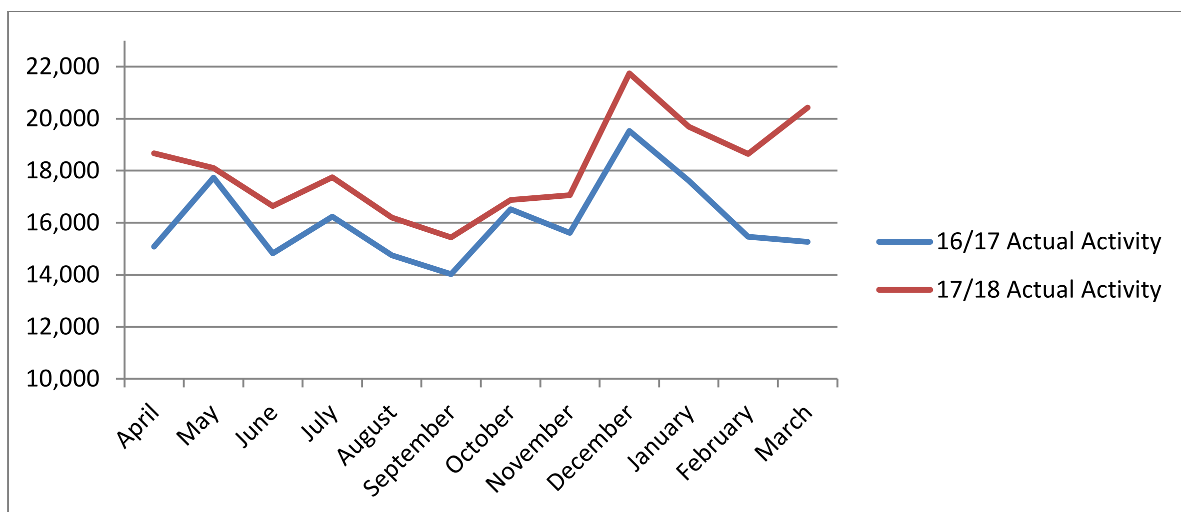
The chart below shows the percentage of calls transferred from the Thames Valley IUC 111 service to 999:



The chart below shows the percentage of calls advised by the Thames Valley IUC 111 service to attend an A&E department:



The increase in activity within the Thame Valley IUC 111 service is shown below.



Since going live in September 2017, the service has included other provision such as pharmacists, mental health practitioners, palliative care and third party providers.

The service is also working closely with partners in primary care for direct patient appointment bookings into GP access hubs and Minor Injury Units (MIUs).

There is currently an action Plan in place which is being monitored at SCAS Executive level every two weeks. The main challenges within the action plan are workforce numbers and abstractions.

2.2 Additional ambulance service support

The Oxford SOS Treatment Centre (SOS bus) ran every Friday and Saturday night in Oxford city centre with an additional service provided on Sunday 31st December 2017. A total of sixty three presentations were treated compared to a total of eighteen during the same period in 2016/17. Of the sixty three presentations only fourteen patients required further assessment or treatment at the John Radcliffe Hospital equating to a non-conveyance rate of 78%.

The Patient Transport Service (PTS) was increased between the 20th December 2017 and 15th January 2018 to support short notice discharges out of hospital sites.

2.3 Increased Services available from Community Pharmacies

A new Minor Ailment Scheme was set up to improve access to support to manage minor ailments providing care and support through community pharmacies went live in November 2017 and saw in excess of 530 patients over the winter period. Due to the success of the project the service is now being expanded to include additional pharmacies in Banbury and Oxford City from June 2018.

Oxfordshire pharmacies have also supported the wider system managing demand with interventions to diagnose and treat manage urinary tract infections (84 consultations) and increasing the use of NHS Urgent Medicine Supply Advanced Service (NUMSAS) pharmacies to provide repeat prescriptions out of hours . The NHS Urgent Medicine Supply Advanced Service (NUMSAS) commenced September 2017 in Thames Valley as an additional service to provide repeat prescriptions. It is fundamentally a service that manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 because they need urgent access to a medicine or appliance that they have been previously

prescribed on an NHS prescription. During Christmas 2017 it was noted that many repeat prescriptions were still being directed to Oxfordshire OOH services and 111 were not utilising the designated pharmacies. A task and finish group was established to perform a concentrated piece of work with 111 to improve this. In January 88% of repeat prescriptions were being directed to OOH and only 12% to the pharmacies but by the end of May, following the work of the group, the balance had changed significantly with 51% being directed to pharmacies.

2.4 Primary Care

Primary care continues to face particularly challenging times with

- Shortage in workforce and difficulty recruiting staff
- Increasing demand for same-day access for urgent care
- Increasing pressure in managing complex, frail or elderly patients
- Vulnerable practices and practice sustainability.
- Areas of significant housing growth and population increase.

In order to ease demand pressures in the system, Oxfordshire Clinical Commissioning Group (OCCG) commissioned an additional 2,036 primary care appointments during the winter period. These consisted of 1,713 GP appointments and 323 ANP/Practice Nurse appointments at a total cost of £81,400. 91% of the appointments were used. Additional appointments were created through the GP Access Fund (GPAF).

2.4.1 GP Access Fund

The GP Access Fund was created to increase capacity within GP surgeries to enable primary care to meet additional needs across the county and release GP time to spend on complex patients where they can make most difference to outcomes. The services provided include:

- Weekday practice-based hub offering face-to-face services, 18:00-20:00, with at least one GP and one other clinician (nurse/HCA) in all localities.
- Saturday Hub service, 09:00-12:00, with at least one GP and one other clinician. (GP/nurse/HCA) in the city and Banbury.
- Sunday Hub service for 3 hours in the morning, with at least one GP in the city and Banbury.

The volume of appointments required is calculated at 30mins/1000 patients. Converted to appointments this equated to an additional 74,532 appointments across Oxfordshire in 2017/18.

The table below shows appointments available and utilisation against this target for the period April 2017 – March 2018 (Inc.). The utilisation (% Used against required) has now increased and being maintained to greater than 80% across all federations. Utilisation will continue to be reviewed with the aim of capacity being matched to patient need.

All Federations Analysis	Total Available	71918
	Total Appointments Used	53851
	% Total Available Appointments Used	75%
	Total Appointments Required	74532

	% Available Appointments of those required	96%
	% Used against Required	72%

2.4.2 GP workforce

There is currently a shortage of GPs and Practice Nurses in Oxfordshire, despite a number of recruitment initiatives.

OCCG is currently supporting the recruitment of an additional 20 GPs from overseas. This process is likely to take some time and may not be in place for winter 2018/19. As such there is a focus on releasing existing GP time to support the additional winter demand. As part of this a Health Care Assistant (HCA)/Practice Nurse (PN) training plan is being developed to upskill HCAs and graduate PNs more quickly, so that they can deliver more services thus freeing up GP time. Dependent on Health Education England's (HEE) timelines it is hoped that a significant amount will be delivered before the winter pressures.

2.5 Proactive Medical Support to Care Homes

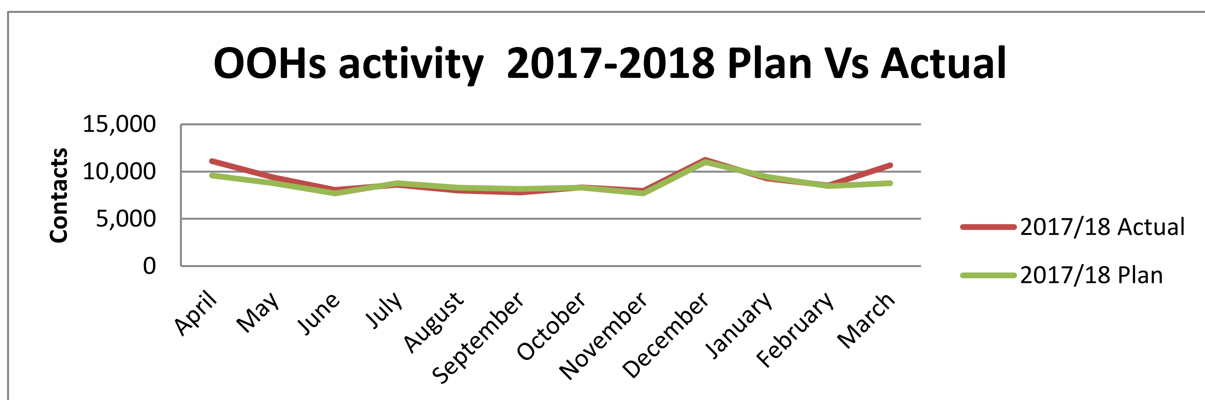
Our proactive medical support to care homes service provides additional GP time and support to care and nursing homes. A&E department attendances for patients in care homes supported by this service fell by 3% in 2017/18 compared to 2014/15; In contrast attendances at A&E from the non-participating home rose by 1%.

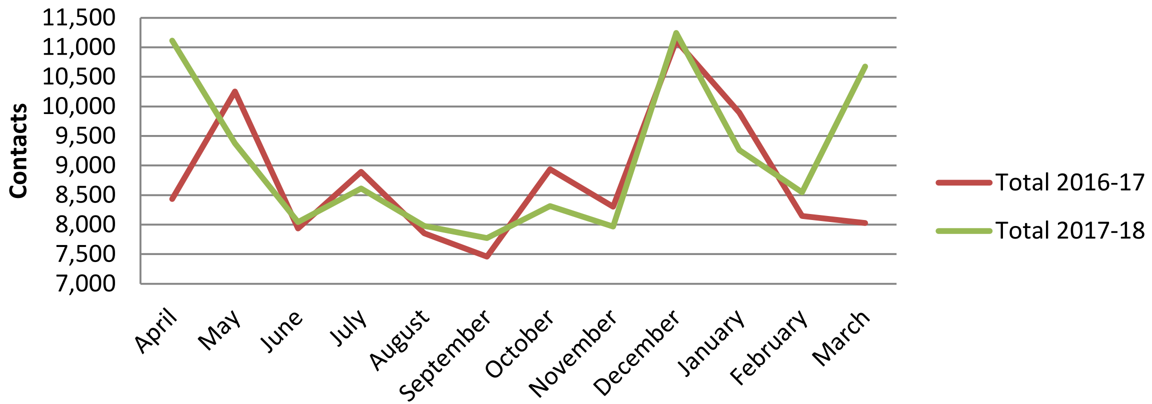
Taking the learning from this work we are now undertaking a review of all services going into care homes to see how they can be remodelled to ensure integrated working between different services and teams, ensuring services are meeting the needs of the residents. A collaborative approach is essential for success.

During this year we are aiming for 100% coverage of homes within Oxfordshire.

2.6 Out of Hours (OOH)

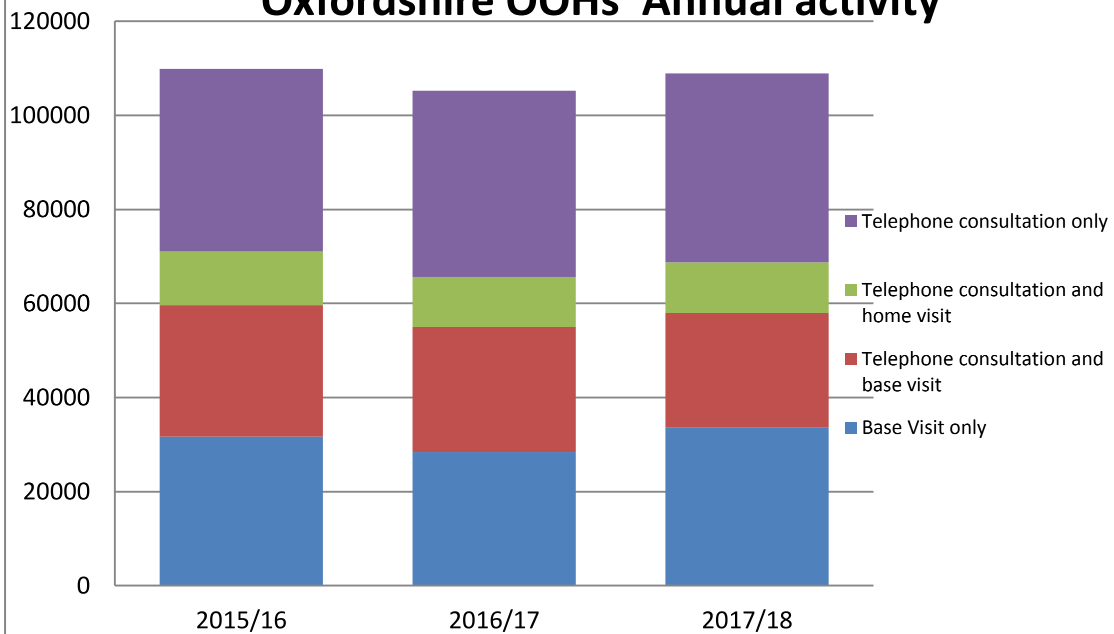
OOH activity was similar to the planned and previous year's activity levels until March 2018 when it saw a spike in contacts. This indicates that the modelling of actual and anticipated demand has been consistent; however the cold weather during March and the protracted winter had a direct impact upon demand.





Most prevalent within OOHs was the increase in base appointments, in particular the number of patients that had an appointment booked directly from 111 via the electronic link providing a seamless service. This increase in directly booked appointments compares to a reduction in patients requiring a telephone consultation from a GP prior to being given a base appointment and is an indication of the confidence that has been achieved in the 111 service.

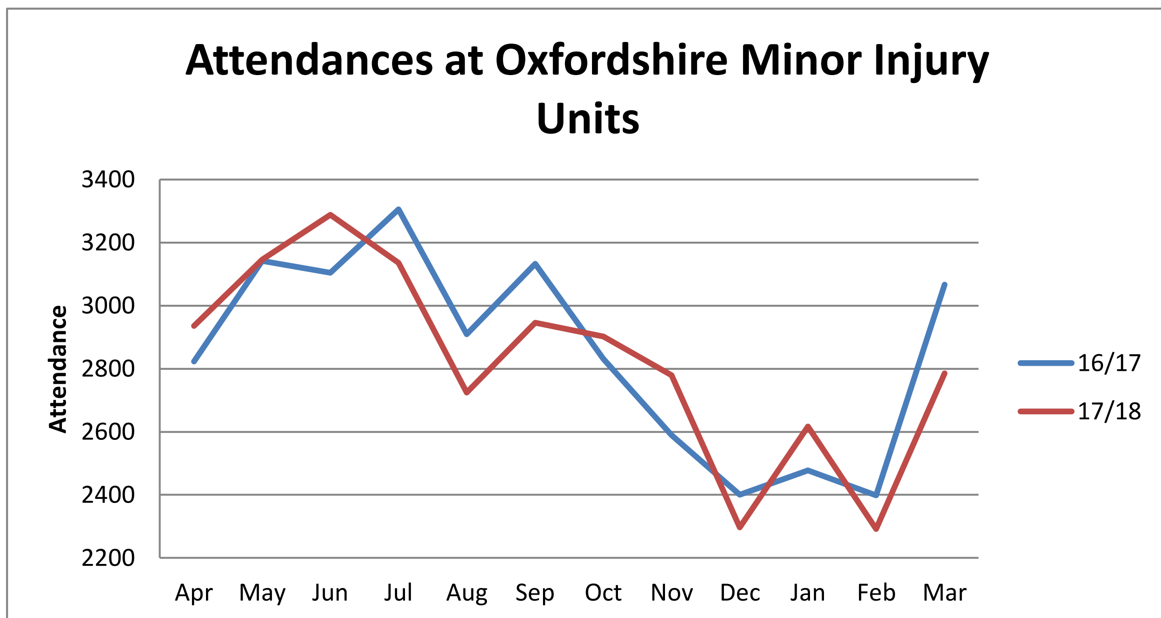
During the past two years, there has been an increased pressure on primary care and new schemes to increase primary care capacity have presented opportunities for GP's. This has challenged the ability for the service to attract GP's leading to the service being unable to cover all rostered shifts. The Trust continues to explore ways in which to encourage take up of shifts and to review different skill mixing insuring the most appropriate clinician for the patient's needs.



2.7 Minor Injuries Units (MIU)

MIU attendances were slightly lower than last year at 33,849 compared to 34,179.

This is a nurse and paramedic led service which has strong links with the Oxford University Hospitals NHS Foundation Trust (OUHFT) and the Royal Berkshire Hospital NHS Foundation Trust (RBH), this has supported the ability for the service to manage more complex presentations and complete treatment without the need to refer onwards. During the winter months activity through the MIU's is slightly lower as shown in the graph below. The seasonal variation is primarily due to the dark evenings and fewer sports related injuries. Lower patient numbers attending with minor injuries allows the MIU clinical staff to support the OOHs service and patients with minor illnesses which tend to increase during winter months.



2.8 Emergency Multi-disciplinary Units

There are two Emergency Multi-disciplinary Units[1] (EMUs) in Oxfordshire. Abingdon EMU is a 9-bed/chair unit and Witney EMU is a 6 bed/chair unit.

The aim of the Emergency Multidisciplinary Units is to provide assessment and treatment for adults with sub-acute care needs as close to patients' homes as possible. Providing medical, nursing and therapist assessments and treatments, the units are designed to offer patients a faster and more convenient alternative to admission to an acute hospital.

Our teams deliver a comprehensive assessment, acute medical diagnosis and treatment plan with ongoing care to support patients and carers during episodes of illness without acute hospital admission.

[1] There are also two ambulatory assessment units based at the John Radcliffe Hospital and Horton General Hospital (see page 19). They also assess and treat patients on a same-day basis so they do not have to be admitted to a hospital bed, which is better for patients.

Located within a community hospital site, the emergency multidisciplinary unit will rapidly assess any patient, following contact with a healthcare provider (for instance, a GP, community nurse or ambulance paramedic) who feels that further assessment is needed.

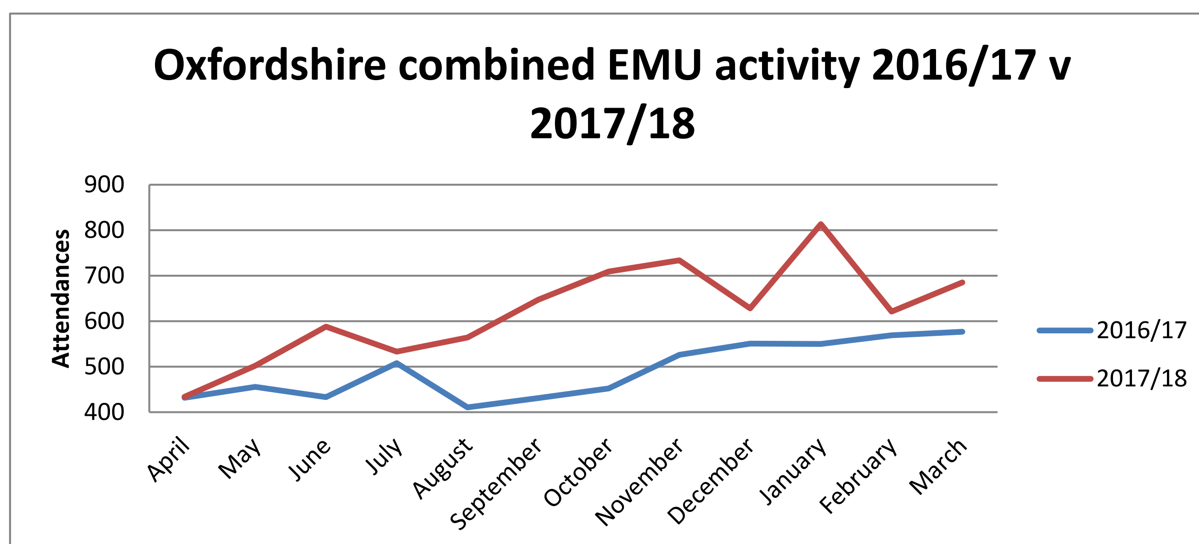
EMUs do not assess patients with suspected heart attacks, strokes, head injuries or those who may require surgical intervention. These will need to be seen at the A&E or as a direct referral to the surgical teams.

There was a 26% increase in total contacts at these units in 2017/18 compared to 2016/17. This equates to an increase of 1562 contacts - averaging 130 contacts per month for both EMUs and with each EMU having an average increased activity of 65 contacts per month.

The average monthly activity in EMUs in FY16/17 was 491 and this increased to 622 in FY17/18.

EMU Activity (Contacts)	**FY17/18**	**FY16/17**	**Activity variance**	**% increase in Activity from FY16/17 to FY17/18**
Abingdon EMU	4221	3344	877	26%
Witney EMU	3237	2552	685	27%
Total for both EMUs	7458	5896	1562	26%

Monthly activity peaked in January at 813 attendances:



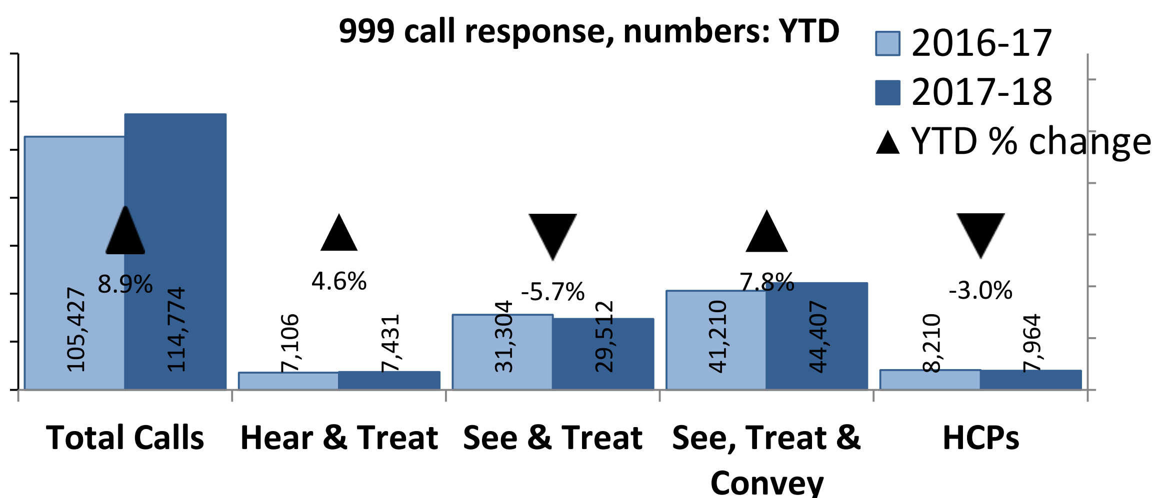
2.9 999

Nationally NHS England have been rolling out the new Ambulance Response Programme. This has meant a change in ambulance targets which came into place locally for SCAS from November 2017. The response targets were amended to ensure the correct response and vehicle was getting to the patient for their clinical needs. The response times are now measured in mean and 90th percentiles rather than percentages as previously. This has been the biggest change to ambulance targets nationally for 30 years and was well managed and successfully mobilised by SCAS. It has required major IT changes, operational policy change, coding changes, staff training, modelling and fleet mix changes.

NHSE have allowed a period of transition in achieving the new targets until September 2018 however the Trust is benchmarking well nationally against other ambulance trusts and has achieved performance at contract level across all indicators in April 2018. The Trust expects to remain on track to achieve performance by the September deadline.

There has been some changing acuity of patients over the winter period which has meant a drop in 'see and treat' activity and an increase in 'see, treat and convey'. This has been challenging for the local acute hospitals, Commissioners are working with the Trust to manage this increase through alternative pathways and additional clinical validation of 999 incidents in the Integrated Urgent Care (IUC) contract. Oxfordshire has undertaken an audit of the ambulance arrivals which will seek to give greater understanding of alternative pathways and actions we can take. The increase in levels of ambulance conveyance is a key area for us to understand for next winter's planning.

The Trust continues to work hard to recruit to vacancies and where there are gaps this is backfilled using private provider resources.



Response times for 999 calls (November 17 – March 18 inc) are shown below:

Category	Cat 1	Cat 1		Cat 2	Cat 2		Cat 3		Cat 4
Target	7 minutes	15 minutes		18 minutes	40 minutes		2 Hrs		3 Hrs
Month	Mean	90th Percentile		Mean	90th Percentile		90th Percentile		90th Percentile
November	0:07:45	0:15:42		0:15:19	0:28:21		1:32:24		2:36:41
December	0:08:34	0:15:59		0:17:35	0:33:10		2:28:43		4:18:49
January	0:07:26	0:14:15		0:16:21	0:31:33		2:02:53		3:04:14
February	0:07:07	0:13:48		0:15:55	0:29:47		1:51:53		2:57:24
March	0:07:18	0:14:10		0:17:50	0:33:39		2:06:53		3:45:38

Overall performance for Oxfordshire, Thames Valley and SCAS for 201/18:

Category	Cat 1	Cat 1		Cat 2	Cat 2		Cat 3		Cat 4
Target	7 minutes	15 minutes		18 minutes	40 minutes		2 Hrs		3 Hrs
Year to Date	Mean	90th Percentile		Mean	90th Percentile		90th Percentile		90th Percentile
OXFORDSHIRE CCG	0:07:40	0:14:54		0:16:41	0:31:39		2:00:48		3:19:23
TV Total	0:07:22	0:13:42		0:16:18	0:32:30		2:18:06		3:27:21
SCAS Total	0:07:20	0:13:21		0:17:25	0:35:05		2:22:58		3:28:33

Engagement continues between the A&E staff and the Ambulance trust to ensure delays are kept to a minimum when handing over patients. Both SCAS and OUHFT have reviewed their handover processes to improve the efficiency of handovers, in an attempt to reduce patients waiting in ambulances and release ambulance capacity for patients requiring ambulances in the community.

The table below shows the cumulative amount of time ambulances are delayed by at each A&E department by month. These figures are in hours per month and do not take into account the number of ambulance arrivals at each department.

Excess Handover	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
HORTON GENERAL	2:02:05	2:18:32	8:48:20	19:16:35	14:44:44	5:20:19	16:23:46	22:13:18	17:58:31	50:10:02	33:43:45	3:03:01	0:00:00
JOHN RADCLIFFE	79:53:44	74:25:31	96:09:54	89:28:21	105:41:51	95:55:11	121:04:17	101:17:41	131:19:15	156:55:42	156:53:26	121:52:55	131:21:11
MILTON KEYNES GENERAL	117:43:55	88:34:24	57:25:41	67:41:01	48:23:18	22:43:29	59:52:31	72:03:07	150:01:05	231:02:57	159:42:51	124:15:05	128:07:03
ROYAL BERKSHIRE	42:52:56	53:57:34	59:16:47	57:55:48	61:53:53	60:27:19	60:50:28	55:05:31	102:10:10	161:25:41	153:10:40	148:48:24	132:25:47
STOKE MANDEVILLE	65:05:17	61:04:22	98:25:42	101:31:05	100:56:37	125:38:43	81:19:22	97:51:36	106:17:15	207:50:51	131:49:11	119:23:58	153:58:56
WEXHAM PARK	105:26:21	48:39:59	67:31:40	44:33:01	91:15:42	117:31:50	80:19:40	62:58:11	99:55:20	248:28:29	249:07:00	266:18:08	245:48:33

2.10 Mental Health Crisis Response Services - Oxford Safe Haven (OSH)

The OSH is a service_provided by Mind and Elmore and offers an alternative (non-statutory) ethos in responding to mental health crisis. It is available for:

- Over 18's living in Oxfordshire
- People experiencing a mental health crisis who wish to access support and could benefit from a supportive, non-clinical environment out of hours
- People who historically may have attended the A&E in the absence of other options for accessing assessment, support and safety
- At risk of self-harm or suicide, but no immediate risk to self or others

The service does not provide for:

- Clients under 18 or living outside of Oxfordshire
- Immediate risk to self or others
- Likely to be disruptive or aggressive in an informal social environment
- In immediate need of medical treatment
- Clients who are significantly intoxicated with alcohol or drugs on arrival will not be admitted

Winter funding provided by NHS England (NHSE) has enabled OSH to be set-up and piloted for 6 months with the intention that it will be sustained and further developed. OSH is provided by Oxfordshire Mind and Elmore Community Services commenced operation in mid-March. OSH is open Friday, Saturday, Sunday 18:00hrs to 01:00hrs and is based in Oxford Health NHS FT premises on Manzil Way in East Oxford.

The main aim of the service is to improve access to, and the overall range of, crisis response services available (in particular in the evenings and at weekends) and to reduce use of urgent and emergency services (health, social care and Police) where other mental health pathways are available. Since opening the service has received 49 referrals and had 32 attendances. Service user and referrer feedback has been overwhelmingly positive including some early evidence of diversion from use of emergency services including the A&E.

Referral pathways are continuing to be expanded with the aim of progressing to self-referral by mid-June. Additionally, service users identified as 'high intensity users' of urgent and emergency services have been specifically focused on in terms of publicising the service with them and supporting their engagement with it. Again, there has been some early successes with this particular approach. Data collection regarding activity and outcomes continues and we are developing a framework for evaluating the impact of OSH using a variety of data sources.

2.11 Mental Health Assessment Hub (Littlemore Hospital site)

The assessment hub offers formal mental health assessment and can be utilised by patients of all ages with all mental health conditions and risk profiles.

Further winter funding from NHSE has enabled the physical environment of the Assessment Hub to be built on the Littlemore site and has funded two clinical staff at Band 6 for one year. A business case for further funding for clinical staff in order to be able to fully operationalise the Hub 24/7 within a defined clinical service model is being developed. The physical environment of the Assessment Hub will be completed on 6th June and handed over to the clinical service.

The Assessment Hub is comprised of two assessment consultation rooms, a comfortable waiting area, clinical office space, treatment/clinic room and toilet facilities. The two assessment rooms have been created with a number of requirements in mind (all ages and all mental health conditions) and can be used flexibly to meet a variety of needs and purposes. One of the assessment rooms has been built to the specification of a Hospital Based Place of Safety (HBPoS) and could be used for this purpose to support existing HBPoS capacity as an 'other suitable place' (Police & Crime Act 2017) where appropriate. This room is also the 'low stimulus' room and would be suitable for people who have sensory sensitivity (for example people with autistic spectrum disorders as a primary or comorbid condition).The second assessment consultation room has been designed to be a comfortable and visually appealing assessment area for young people, adults and older adults and is equipped with tele-psychiatry facilities and opportunities for distraction activities.

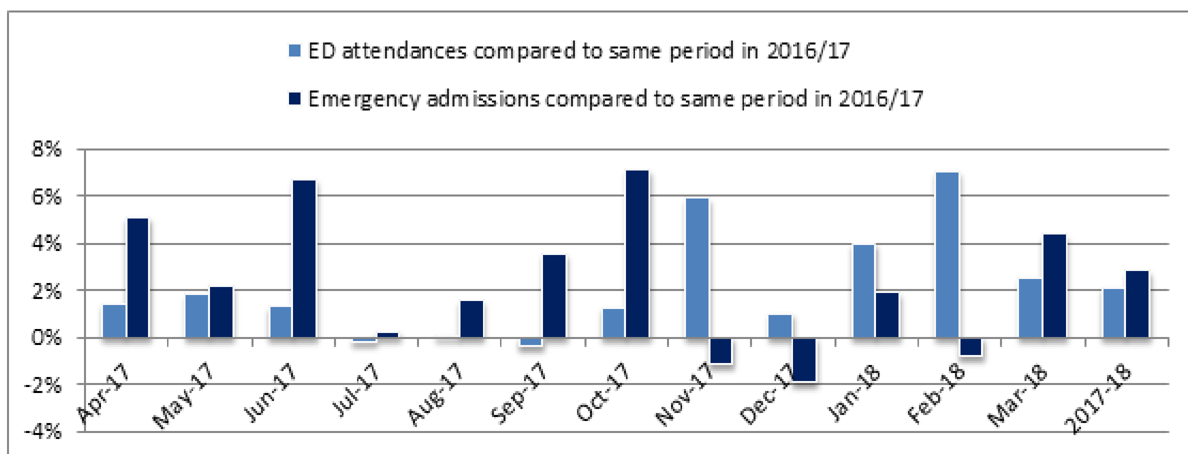
The Assessment Hub replaces the single room emergency assessment facility at the Warneford Hospital 'front door'. The future vision is to be able to undertake all emergency assessments and reviews at the Hub but also to use it flexibly to provide care and support patients who are awaiting their onward step having been assessed in the HBPoS, A&E, Police Custody or other OHFT clinical team base (e.g. awaiting admission or return home with care plan).

3. In Hospital

3.1 A&E activity

In 2017-18, growth continued in the numbers of people attending and being admitted for urgent care. As shown below, in most months of the year there were more A&E attendances and emergency admissions than in 2016/17. There was also considerable variation. The highest number of attendances per day were seen in June and November 2017 and the highest number of admissions per day in January-March 2018.

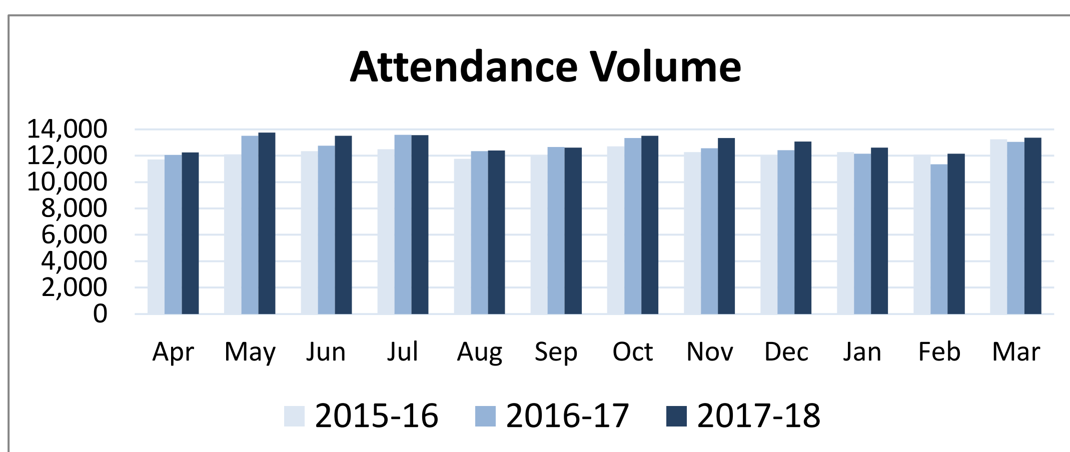
Over the past three years, emergency admissions have grown by a higher percentage than attendances, probably reflecting the ageing population that OUHFT is caring for. The below table shows OUHFT A&E Department attendances and Emergency admissions (Non-elective first finished consultant episodes) per month in 2017/18 compared to the year before:

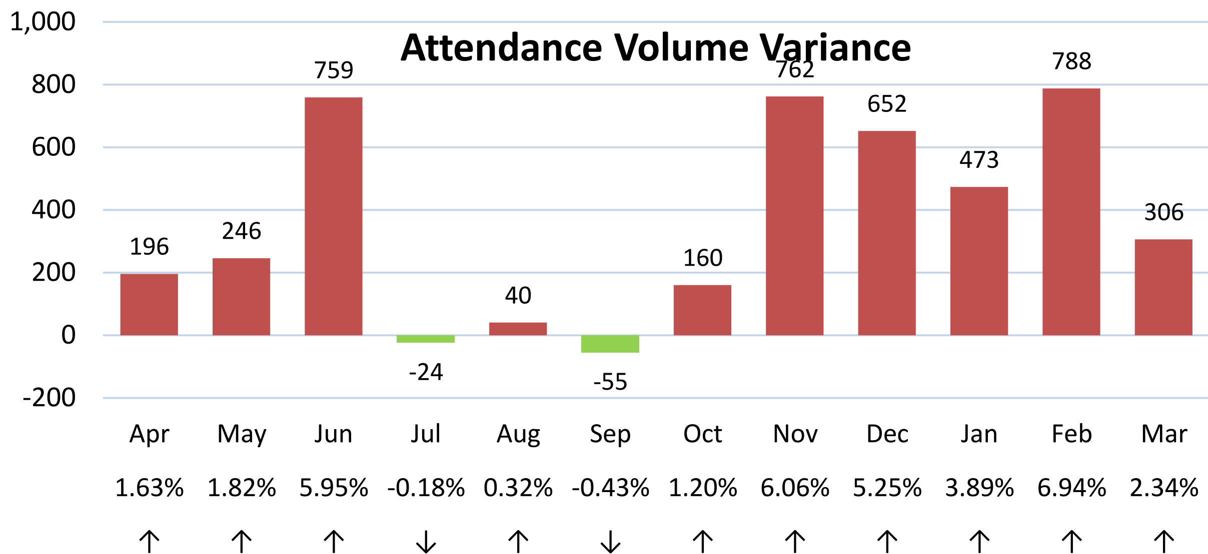


The growth seen by OUHFT in 2017/18 was above that in the NHS in England for A&E attendances (OUHFT 2.83%, England 2.21%) but lower for emergency admissions (OUHFT 2.13%, England 3.71%). This may indicate some success in local measures to provide alternatives to admission.

In November it was reported that A&E attendances for Oxfordshire patients had increased by 1.45% compared to the previous year, this has risen to 2.9% by March 2018.

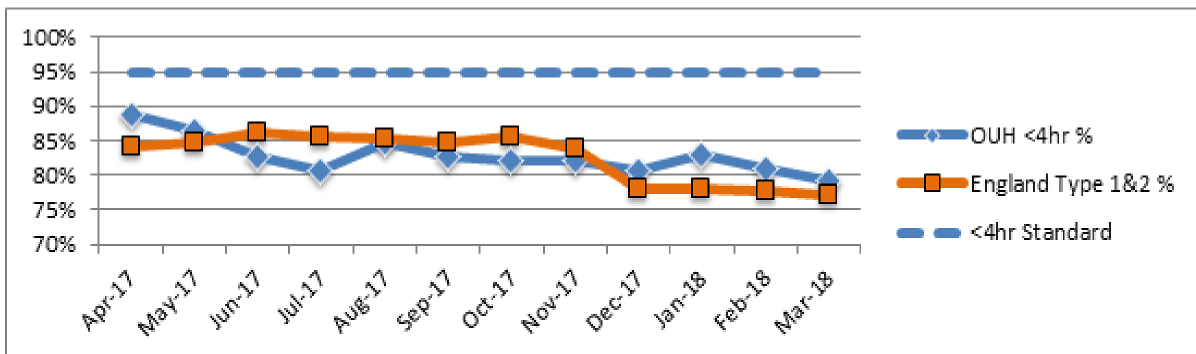
3.2 Attendances





3.3 Four hour A&E target

OUHFT has faced significant challenges in delivering the capacity required to see, treat, admit or discharge people within 4 hours of arrival at its A&E departments. The 95% 4 hour standard has not been met by the NHS in England or by OUHFT since July 2015. As shown below performance reduced during the year. The NHS in England experienced a rapid drop in performance from October 2017, with performance below OUHFT's from December in comparable A&E. The performance since April 2018 has seen some improvement particularly on the Horton Hospital site.



OUH <4 hour wait %, 2017-18, and NHS England performance for Type 1 and Type 2 A&E[1]

3.4 12 hour breaches

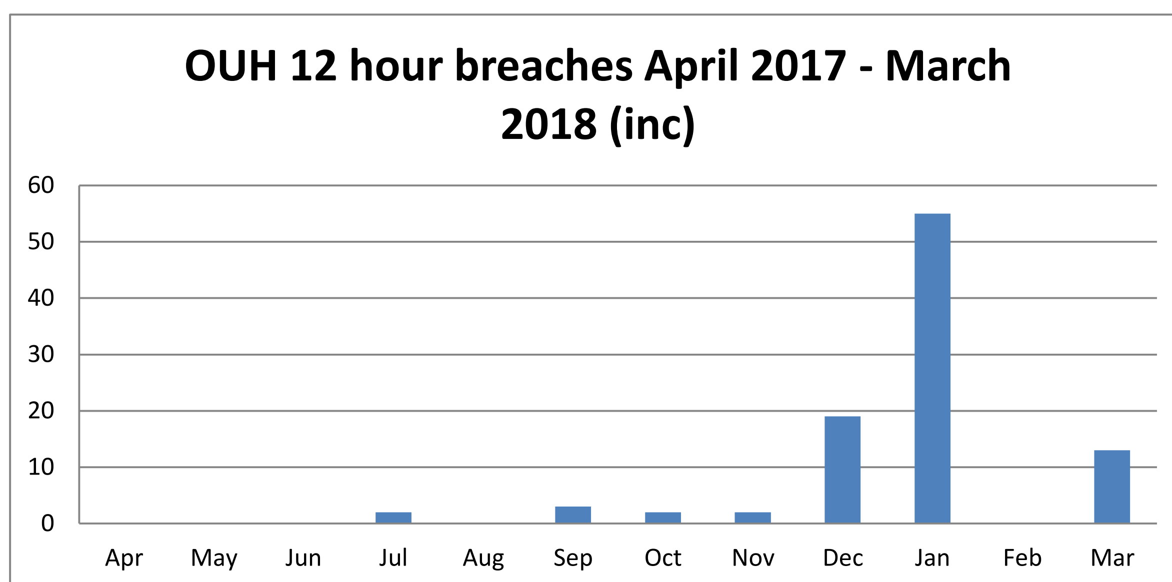
In 2017/18 the OUHFT began to experience 12 hour trolley waits in A&E. This means that there is a period of over 12 hours between the decision to admit and admission. Each breach must be reported to commissioners and investigated.

During January 2018, an unprecedented number of people waited over 12 hours in the OUHFT A&E departments after decision to admit. A further 13 patients waited over 12 hours

[1] Type 1 being 'major' Emergency Departments, as at the John Radcliffe and Horton General, and Type 2 being single-specialty departments as at the Oxford Eye Hospital.

in March 2018. These delays happened at the peak times of pressure on inpatient beds and on services conducting emergency assessment.

It was disappointing that patients waited for such long time to be admitted. Systems have been reviewed and adapted and best practice publicised in the clinical areas involved – focusing on particularly on identifying delays in admission, appropriate escalation of potential 12 hour delays and timely investigation of delays. The Oxfordshire system is also revising the escalation framework to ensure that partner organisations work together to create enough bed capacity or bed equivalent capacity in times of significant pressure.



The OUHFT has undertaken an in depth clinical review of patients waiting over 12 hours in order to establish whether any clinical harm resulted and what lessons may be learned. This review found that these patients had received high quality care with clearly documented maintenance of hydration and nutrition, safe skin checks, prevention of deterioration of pressure ulcers, evidence of clinical review, recording of vital signs, good clinical management and no delays in accessing diagnostics or treatment. The system is assured that while the experience of these patients is not optimal, OUHFT did provide safe, high quality care during these challenging periods.

3.5 Bed occupancy

OUHFT continued to have a high level of bed occupancy through the autumn and winter. Locally and nationally, monitoring began of the numbers of patients assessed as medically fit for discharge but still in hospital as inpatients. Throughout February and early March 2018, 47-57% of OUHFT's General and Acute beds[2] were occupied by patients in this category. From late summer 2017, shortages of nursing staff meant that OUHFT needed temporarily to close some inpatient beds. These staffing-related bed closures particularly affected services at the Churchill Hospital and Nuffield Orthopaedic Centre, with a staff Incentive scheme used to keep adult inpatient beds operational at the John Radcliffe, open additional beds and avoid weekend closures. This enabled the Trust to keep beds equivalent to a ward open on the John Radcliffe Hospital site.

The availability of nursing staff continues to be a challenge to OUHFT. Continuing vacancy rates among ward nurses and smaller but equally significant vacancies amongst theatre

[2] Beds where overnight care is provided, excluding maternity and neonatal care beds.

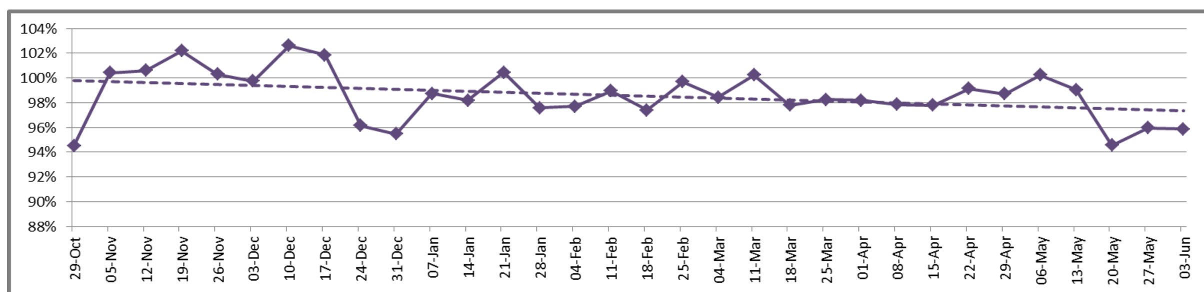
nurses are influencing the capacity OUHFT has available to treat patients requiring inpatient surgery. In concert with system partners, OUHFT is developing its plans for the coming winter which will include how best to make use of the nursing staff it has and how best to minimise vacancies.

On 2 January 2018, the National Emergency Pressures Panel (NEPP) recommended that NHS providers extend the normal reduction in elective activity seen over the Christmas and New Year period, maintaining reductions throughout the month of January where this was necessary to maintain prompt access to emergency care services. OUHFT postponed non-cancer and non-urgent planned surgery for some 100 patients per week until services were able to return to normal by 12 February.

Actions to improve urgent care and shorten waits included changes to the operation of the Emergency Assessment Unit and Short Stay Wards, improved internal communications, close work with system partners on capacity and patient flow and strengthened arrangements for bed management. Learning from experience elsewhere, arrangements were also strengthened for the provision of clinical 'Board rounds' on wards and the review of patients ready for discharge.

Bed occupancy is a key measure of pressure a system is experiencing. It is calculated from the established (funded) number of General & Acute inpatient beds (excluding day case beds, theatre recovery areas, maternity and neonatal intensive care), then adjust the weekly total (denominator) to take account of bed days lost due to short staffing. Levels of over 100% are when additional beds have needed to be opened during the week to accommodate emergency admissions.

The chart below shows the percentage bed occupancy/week October 29th 2017 – June 3rd 2018 (inc)



The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. Occupancy rates for acute beds nationally have increased from 87.7% in 2010/11 to 89.5% in 2014/15 so few hospitals are achieving the 85%.

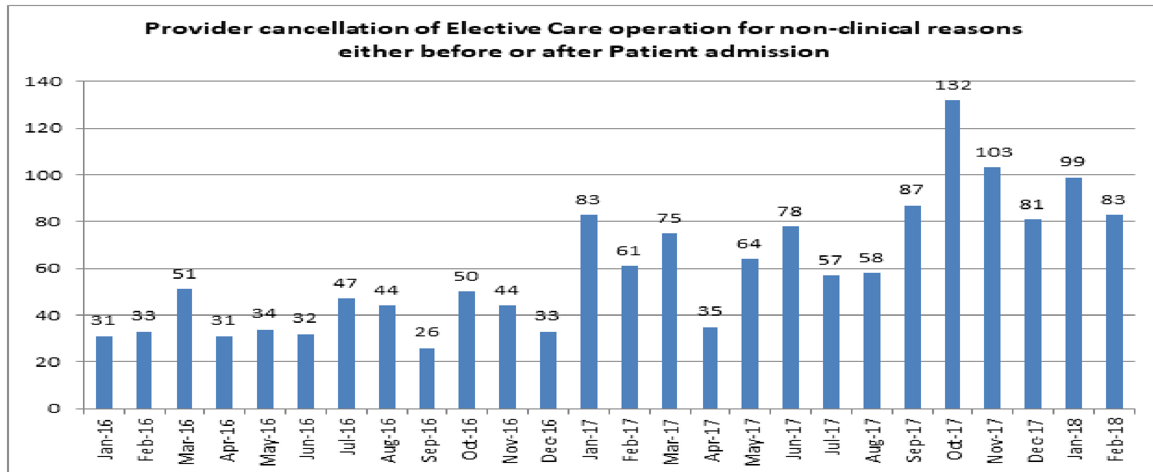
In Oxfordshire we acknowledge the challenge of achieving 85% bed occupancy and have set a local target of 92%. However, as the chart above shows we have not been below 94% since 29th October 2017. This is a key area to improve for next winter.

3.6 Cancellations

Cancellations by OUHFT for non-clinical reasons (not necessarily on the day) rose in 2017, peaking in the autumn at a time when West Wing theatres were experiencing acute

shortages of Anaesthetic Nurse Practitioners. Two of ten Churchill theatres are currently closed due to staff shortages.

These cancellations include those which took place in January and early February as recommended by the National Emergency Pressures Panel (NEPP).

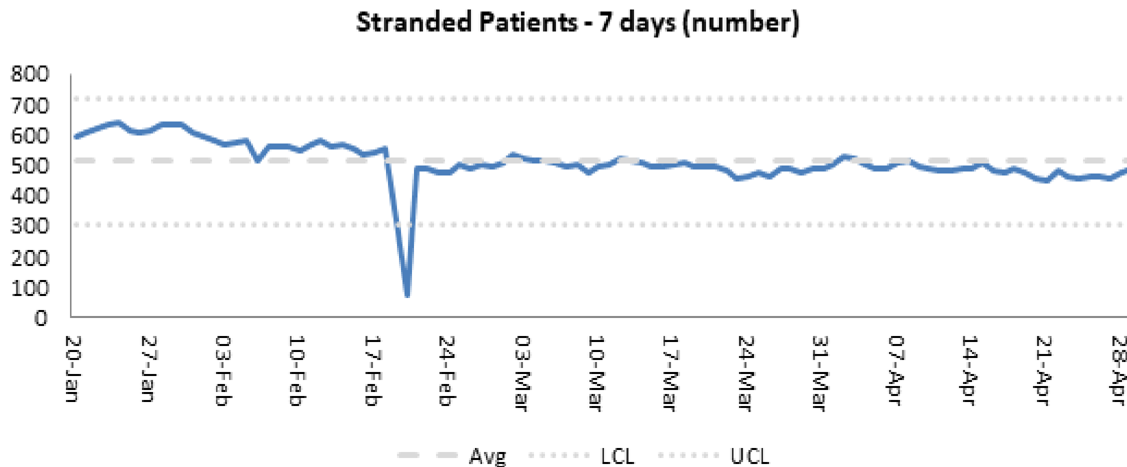


3.7 Stranded patients

During the course of the plan the system also responded to the findings of the CQC review of the Oxfordshire system and further reviews by national teams (ECIP and Dr Ian Sturgess) and adopted a *stranded patient* approach. This model works on the basis that any patient in a bed for 7 days or more is reviewed and plans checked to assure that the patient needs to remain in the bed. Where blocks are identified these are escalated to a senior officer team with the power to deploy resources; and where this level of escalation is insufficient to escalate weekly to CEOs.

This measure is gaining favour nationally as an indicator of how beds are being used, and of the efficiency of local health and social care systems at moving people on from hospital when they are medically fit for transfer. The Emergency Care Improvement Programme (ECIP) defines stranded patients as those with a length of stay of seven days or more.

Systematic weekly review takes place every Wednesday of all inpatients in OUHFT beds to identify those who have been in hospital for at least 7 days and are medically fit for discharge. A process for escalation is in place from wards to the Chief Executive. The number of patients in this group reduced from early February but with a reduction in the overall number of non-elective patients in OUHFT beds in recent weeks, have accounted for a growing proportion of OUHFT's occupied beds.

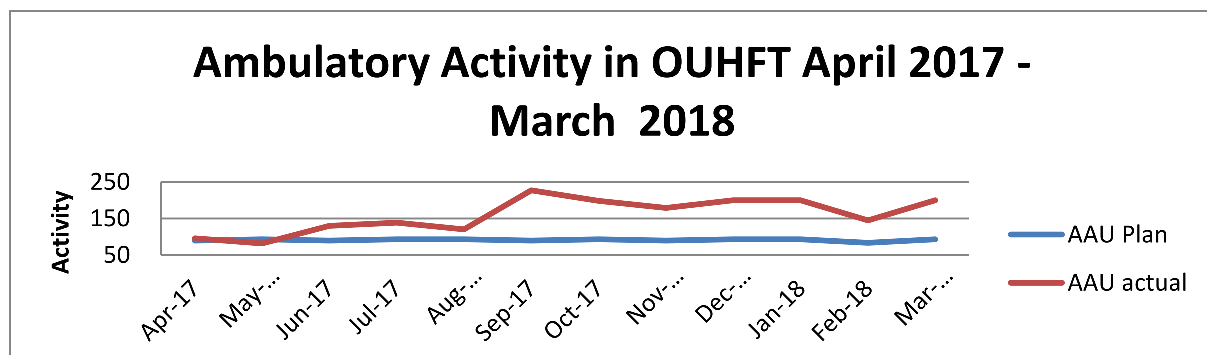


Across the South of England, there has been a slow but steady reduction in stranded patients to 48.88% (7 days) and 18.71% (21 days) (figures from NHS Improvement for 7 June 2018). OUHFT's equivalent figures are 48.86% and 21.34%. The Horton's figures are 53.51% and 24.56%, with the site having been adversely affected by problems in Northamptonshire.

Continuing focus is being given to reducing delays for this group of patients, with work including the strengthening of daily systems for ward 'Board rounds' to maximise the efficiency of discharge planning and actions.

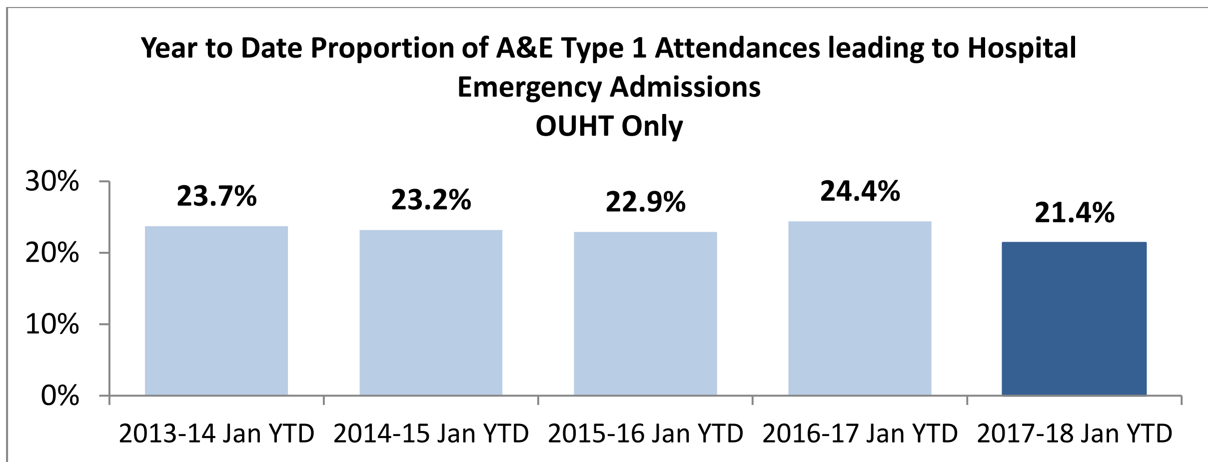
3.8 Ambulatory Care

The number of patients treated in one of the 2 Oxfordshire Ambulatory Assessment Units increased above planned levels. This activity relieved some pressure from the acute hospitals as historically these patients would have been seen in the Accident and Emergency departments.



3.9 Admissions

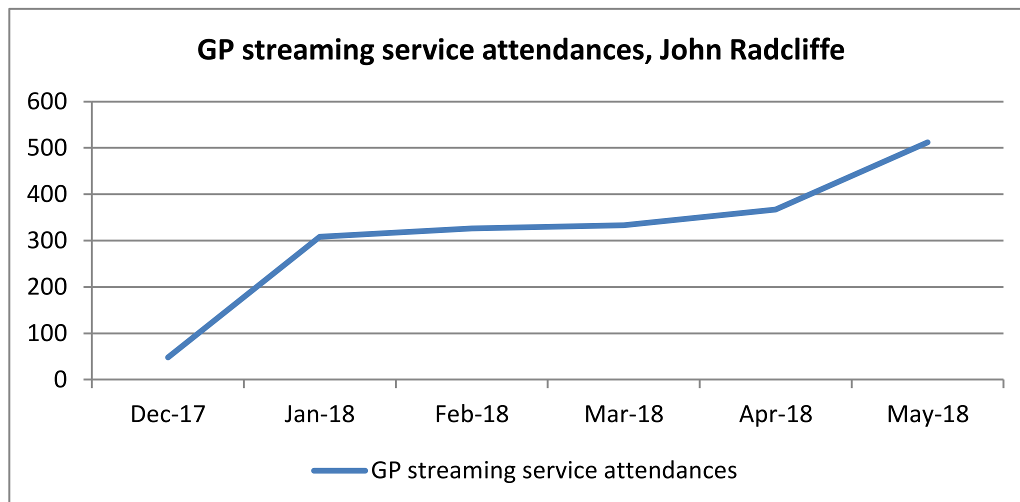
The proportion of people admitted from A&E into a hospital bed continues to decrease over time indicating that alternatives to bed based care are being implemented successfully.



The average length of stay (LoS) for a non-elective admission (NEL) reduced from 3.5 days 2016/17 to 3.3 days 2017/18.

3.10 GP streaming

Streaming of patients attending A&E who are suitable for a GP service began at the John Radcliffe for 7 days per week in January 2018 (GPs having been available on site for some weeks before that). The GP streaming team relocated to a dedicated building which opened on Tuesday, 1 May. In April, 387 patients were seen by the service. In May, this rose to 512. The service is working towards seeing up to 600 patients per month.



Actions that that have improved usage of GP streaming include having a second GP at peak periods working with the GP streaming nurses for adults; a GP working with children's triage nurses to increase the number of children to GP streaming; and the use of the Rapid Assessment and Treatment (RAT) approach with on-site GPs. Overall we must retain focus on patients who need a GP accessing them via their own practice.

4. Out of Hospital

4.1 Delayed transfers of care

At 30 November 2017 the average weekly snapshot of delayed patients in the Oxfordshire system stood at 143. The Delayed Transfer of Care (DTOC) rate (percentage of bed days

lost to delayed transfers of care) in OUHFT was 6.47%. Data indicates that this rate increases in the winter period with a fall in December (linked to Christmas) increasing in Q4. The tables below show the OUH position on delayed transfers of care for the last three years.

2015/16:

Month	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Bed days	3963	2781	3222	2956	3265
DToC rate	11.19%	7.60%	9.04%	8.29%	9.16%

2016/17:

Month	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Bed days	2674	2517	3166	3441	3448
DToC rate	8.18%	7.45%	9.04%	10.88%	9.85%

2018/19:

Month	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Bed days	1991	1793	1976	1959	1725
DToC rate	6.47%	5.64%	6.21%	6.82%	5.42%

*Q4 figures (months in dark blue) are derived from local data; national ratified figures not yet released

As shown above this winter, despite the pressures, Oxfordshire made very considerable progress on the numbers bed days filled by people who were medically fit to leave. Given the evidence on the risks of remaining too long in hospital beds this should have a positive impact on health outcomes.

The discharge flow plan for winter 2017/18 was based on

- Increasing Nursing Home provision, especially for people with complex dementia and other complex needs
- Scaling up short-term step down beds to create capacity and mitigate pressures elsewhere
- Increase in domiciliary care hours to support especially flow through reablement services
- Creation of a new multidisciplinary team to support discharges from short stay wards to ease pressure especially on emergency department
- Focus on those High Impact Changes that would address some of our local discharge challenges

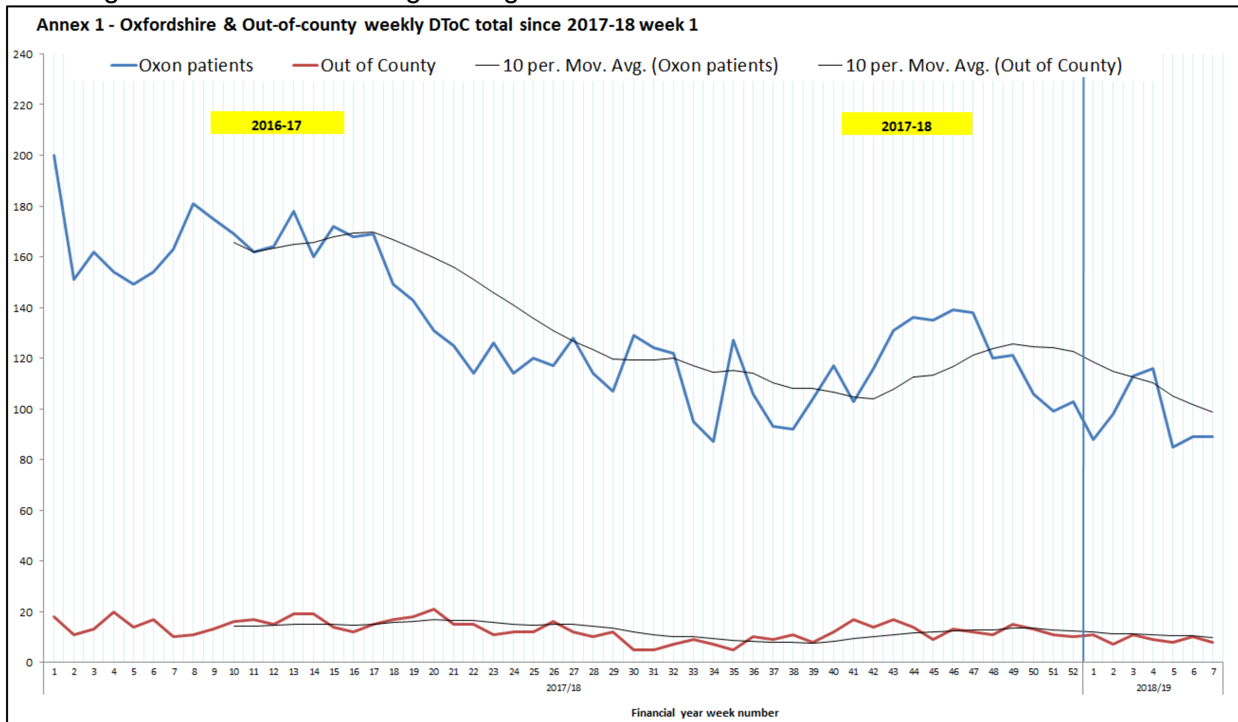
The winter plan to support discharge in full was as follows:

Increased Nursing Home provision	OCC/OCCG successfully re-procured 25 complex dementia beds but were unable to create significant levels of extra capacity. However, the level of delays fell from 21/week in November to 8/week by March. OCCG and OCC have jointly appointed to a care home post who will

	now develop plans to improve the capability and capacity of our nursing home sector during 2018-19
Increase in short-term beds	67 beds are commissioned by OCCG via OUHFT to support the step down and management of complex patients who need further assessment and support in nursing home settings prior to a final decision on discharge settings. furthermore additional beds had been commissioned from time to time to manage short-term pressures especially owing to the lack of domiciliary care pick up from reablement services. At 30/11/17 there were 94 short-term beds. This number was flexed up through winter: 99 at 31 Dec; 113 at 31 Jan; 112 at 28 Feb and 98 at 31 March. The figure will now be reduced in stages partly through improved performance across the pathways. A project is under way to look at the scope and capacity requirement across a range of short-term beds to deliver a new model prior to winter 2018/19.
Increase in domiciliary care hours	An extra 200h of domiciliary care hours were purchased in a block to improve flow through the reablement service.
New team in short stay wards	A new team was established compromising OUHFT, OHFT and OCC staff from a number of disciplines together with Age UK to support hospital discharge from OUHFT short stay wards at the John Radcliffe Hospital. Working 7 days a week as part of a dedicated team made up of OUHFT discharge liaison leads, OCC social workers, OHFT lead community therapists and OUHFT therapy leads the team was tasked to find new ways of supporting people to get home when they might otherwise be queueing for bed-based pathways. Age UK have particularly worked with patients and families to identify what would work for them. Their patient focussed approach has enabled some people to move home when they would otherwise have been waiting, and has acted as the oil in the wheels of complex processes in other cases. They have made effective links in the community outside of formal discharge pathways and been able to follow up people that they have supported home. Lessons learnt are currently incorporated by OUHFT in a Home First approach to be piloted in the A&E during 2018/19.
High Impact change: Trusted Assessor	A trusted assessor model for people discharging from acute to community hospital has been developed and refined. This matches patients to beds without a secondary assessment and has contributed to improved flow into the rehab beds. Additionally OCC has piloted a trusted assessor approach with intermediate care providers.
High impact change: Complex	OCC and OHFT have developed a joint approach to

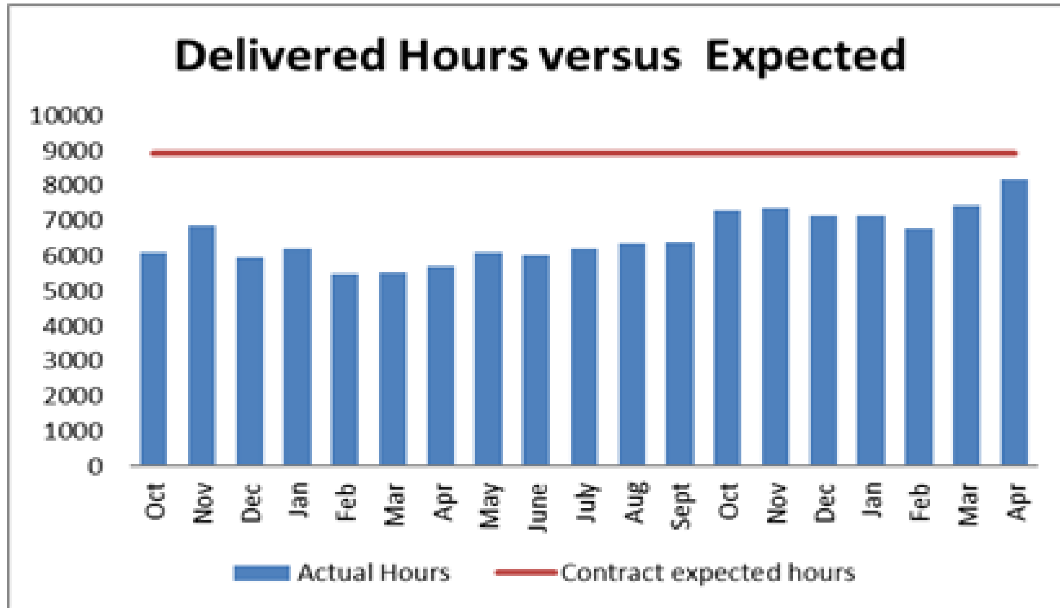
discharges	assessment and care planning for people in community hospital who have complex needs such as relating to housing, family dynamics and best interest approaches. This has proved very successful to the point that by adopting an anticipatory approach with social care colleagues the OH discharge liaison leads have reduced housing and equipment delays to virtually zero and reduced “choice and family delays” from 15-20 a week to <5 per week. OUHFT have worked with the City Council around the Trailblazers initiative to improve outcomes for people needing housing support to discharge from hospital. Both OUHFT and OHFT have developed a daily call for patients in the continuing healthcare pathway and this escalates into the wider stranded patient escalation process. Divisional nursing leads for OUHFT and OHFT meet colleagues from social care and commissioning each week and this process means that complex patients are known and can be problem-solved by senior officers. Any problems that cannot be resolved to move the patient on are escalated by OUHFT Chief Nurse to system CEO weekly. Other than out of area patients in our system no cases have needed to be escalated.

Winter performance in OUHFT for 2018-19 for delayed transfer of care patients was improved over previous years and did not spike to the same extent in Jan and Feb. Performance was not as strong in community hospital beds which were disproportionately impacted by delays in the reablement pathway, but the work of stranded patient reviews has supported an improvement since March. The table below shows DToC rates over time including the 10 ten week rolling average to indicate trend.

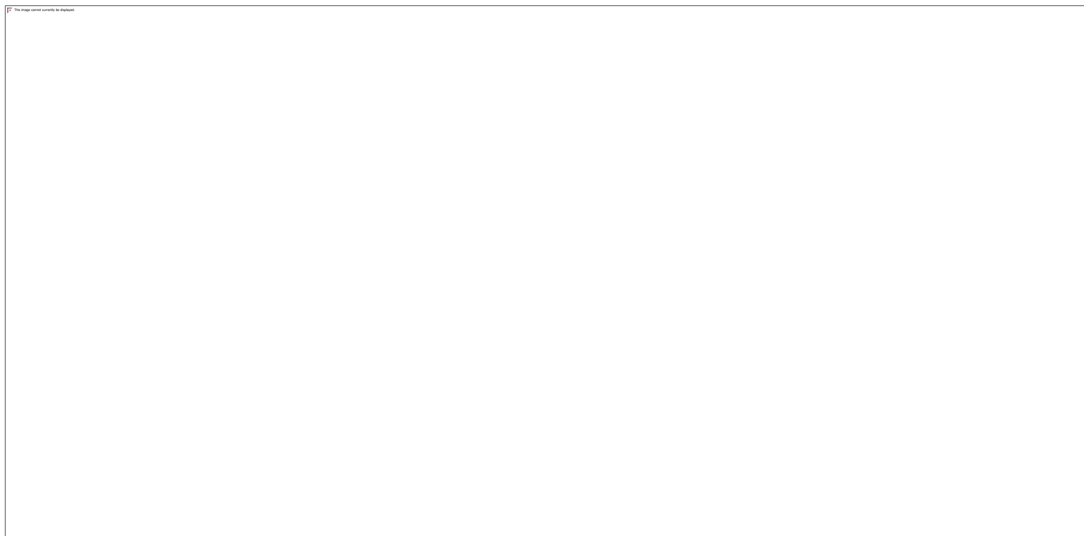


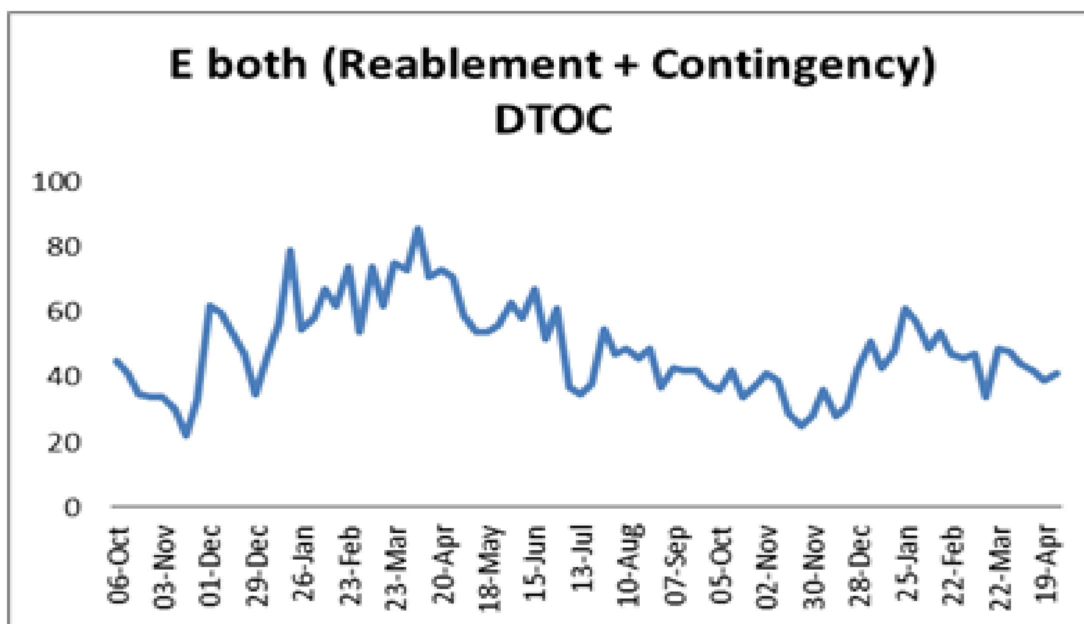
4.2 The Home Assessment Reablement Team (HART)

It is recognised that the HART service has not been delivering at full capacity. In recent months the % of contracted hours has increased (92% in April) however for the life of the contract 73% of contracted hours has been delivered.



Service capacity can affect the speed we can put care in place, so timelines of the new package starts, particularly people in hospital. In April 62% of cases were picked up on time - 49% from hospitals and 76% from the community. DTOCS attributable to HART are recorded as ‘both’ delays in recognition that the service is provided by an NHS provider. They remain overall on a downward trajectory from February to mid-March.





Whilst the performance of the contract has been improving, and associated DTOCs are on a downward trajectory, the service has not performed to full capacity over the winter. To mitigate this £1.9m was invested to provide additional provision to support hospital flow and to mitigate for under capacity in the Home Assessment & Reablement Team. This provision included 30 care home beds to support people requiring larger packages of support at home; 10 beds for people awaiting a care home placement; and additional community reablement packages delivered by Oxford Health Foundation Trust.

In recognition of the challenges to flow presented by under capacity in the HART pathway, the hospital social work team have focused on supporting discharges for people who have been waiting more than 30 days for discharge with HART. This focused work facilitated additional discharges since Christmas (22 in April for example) and has helped people by avoiding deconditioning attributable to delayed discharge. This approach is planned to continue.

In addition, system partners have been working closely to support OUHFT in delivering an internal HART improvement plan. Performance against the contract has improved, the service delivered 92% of contracted hours available in April 2018; this is the highest level to date. Work is ongoing to support this to ensure that people's reablement goals are maximised and that levels of ongoing care that people need upon completion of reablement is correct.

4.3 Care home support

The care home support service proactively supports residents to return to their care home after a stay in hospital and also works directly with care homes to avoid admission.

The team visits the John Radcliffe Hospital 3 times a week (there is an average of 5-10 residents in an acute bed at any one time) to support the discharge of existing care home residents to their care home and provide support to the Horton Hospital as required.

The team is also trialling the red bag vanguard in the 18 Order of St John's care homes (the resident going to hospital has all their belongings and information about their care in a red

suitcase which remains with them throughout their stay.) CCG have provided the funds for the red bags.

We are running a small project in one nursing home with a pro-active GP to improve access to pro-active care plans and the early detection of deterioration, working with GPs, SCAS and EMU.

5. Reflections

Nationally it is acknowledged that the 2017/18 winter crisis was the worst ever for the NHS. In Oxfordshire, as nationally, we experienced an increase in urgent care activity above that planned for putting unprecedented stress on our workforce and services. In responding to this demand lessons have been learnt that will inform plans for winter 2018/19.

5.1 What went well

The health and social care system partners have worked together to identify opportunities to improve flow out of hospital by developing a person-centred approach focussed on people's strengths (e.g. Age UK work in short stay wards) and a 'Home First' culture. This has been supported by dedicated social work support in A&E and a 3rd sector pilot in ED to enable patients to return home. This has resulted in a pragmatic and effective approach without the organisational boundaries which has been well received by patients and carers.

There was whole system focus to reduce the number of 'stranded' patients and significant improvements were identified from the adoption of a high quality, consistent, multi-disciplinary team (MDT) approach (e.g. OCC-OH work in community hospitals and OUHFT-OCC work around stranded patients).

Increasing the number of non-clinical staff available porters, cleaners, drivers etc.) has supported patient flow through the urgent care pathway and subsequent discharge. Additional transport enabled greater uptake of ambulatory services. Incentive schemes targeting nurses, GPs and SCAS staff were put in place providing additional resources to patients. Business cases will be produced with the aim of securing these initiatives in future years.

The improvements in delayed transfers of care, which has been a very long standing and intractable issue for the system should be acknowledged as a significant step forward and give renewed confidence and impetus that we can work together effectively as a system to support best outcomes for patients.

5.2 Lessons learnt

- In a recent system CQC review a lack of leadership alignment across organisations was identified. This was apparent in the differing approaches to the right way to mitigate acute bed capacity and the absence of resolution on how to achieve an effective Discharge to assess (D2A)/reablement model.

- There are several pinch points in the patient pathway. Activity in primary care and MIUs is not mitigating the demand in A&E and there is no effective real-time toolkit to support operational management of demand & capacity across the system.

- During the winter there was a continuous period of high level escalation (6 months x OPEL 3, 7 days at OPEL 4) which exposed a lack of alignment between locally

developed processes and OPEL escalation framework (e.g. call sequencing) and a system with no capacity to 'turn on' at escalation OPEL3/4.

- System partners experienced workforce difficulties relating to both vacancies and sickness; this was exacerbated by the increasing demands for clinicians to input into additional services (GP streaming, 111 clinical validation etc.). The need to address this through joined up ways of working was agreed.

- The reablement service was not delivering at the required capacity and we had not optimised flow in or out of the service.

- Patients from other areas were often stranded in Oxfordshire acute or community beds awaiting discharge or repatriations into external systems; regular, intensive 'policing' and escalation of these issues was required to facilitate these patients returning home. The same issues applied to Oxfordshire patients in beds out of the county.

The key dilemma for our Oxfordshire system is to design services that best serve patients – giving the best outcomes whilst achieving quickest recovery. In doing this the workforce shortfalls on home care provision, reablement and qualified staffing mean we need to find better ways of using the resources we do have. In this last winter we opened many more nursing home beds with multi-disciplinary cover and also beds in the Community hospitals. Our learning was that we spread the therapeutic and social care staff too thinly to support these beds and on each transfer we need to resettle patients, restart processes and prolong the episode. As a result we did not achieve the level of patient flow through the beds we would hope for. Our approach for next winter must be to look at the individual strengths each of our patients have, their preferences, the resources around them such as family and friends, even familiarity with their own setting eases the recovery process. We then need to match our resources to support the patients to return to their own homes as rapidly as they can. The clinical evidence is very strong that we will support the patients in regaining (or retaining) their greatest independence if we take this approach. There is a risk, that our prior efforts to fill workforce gaps with bed based alternatives – albeit in the community perpetuate the risks of decompensation. The transformational priorities we are setting ourselves in the AEDB seek to take the "home first" approach and draw on the blend of services in each of our local communities to provide creative solutions to workforce challenges. Every day that we have patients waiting for a service that we cannot staff exacerbates the issues for the patient but also potentially adds to their long term support needs.

5.3 Priorities for 2018/19

The A&E Delivery Board (AEDB) have agreed a number of priorities some of which will be taken forward by the Winter Plan group (a sub-group of the AEDB).

The priorities are:

- Frailty - mobilisation of a community frailty model to avoid unnecessary attendances and admissions and an acute frailty pathway approach when admission is indicated.
- Home First - embed new initiative to avoid admission and support people in their own homes. Collaboration with the third sector will be a key part of this.
- Self-funders – reducing the amount of time people wait in hospital whilst sourcing self-funded care.

- Mental Health & Urgent Care – ensuring timely access to a range services to optimise outcomes for patients.
- Locality based planning framework – using local knowledge to design and develop services for a specific population.
- Demand and capacity - ensuring the right services are available at the right time.
- Winter Plan

The following actions have been agreed to support this.

- **7 day working** – more collaborative working to ensure consistency in patient flow 7 days per week,
- **Forward planning** – share learning and continue to strengthen the daily 8:30 operational system call to improve daily and forward planning for discharges.
- Informed by the demand and capacity planning work we aim to **improve forward planning for known days of system pressure** e.g. first 2 weeks of January. Specific review of staffing profiles during these periods.
- **Establish a System Wide Winter Group** to meet regular to coordinate planning and also to ***strengthen links of communication at a senior level during times of pressure and escalation***.
- Agree **System KPIs for Winter** e.g. target discharges per day.
- **Build intelligence to recognise changes** in trends and anticipated pressure points to support more effective planning. Share learning from SCAS from 999 conveyance profiling.
- Refresh **Oxfordshire System Escalation process** with local action cards for each partner organisation to define individual actions and resources to maximise flow.
- **Improve community/primary care links to support earlier discharge-** strengthen our system communication and coordination to facilitate.
- **System risk management** – including improving knowledge of patient prior to admission/attendance. Share learning from review of readmissions.
- Develop **neighbourhood resilience** to support patient care of patients at home where appropriate. Review of assets within each neighbourhood to support care closer to home.
- **Communication**- across the health and social care system to *optimise our urgent care pathway to support care closer at home and* delivering the 'Home First' principle whilst avoiding 'bed based deconditioning'.

Our Winter Plan Group is already meeting and taking these actions forward with clear direction from the AEDB.

Oxfordshire Joint Health Overview & Scrutiny Committee
21 June 2018

Update Briefing - Care Quality Commission Local System Review

Briefing by Oxfordshire Heath & Social Care System Leaders

1. Introduction

This briefing describes recent progress in the three keys areas that HOSC have requested they be kept up to date with, namely; developing the governance around the CQC plan and in the areas of innovation, best practice, and housing and workforce. It also addresses the request from HOSC for an evaluation framework for actions arising from the system review.

HOSC are asked to note the progress made and provide input on the suggested measures for an evaluation framework, the final version of which will be presented to the Health and Wellbeing Board for their agreement.

2. Progress update

The system continues to make progress on the CQC action plan and, as reported to HOSC in April, the Health & Wellbeing Board has undergone a review of its function, structure and governance, and in accordance with the CQC's methodology retains overall responsibility for delivery of the action plan.

A multi-agency sub-group, the Integrated System Delivery Board, has been formed to oversee a transformative programme of work between all NHS organisations and Adult Social care (including oversight of the CQC action plan). The Integrated System Delivery Board met for the first time in May and agreed that the Quality Leads for each organisation in the system will have oversight of the delivery of the CQC action plan and produce highlight reports for Integrated System Delivery Board, with onwards reporting to the Health and Wellbeing Board.

In terms of an evaluation framework section 6 of this paper provides some early thoughts around measures that could be tracked to assess the impact of actions agreed in response to the CQC's recommendations.

3. Update on innovations to address the CQC findings

The following innovations are worthy of note:

3.1 <u>Wellbeing Teams</u>

Inspired by the Buurtzorg model from the Netherlands, we are piloting a new approach to home care to help increase home care capacity and reduce delays in discharges from hospital. Small, not-for-profit, neighbourhood home care services will be set up to deliver homecare focussed on personalisation and reducing reliance upon services. They will support people to stay in their own home doing more of what matters to them.

The aim is to enable people to stay in touch with their local community which helps them to be happier, healthy and more connected with the support of those around them.

Because the teams will be locally based it will reduce travelling time and enable them to build strong local knowledge and relationships. This allows them to make best use of community assets, reducing the need for paid support. Wellbeing Teams work on self-management principles, enabling individual Wellbeing Workers to make decisions that are in best interests of the people they support. This means that teams are much more flexible and responsive to the individual's needs. They work to non-traditional shift patterns, which gives the teams an ability to attract and retain a previously untapped workforce, giving the potential to further stabilise the homecare market in Oxfordshire.

The Wellbeing Teams also work in partnership with 'Community Circles' which is a charity working to deliver circles of support at scale. A volunteer Circles facilitator helps support the person to achieve their outcomes and reduce social isolation. This innovative way of working enables Wellbeing Teams to achieve better outcomes for people without having to jump directly to paid support.

Pilots are being setup in Abingdon and Wallingford; the Abingdon Wellbeing Team will start delivering care to people in July.

3.2 Homecare Scheduling

We are exploring the use of IT to improve capacity and maximise efficiency in the Oxfordshire homecare market. One example of this is the use of ArcGIS mapping tools which allow us to look at the locations of visits online when scheduling visits. This offers the potential to reduce the amount of travelling time for each care worker and increase the number of visits they can complete.

This pilot builds on work already undertaken to map the locations of people receiving homecare and provides information about which provider is supplying the individuals. The next stage will be to match existing people and providers against the list of people waiting for care, in order to be able to best allocate to providers already operating within their locale. This should help prevent situations where different providers are visiting different people in the same street.

The homecare scheduling pilot takes this work to the next level, by introducing modelling. This will involve working together with individual providers to assess whether their current scheduling of homecare visits could be improved. This work is set to commence during the summer and is expected to span a 6-month period.

3.3 **Project COACH** (Connecting Older Adults to Care and Health)

Oxfordshire is piloting an innovative approach to supporting people in their own homes by assessing the potential the use of the digital devices such as the Amazon Echo Show (a voice activated device, connected to the internet with video capabilities) to support delivery of some specific (low risk) care visits, e.g. whether medication prompt visits could be provided via video calls, rather than directly in person. This pilot will also assess whether this device can provide additional benefits

such as supporting people in reducing loneliness by making connecting to others easier.

This builds on work being carried out in Hampshire, where they are piloting the use of similar devices to help improve the quality of life for people with little or no mobility.

This will be piloted with a single care provider, focusing on a small number of people (3 increasing to 10) who are receiving some care visits which have relatively low-level care requirements. Keeping the pilot small will enable close monitoring of how effective this will be.

Training on the use of the devices will be provided and the implementation will be phased to ensure that the person receiving services and the carer are comfortable with the device. An assessment will be completed to confirm that video calls are appropriate and the arrangement will be monitored to ensure the person is not at any risk.

The pilot will be delivered during the summer and early autumn of 2018.

3.4 Sustainability and innovation funding

As noted by the CQC, Oxfordshire has a strong community and voluntary sector with an example being the 200+ groups providing daytime support opportunities across the county to approximately 4000 people.

In order to encourage these groups and in light of the other changes to the daytime support services, we are providing ongoing sustainability and innovation grant funding to enable these groups to thrive and develop as well encouraging them to be innovative in their approach.

Examples of proposals put forward so far, include:

- Variation on the existing ‘gig buddies’ scheme, enabling people of all ages and needs to get out and do things that interest them, e.g. go to gigs / museums /etc. They are supported by people who themselves are part of a scheme which is helping them back into employment.

- Matching service for people living locally to each other, with similar interests to help develop friendships and to get out and about together.

- Cycling project helping older people and people with disabilities to get out and about with volunteers.

4. How learning from best practice examples elsewhere in the country is being incorporated in the work in Oxfordshire.

Stranded Patient Review

It is a fact that 48% of people over the age of 85 die within one year of hospital admission (Clark et al 2014) - the challenge therefore for health and social care

professionals is to value patients’ time and reduce any unnecessary time spent in a hospital bed.

In early 2018, a national expert in improving care for older people, Dr Ian Sturgess visited Oxfordshire. He spent time with health and social care teams reviewing how our patients accessed our services and particularly how we review our stranded patients.

The national definition of a stranded patient is someone who has been in hospital for more than seven days – the definition of a “super stranded” patient is someone who has been is hospital for over 21 days.

In April 2018 over 50 health and social care colleagues from across Oxfordshire came together at a workshop run by Dr Sturgess and made a commitment to reduce the number of stranded patients in our facilities that have in-patient beds. One of the areas he recommended that we strengthen was to adopt a more system wide approach when reviewing stranded patients.

We have worked together as a system to identify opportunities to streamline the patient journey and avoid the number of inactive or “red days” a patient remains in hospital. The approach seeks to put the patient journey at the centre of provision and to fully recognise inactive periods in hospital as a harm event, resulting in deconditioning of the patient.

Our revised Stranded Patient process now runs every week and captures information on all acute and community hospital in-patients with a length of stay of seven or more days.

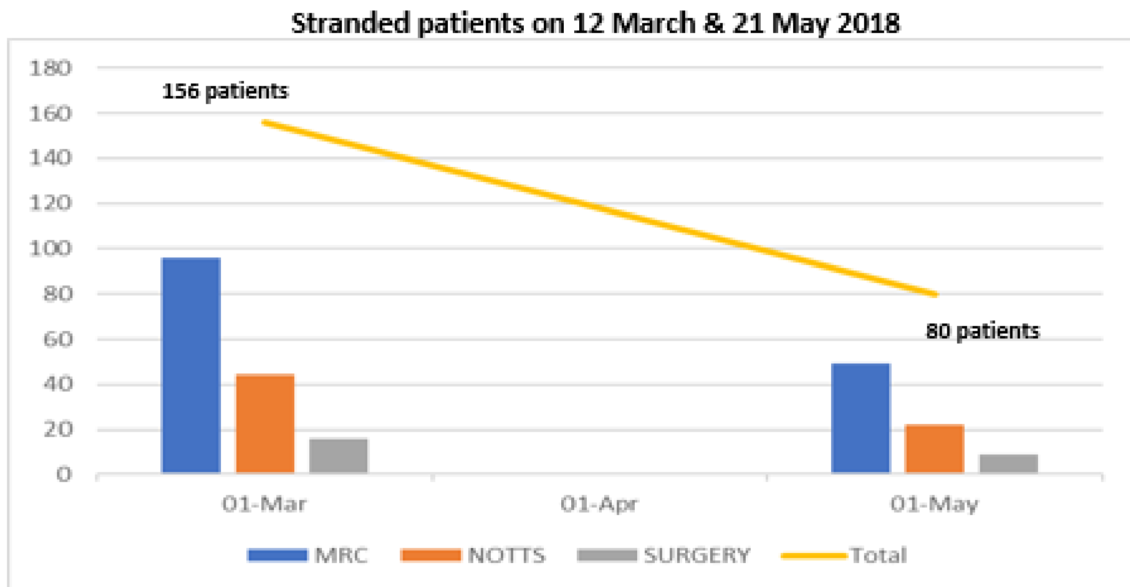
At ward level there is an escalation process (Level 1) involving a joint health and social care review of the patient asking the following key questions:

- Why does this patient need to remain in hospital?
- What is being done to get this patient home and by whom?
- What could have been done in the first few days to prevent this patient becoming ‘stranded’?

As a system we agreed to come together at a senior management multi agency level escalation (Level 2) meeting every week to enable further escalation of process and provision problems that might be preventing the person moving on. This involved bringing management teams together from across the system including social care, community/integrated care, therapy services, discharge teams, mental health, the acute trust and commissioners.

This clearly defined escalation process is in place to enable complex cases to be referred up to system leads and where appropriate via a weekly escalation conference call with all Chief Executives participating and discussing wider issues for resolution.

This process has become a system priority at all levels and has resulted in a steady decline of stranded patients as detailed in the graph below. This in turn has contributed to the falling number of Delayed Transfers of Care.



The ultimate aim is for 85%-90% of acute admissions to be moved on before seven days, enabling resources to be concentrated on the 10%-15% of cases that are most complex.

The goal is to reduce harm from loss of muscle and physical fitness associated with increased admission length. In turn this will bring positive health, wellbeing and economic benefits for all by supporting people to maintain their independence at home at the earliest opportunity.

5. The work being undertaken to address the housing and workforce issues in the system.

Workforce and Housing issues were highlighted in the CQC report as two of the key challenges facing Oxfordshire, these were known issues and work had already begun on creating a systemwide programme to tackle these challenges.

The Oxfordshire System Workforce Action Group has been created to drive the workforce and housing programme and it has agreed the following objectives:

- Increase the number of care workers recruited to care roles
- Seek solutions to the barriers for care staff
- Improve recruitment process
- Implement a career progression and pathway
- Increase retention of carers within the sector
- Improve data and intelligence

This group is responsible and accountable to Health and Wellbeing Board and reports to the Berkshire, Oxfordshire and Buckinghamshire Local Workforce Action Board.

Work is well underway with several system 'Task and Finish' groups having been created with sponsors from each of the key system partners meeting regularly to deliver the changes required, with an initial focus on:

- Workforce Recruitment, Identity and Branding
- Retention, valuing staff initiatives, Home share, Shared Lives and Keyworker Housing
- Skills and Leadership, Mentoring, Career pathways, sector passport

Notable successes so far:

- Successful recruitment campaign that was funded across system partners

- We've come together as a system to ensure workforce is given a national agenda

    - Providing a response to the Draft Health and Care Workforce Strategy
    - Co-Chairing the Association of Directors of Adult Social Services (ADASS) Workforce Development Network
    - Nationally recognised Values Based Recruitment work
    - Department of Health and Social Care visit with System Leaders on 22nd May 2018

- A strategic workshop on key worker housing resulted in positive buy in to exploring how we take this issue forward, including:

    - Agreement in principle for a countywide definition of a Key Worker
    - Innovation and Best Practice Workstream
    - Quick wins (i.e. next six months) electric cars, staff discounts.

- Care Leadership programme finalised with providers and Health Education England and first cohort identified.

6. Evaluation Framework

To aid its scrutiny of the CQC action plan, HOSC requested an evaluation framework for actions arising from the local system review in order to assess the impact these will have on people receiving services.

The system is currently in the process of devising an evaluation framework in order to measure the overall impact of the action plan and this will need to be agreed by the Health and Wellbeing Board. It is suggested that rather than producing a separate framework, one version is used for both the Health and Wellbeing Board and HOSC.

It is clear on undertaking this work that there is no national set standard for measuring the performance of a system or specifically for the outcomes of the CQC action plans. It should be noted that for certain actions it may be difficult to measure the real impact on people, for example simplifying governance is unlikely to result in a tangible difference to people. However, they will of course feel the benefit that better governance will bring to frontline services via improved strategies and plans.

Across the system a considerable number of performance indicators are already being measured and reported on. It is from these that an evaluation framework could be drawn together to give an oversight of the impact the work carried about in relation to the CQC action plan.

- **Department of Health metrics: (used to determine which systems would be reviewed:**
  - Emergency Admissions (65+) per 100,000
  - Length of stay for emergency admissions (65+)
  - Total Delayed Days
  - People still at home 91 days after discharge from hospital
  - People who are discharged from hospital who receive reablement
  - Proportion of discharges which occur at the weekend

- **NHS Family and Friends Tests** – Measures if people are happy with the service provided, it is a quick and anonymous way of a person giving their views

- **Adult Social Care Outcomes Framework (ASCOF)** – A suite of metrics that measure how well care and support people achieve outcomes that matter the most to them. Some of the measures within this framework maybe suitable for the evaluation framework

- **Better Care Fund (BCF) Measures** – There are national measures and local metrics that are measuring how the BCF is making a difference

As a system we would value the input from HOSC on the measures suggested above and whether additional measures should be considered

<u>Responsible Officers</u>

Kate Terroni – Director for Adult Services - Oxfordshire County Council
Louise Patten – Chief Executive - Oxfordshire Clinical Commissioning Group
Stuart Bell – Chief Executive - Oxford Health NHS Foundation Trust
Bruno Holthof – Chief Executive - Oxford University Hospitals NHS Foundation Trust
Will Hancock – Chief Executive - South Central Ambulance Service

This page is intentionally left blank

Your voice on health and social care

Healthwatch Oxfordshire Update June 2018

Patient voices…Our Story

A short video co-produced by the Luther Street Medical Practice Patient Participation Group, Healthwatch Oxfordshire and Luther Street Medical Practice staff. This video looks at the work of the PPG of Luther Street Medical Centre, Oxford, a GP surgery which specialises in offering primary care to homeless people. The four-minute film includes interviews with patients and staff at the practice, who describe how working with the PPG has brought improvements for people using the surgery. To watch the video, click here.

Stroke services and Early Supported Discharge

The following paragraphs reproduce experiences share by people who have had a stroke and used health services. These have been gathered from the Healthwatch Oxfordshire Feedback Centre, a short survey and email contacts. Comments from a survey about Early Supported Discharge on the Healthwatch Oxfordshire website and feedback received via email over the past three months.

- Person was admitted in the early hours in early 2018. Examined by a Dr 4 hours later. TIA diagnosed on the basis of past history. Discharged 4 hours later (same day) following review by Physiotherapy and Occupational Therapy staff. Support by Bicester Community services and treated by physiotherapy for the following six weeks.
- A member of my family had a stroke just after Christmas and was in Abingdon hospital for nearly 4 months waiting for a discharge package. This was very hard for her as she desperately wanted to go home and was very aware that she was 'bed-blocking'. It has also meant that she became quite 'institutionalised' and since coming home is finding it very hard to adjust even though she is usually an extremely independent person. She now has a care package with care 4 times a day which is good. However, since leaving hospital all OT and Physio assistance stopped and she has not progressed and in fact she has gone backwards having had a couple of falls and hurting her leg. A doctor has been out to see her 3 times since arriving home. She had a letter to say that that the Community Therapy Service would be coming out to assess her at some point. I rang them to find out when this would happen and voiced my concerns and they said that 70 clients were in front of her on the list and it would be weeks! Anyway, they must have thought about it and realised she was ‘at risk' and thankfully we now have an OT assessment happening this week.

- My friend had a severe stroke early January and was admitted to the JR. And then transferred to the stroke hospital. He unfortunately died last Saturday. His wife has been through hell to get him a care package so that he could come home, but to no avail.
- Four years ago, I had a TIA. I phoned 111 and the system worked well. After the initial call, I was called back by a doctor who made an immediate appointment at the Abingdon Community Hospital. The doctor there made some checks and made an appointment there and then to attend the neurology department at the JR in 3 days' time. She also prescribed aspirin to minimize risk before the appointment. The JR phoned me the day before the appointment to tell me a bit about what would happen the next day and how much time it would take. I had a full battery of tests. Overall, I feel that everything went extremely [well] and I was treated with great courtesy. The link between the 111 service, OHFT (who run the community hospital) and OUHFT (who run the JR) was seamless. However, there was one minor link-up that could be made in an ideal world. As my symptom was temporary blindness I saw my optician on the day before my first JR appointment to rule out any possible eye problem. She gave me various tests. The JR repeated this test in a very low-tech way. In an ideal world, the optician's test results would have been passed on the JR.
- Had a minor stroke in September. They took me to the JR. Paramedics were excellent, care quick. Very kind and good at explaining things.
- Had third stroke and fell badly down stairs, smashed up leg, foot and ankle. In hospital and care home for 8 months. After 16 months just started to live a near normal life. **John Radcliffe. Star Rating: 5**
- No help, 2 hour wait. Poor disabled assess. My father was the patient, I am his daughter. I rang X-ray in advance and was told that staff were not allowed to push wheelchairs due to their backs. There was no porter. In March, Dad just managed the ramp with a few wobbles. It quite steep if the patient wears a splint, When we got there, people were standing and sitting on the floor. I asked if there were more chairs. I was told no. My father waited two hours for his x-ray and this is a long time for a frail 77 year old who had a stroke in 1969. We used to be able to book appointments and were told minor injuries patients etc are prioritised. Lots of the people waiting were elderly, the quality of care from the radiologists was good. **Abingdon Community Hospital. Rating: 1 Star**
- I was in this ward for just over three months after suffering a severe stroke and was very well looked after thanks to the NHS **Witney Community Hospital. Rating 5 Stars**

Healthwatch Oxfordshire outreach activities

Focus on OX4

As reported to the last HOSC meeting in April Healthwatch team has been in Oxford City – particularly in Cowley, Blackbird Leys, Rosehill and Littlemore areas. Over two weeks in January and February, we made face to face contact with over 450 people. Individuals were able to share their experiences through talking directly to Healthwatch staff, by using our freepost 'Tell Us' forms at the time, or by

completing a 'service review' on our website. We also spoke to individuals in more depth, at over 20 community groups we visited.

In total, we collected 315 'Tell Us' forms, in which people told us about their experiences both of specific services and broader health provision and pathways.

The report on this activity has been circulated to all HOSC members and an electronic version is available by following this link.

We heard that while people valued the dedication of health and care professionals, there were serious worries about a few healthcare related issues, including:

- Waiting times for GP and other appointments;
- Perceived barriers to dental treatment, either due to price or lack of available service;
- Concern about pressure on health services owing to new housing developments such as that planned for the edge of Littlemore;
- Factors such as public transport and debt which can have an adverse effect on health.

The findings of the report will now be shared with the county's health providers, commissioners, community groups and other bodies, including Oxford City Council.

Wantage

During May the Healthwatch team spent three weeks in Wantage. We had stalls at 8 outreach venues including Wantage market, Tesco's at grove, and Wantage leisure centre. Held Voluntary Sector Forum for Wantage groups, and visited Wantage Blind social club, Women's Institute, and local toddler group amongst others. A full report will be published in mid-July.

Healthwatch at hospital

Healthwatch Oxfordshire has held a monthly outreach stall at one of the four Oxford University Hospital NHS Trust sites between January and April 2018. After visiting each of the four hospitals we have made contact with and heard from 191 people. This has opened up a good opportunity to hear from patients and visitors and make staff aware of Healthwatch Oxfordshire and what we do. Common themes coming through from people are transport / parking causing delays to appointments and stress; difficulties in accessing the sites by public transport; administrative delays / poor communication between departments; and staff are "excellent, easy to talk to, polite, helpful, efficient".

When we have come across concerns that require an immediate response from the hospital we have duly communicated them to the appropriate director.

Voluntary Sector Forum

Wantage

The May Forum was held in Wantage to coincide with the Healthwatch Wantage town events. It was attended by 26 people being mainly Wantage based groups. Three themes appeared from the Forum:

1. Community support services run by Oxfordshire County council

2. Transport
3. Social care e.g. care homes and care at home

A full report will be available on our web site by the end of June.

Social Prescribing

As reported to the earlier HOSC meeting the March Forum meeting focussed on social prescribing with speakers from the Oxfordshire Clinical Commissioning Group and patient participation groups involved in social prescribing initiatives throughout the county. Social prescribing is defined as "a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector." How it is delivered varies across the country. A full report is now available on our web site by following this link

Having listened to the discussions and comments from representatives of the voluntary sector at the forum, Healthwatch Oxfordshire recommends the following:

1. Better cross system working - We urge Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals NHS Foundation Trust and other system providers involved in different social prescribing initiatives to work together to have a more coordinated approach to social prescribing across Oxfordshire.

2. Better engagement with the voluntary sector - There needs to more engagement with the voluntary and community sector to enable small, medium and large groups to enable them to understand how they can get involved with social prescribing. Groups need information on whom they need to contact and what the procedures are to get involved.

3. Learning from other social prescribing initiatives - We urge the Oxfordshire Clinical Commissioning Group and partners to draw on lessons learned about social prescribing from other parts of the country to ensure they offer appropriate support to the voluntary sector. This is important to enable the voluntary sector to have the capacity to play the vital role envisaged for them in the social prescribing plans for Oxfordshire

YouthWatch

The next Forum is planned for September / October and as part of our YouthWatch activity we will be listening to voluntary sector organisations working with / supporting young people.

HOSC MSK / Healthshare Task and Finish Group

Healthwatch Oxfordshire has been actively communicating with both Healthshare and Oxfordshire Clinical Commissioning Group since September 2017. We are currently collating all feedback to inform the HOSC Task & Finish Group of what people are telling us.

Oxfordshire Joint Health Overview and Scrutiny Committee

Update on implementation of recommendations from the Oxfordshire Health Inequalities Commission, June 2018

Summary
Implementation of recommendations from the Health Inequalities Commission report is continuing successfully.

A multi-agency Implementation Group has been overseeing progress in taking recommendations forward. This has been the job of a range of individual organisations and partnerships. The aim is to make changes to commissioning, planning, strategy development and targeting resources in order to improve outcomes for the most disadvantaged and narrow the inequalities gap. The implementation group aim improve “business as usual” and not just to encourage short term projects or additional action plans.

In the autumn of 2017 a review of work being taken showed that

- 24 recommendations were being taken forward through 5 priority areas of partnership work. Some of this work is now complete and progress reports are given in this paper.
- 16 recommendations had been taken forward by different organisations as part of their business as usual. This was reported to HOSC in November 2017.
- Some work is in progress on the remaining 20 recommendations and more information is needed. A further update on these recommendations is currently being collated and will be discussed at the Implementation Group in July.

Background
The Health Inequalities Commission, chaired by Professor Sian Griffiths, reported its findings and set out recommendations in November 2016. The commissioners were independent members selected from public and voluntary sector organisations and academia.

The full report and Headline report can be found here:
http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/health-inequalities-findings/

A report on progress was presented to the Joint Health Overview and Scrutiny Committee in November 2017. This paper sets out further updates on progress.

Update on the Implementation Group
This multi-agency group meets quarterly and is chaired by Dr Kiren Collison, Clinical Chair of the Oxfordshire Clinical Commissioning Group. Current members of the group represent the CCG, Public Health, Cherwell District Council, Oxford City Council, West Oxfordshire District Council, South and Vale Councils, Oxfordshire Mind, Oxfordshire Healthwatch and Active Oxfordshire (formerly Oxfordshire Sport and Physical Activity).

Updates on priority areas of work
The 6 areas of work outlined below are priority areas agreed by the Implementation Group in September 2017. The areas of work cover approximately 25 of the recommendations from the Commission Report between them. The aims and objectives of each of these pieces of work were outlined in the report to HOSC in November 2017[1]. This report gives an update on progress.

1. Basket of inequalities indicators

The recommendation on this topic has been fully met (Recommendation no. 3)

A set of indicators has been collated and published which set out the following

- Over 30 indicators with Oxfordshire and England average outcome for each indicator and variation across the county.
- The areas of the county which are significantly higher or lower than the county average (by ward, Middle Super output area or district).
- For some indicators the changes in value for areas since the last report
- A summary of which wards are significantly worse than county averages for two or more indicators
- Which GP practices serve the majority of the population in each of these localities.

This tool was approved by the Health and Wellbeing Board as part of the updated Joint Strategic Needs Assessment in March 2018 and has been published on Oxfordshire Insight, here:
https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20ANNEX%20Inequalities%20Indicators%2012Apr18.pdf

This tool will enable anyone involved in commissioning, service planning and community development to be aware of inequalities issues and ensure that their work targets communities with poorer outcomes. It may also be useful as part of monitoring progress in addressing inequalities issues.

[1] http://mycouncil.oxfordshire.gov.uk/documents/s39205/JHO_NOV1617R04%20-%20Health%20Inequalities%20-%20Update%20on%20HWB%20response%20to%20report.pdf

2. Innovation Fund

The recommendation on this topic has been partially met and work is continuing (Recommendation 7[2])

As reported previously, pledges to contribute modest sums of money to an Innovation Fund have been made by partners in the Oxfordshire Growth Board, matched by Oxfordshire Clinical Commissioning Group. The total is £24k.

Extensive scoping of potential projects to support work addressing health inequalities has been carried out. This work included investigating the potential for setting up an interactive directory / map of activities and services which could form a "social prescription" or just enable members of the public to find local groups and activities to improve their health and wellbeing. However, following the scoping exercise the Implementation Group concluded that this might duplicate existing work and that insufficient funds were available to make a good job of it.

At the Implementation Group meeting in April 2018 it was agreed that ideas for use of the Innovation Fund could be sought through Oxfordshire Community Foundation as part of their regular programme of work to tackle inequalities. This will bring several advantages, including increased opportunity for sustainability, potential for attracting further funds, joining an independent, robust and transparent process for disseminating funds and benefitting from the expertise and experience of the Community Foundation and partners. Oxfordshire Community Foundation have agreed in principle to work with the group to take this forward to the next stages. It is expected that the exploration of themes and potential application processes will take place soon.

3. Benefits workshop – Income maximisation

The recommendations on this topic have been met and there is potential to build on this work. (Recommendations 12,13,14).

The Health Inequalities Commission set out three clear recommendations on making benefits advice available in health settings, convening a working group on income maximisation and to discuss funding with District Councils.

A workshop was held in February 2018 with a mixture of providers of advice services and commissioners / funders from local authorities and the health service. The outcomes of the workshop were reported back to the Implementation Group and have since also been discussed at the Joint Management Group for Adults with Support and Care Needs (a sub group of the Health and Wellbeing Board).

The issues that were highlighted at the workshop included

1. The need for a clear, shared definition of benefits advice across the system.

---

[2] An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations

2. The need for a clear pathway of how clients arrive at advice services and how they leave their need of benefits.
3. Recognition that if agencies are in competition for funding there may be tensions and lack of cooperation.
4. Acknowledgement that clients in crisis may approach several agencies at once.
5. There will be potential to make referrals for advice through the emerging social prescribing schemes being set up.

The HIC recommendation is for more advice delivered in health settings. This was debated and the conclusion of those at the workshop was that this was not necessary.

More pressing issues were highlighted including

- It is important to consider prevention and the need for a strategic view of what will have biggest impact on the Wider Determinants of health e.g. strong economy, "good work".
- Demand is currently outstripping supply of advice services so more money is needed to meet that demand.
- Large numbers of clients are of working age and therefore in-work poverty is a contributing factor.
- The future of benefits advice is unknown e.g due to the switch to Universal Credit. However, some clients may be disadvantaged by shifts to digital interactions.
- There is no overview of the number of clients receiving advice or support as the provision is disbursed.
- There is no existing partnership or network of advice service providers or commissioners. There is also no clear lead agency or partnership to take this topic forward.

Follow up work may follow the discussions at the Joint Management Group.

4. Social Prescribing

Good progress is being made in implementing recommendations linked to social prescribing and this will continue to develop.

Oxfordshire CCG is leading work on social prescribing with each of the 6 CCG localities outlining plans for taking this forward in their areas. The recommendation in the Health Inequalities Commission report on this topic stated that "*Consideration should given to the potential of social prescribing for improving the health and wellbeing of Oxfordshire residents, addressing health inequalities in particular, and learning from other areas"*. Other recommendations also called for new models of care, investment in prevention, addressing loneliness and isolation, promoting healthy lifestyles. These areas of work are all covered in social prescribing.

Recent progress includes:

- Hedena Health in Oxford is continuing its social prescribing project. Monitoring has shown a reduction in repeat visits to the GP following take up of social prescriptions.
- OxFed employs Practice Care Navigators who work across clusters of GP Practices. This work initially targeted frail elderly people but is now being expanded to the wider population.
- OxFed are also planning a pilot using a digital platform to monitor uptake of social prescriptions. The GP will (with consent) be able to track whether a patient takes up the social prescription and where they participate in activities run by voluntary or other agencies.
- Cherwell District Council has partnered with North Oxfordshire Citizens' Advice and West Oxfordshire District Council to successfully submit an expression of interest to NHS England. A full bid has been submitted and is awaiting the outcome for funding to cover work across both Cherwell and West Oxfordshire.
- Chipping Norton GP Practice has its own Social Prescribing project.
- In the South West Locality, the Abingdon Practices have Care Navigators who go through available options with patients in the Practice, using the COACH web site. In the South East Locality, the GP Practices are planning, through the GP Federation, to commission a voluntary sector organisation to deliver social prescribing across the Practices.
- The Live Well Oxfordshire[3] website is being developed to include more activities and groups which could be used for social prescription, including healthy lifestyles, physical activity, outdoor activity etc.

5. Physical Activity

Recommendations on this topic are not yet fully implemented.

Recommendations from the Commission included targeting an increase in activity levels in the over 50s, especially in deprived areas and improved inclusion of people with disabilities and mental health problems.

Oxfordshire Sport and Physical Activity (OxSPA) had agreed to lead on this area of work. They are currently in the process of re-organisation and establishing themselves under the new name of Active Oxfordshire. It seems very likely that addressing inequalities and championing the benefits of physical activity will be at the heart of the new organisation, so the Implementation Group will look forward to working with the new organisation when they are fully constituted.

6. Other initiatives to report
    a. Oxford City Inequalities project

This work is a joint project between Oxford City Council and the City Locality of the CCG. Each of these partners has made funding available and detailed planning is now in progress to deliver

[3] https://livewell.oxfordshire.gov.uk/

- Additional training and expertise to support tenants with severe and enduring mental health problems.
- Developing local access to activities which will support health and wellbeing in the community centres.
- Population Health Management approaches to identifying people in some areas of the City who could benefit from “Strength and Balance” classes to prevent falls, “Breathe Better” classes for respiratory problems or “Dance for Health” to increase physical activity and prevent falls.
- Primary prevention initiatives to target areas where people have poor health outcomes, to support healthy lifestyle choices.
- Improved working relationships between Council teams and primary care teams, including Knowledge Exchange events.

b. Making Every Contact Count

A county wide initiative to develop the Making Every Contact Count (MECC) approach is starting. This is a primary prevention initiative which gives front line practitioners and others the confidence and resources to start a conversation about healthy lifestyles with their clients. The work helps implement several of the Commission recommendations on promoting healthy lifestyles.

A strategic Oxfordshire System Delivery group has been set up to track and monitor progress on embedding MECC across all organisations county wide. The group feeds in to a wider BOB oversight group for consistency and sharing of learning across the area.

The work in Oxfordshire is aimed at communities with poor health outcomes or vulnerable people. Training has already started in the Fire and Rescue Service, Barton Healthy New Town, the County Library Service and among Social Prescribers through resources provided by BOB STP and HEE.

The initiative will be rolled out soon in Brighter Futures in Banbury, Bicester Healthy New Town, Community H&WB Partnerships in Oxford and other settings.

Next steps

The Implementation Group will cover the following areas of work in the next 6 months:

1. Complete the work on the priorities already listed above.

2. The Implementation Group is currently collating an update on progress and will be able to identify areas of work that should be prioritised in the coming months. This will be discussed at the next meeting in July.

3. Influence the development of the Joint Health and Wellbeing Strategy to ensure that health inequalities issues are addressed.

4. Monitor the impact of this work on inequalities issues in the County, using appropriate measures to track progress where possible, updating the Basket of Inequalities Indicators.

Dr Kiren Collison, Clinical Chair, Oxfordshire Clinical Commissioning Group
Jackie Wilderspin, Public Health Specialist, Oxfordshire County Council

Annex 1. Recommendations where updates are currently being collated

	Recommendation
7	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. • The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations. • The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes. • The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend.
8	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organizations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. Regular review of progress should be undertaken by HWB
9	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board
16	Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant .
21	An integrated community transport strategy should be developed
22	A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the % of older people over 65 with access to on line support regularly reported
27	Robust pathways to community services for community rehabilitation (including Community Rehabilitation Companies) on release, particularly for short term offenders, need to be developed
34	Building on experience from Wantage, Community Alcohol Partnerships should be established across the county to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.]

37	School based initiatives should be promoted for all age groups
39	The under provision of resources for Mental health services should urgently be addressed
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.
41	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund
48	The NHS workforce should engage in equity audit and race equality standards should be routinely reported
49	The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities .
51	Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers
52	Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies
55	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: o physically through a better coordinated approach to transport across NHS, local authority and voluntary/community sectors o digitally through a determined programme to enable the older old in disadvantaged situations to get online o financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.
57	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.
60	The resources produced by PHE to support local action should be used as part of the formal review process.

NHS
Oxford Health
NHS Foundation Trust

REPORT FOR THE OXFORDSHIRE JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE - 21 JUNE 2018

Situational Report Regarding Oxford Health Community Stroke Ward Co-Location

Summary

Following the decision to co-locate the stroke units onto a single site at Abingdon Community Hospital there has been improvement to the level of therapies provided to patients. As anticipated relocation to one site has provided the ability to recruit occupational and physiotherapists, and reduced vacancies. This has allowed us to treat more patients, enabling them to return closer to home sooner and is reflected in improved flow through the system

Workforce developments are continuing with the aim of providing a comprehensive workforce that aligns more closely with national recommendations. Following our reconfiguration, the ability to recruit a specialist stroke rehabilitation workforce is demonstrated by the staff recruitment successes to date with further recruitment events planned.

We would recommend that the current situation, one single site stroke rehabilitation unit in Abingdon, continues, acting as a foundation for continued improvements to stroke care for the patients across Oxfordshire.

Background

Oxford Health presented a case for change to the Health and Oversight Scrutiny Committee in early 2018. The decision was made on the premise that co-location of services from two, ten-bedded, stroke units based at Witney and Abingdon to a twenty-bedded unit at Abingdon, would provide a higher quality service for those patients requiring post-acute

stroke rehabilitation in-patient care. Without repeating the full paper, the primary anticipated benefits broadly comprised:

- Dedicated geographical co-location to provide better focus on stroke rather than diluted with more general medical rehabilitation, and a more consistent approach to care

- Improved specialty stroke staffing levels by avoiding separation across two community hospitals

- Improved staffing increases the amount of therapy provided to patients, in turn leading to decreased length of stay and return closer to home more quickly.

Progress

Phase 1 of the project to manage the consolidation of the two stroke wards onto one site was completed on time and on budget by 15th February 2018. This included staff consultation across both wards and 16 beds are now located on the original Abingdon stroke ward with four step down beds provided on Ward 2.

Phase two of the co-location project will see the existing Ward 2 reconfigured internally to encompass all 20 stroke patients on one ward by July 10th 2018. Following completion of phase two this ward will be known as the Oxfordshire Community Stroke Rehabilitation Unit (OCSRU)

.

The following tables present data across several key quality standards and performance indicators to demonstrate the impact of the co-location. It should be noted that it is difficult to draw conclusions regarding statistical significance of this data due to the limited number of months available for interpretation.

Staffing levels

The number of vacancies across the staffing groups has dropped, except for nursing, where there is still a gap requiring substantive staff recruitment. This will be filled by long-term agency (agency staff who commit to working for a longer length of time). Whilst the position now looks more favourable, it should be noted that staff turnover required further recruitment and compromised the staffing of the ward in the short term. However, we anticipate that the situation is now more stable, especially in therapy.

Staff group	Pre 16.02.18 (full time equivalents)	Post 16.02.18 (full time equivalents)
Nursing		
Registered nursing	3.22	3.22
Health care assistant	3.31	1.31
Therapy		
Physiotherapists	1.0	0.0
Occupational Therapists	1.1	0.5
Rehabilitation Assistant	1.0	0.0

Length of stay

Early indications suggest that length of stay (figure 1) has been reduced. Patients are being discharged from a hospital bed, and closer to home, earlier. The reduction in length of stay is mirrored by an increase in total number episodes of care delivered across this time period (figure 2). Broadly, this suggests we have discharged more patients, allowing more to rehabilitate, due to an ability to increase flow.

Figure 1.

NHS
Oxford Health
NHS Foundation Trust

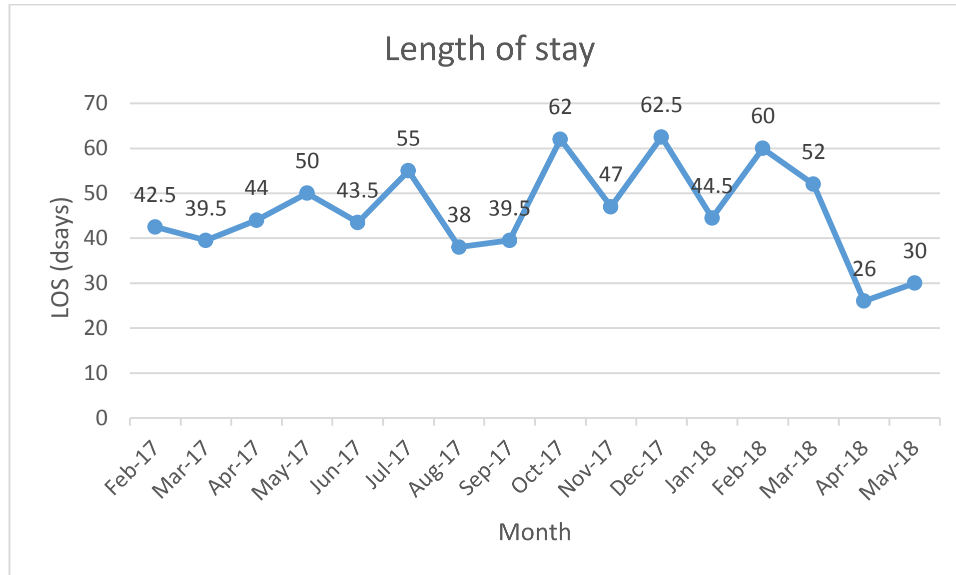


Figure 2.

	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	March 2018	April 2018	May 2018
Number of discharges	8	13	13	10	14	8	16	9	22
Average	11						15.7		

Outcome Measures and quality of care

Barthel Index outcome measure

The Barthel Index is a functional outcome measure where an increase in score demonstrates an improvement in patient independence, (as measured by the ability to undertake activities associated with daily living.) Evaluation of patient outcomes in the three months following co-location has shown an improvement in the average increase of the

Barthel index score during admission. This indicates the patients are reaching a higher level of functional independence now as a result of increased therapy and rehabilitation focus on the ward.

Average improvement on Barthel index before 16.02.18	Average improvement on Barthel index after 16.02.18
5.73	6.69

SSNAP (national stroke statistics) Performance

The dependency of our stroke patients remains high yet we have consistently maintained the NICE quality standard of the number of minutes (45m) that patients require therapy on the days that they receive it. Patients should receive physiotherapy and occupational therapy on 60% of the days that they remain an in-patient, with a 50% target for speech and language therapy. Whilst we have been unable to meet this consistently (figure 3), the average of reported data in the four months pre- and post- co-location (figure 4) has increased across physiotherapy and occupational therapy with a slight drop for speech and language therapy (SALT). Variability of performance has reduced and this is most likely due to removing travel time and the resulting increased availability of therapy staff.

Figure 3.

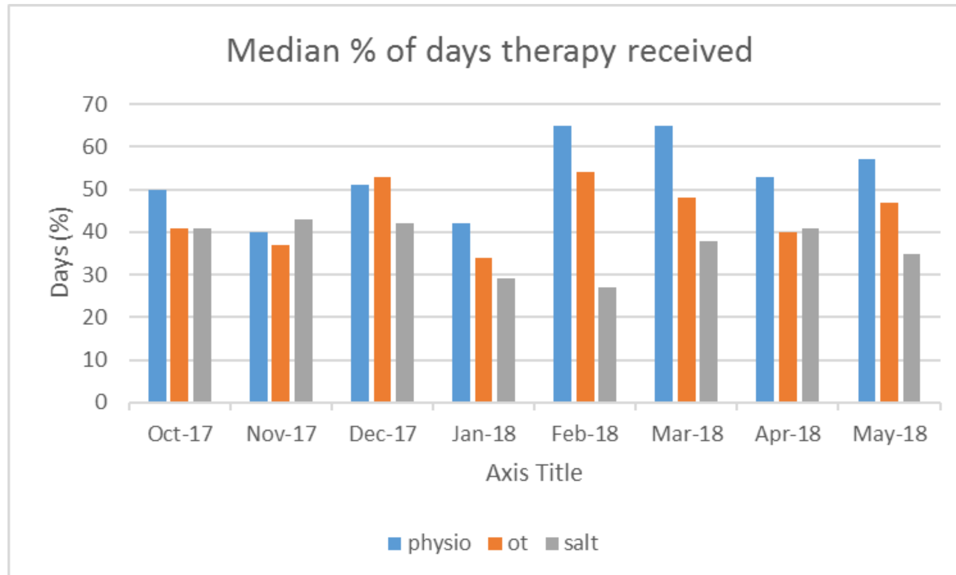
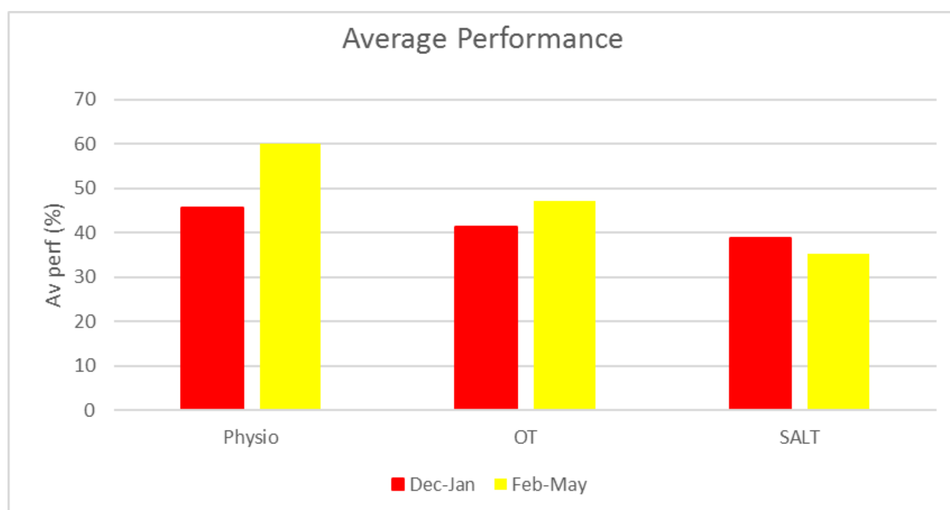


Figure 4.



Future development

A multidisciplinary stroke improvement plan is underway which aims to:

- raise the quality of clinical care
- improve patient outcomes
- increase performance of the team
- improve the SSNAP* rating of the OCSRU

The Stroke Quality committee meets monthly to review this plan and escalate as necessary to the senior clinical leadership. Close links already exist between Ward 1 and the Stroke Association and further work is underway to strengthen the partnership working with carers and families.

*Sentinel Stroke Audit Programme.

Conclusion

Following the co-location of the stroke units to Abingdon, we are able to rehabilitate more patients, with an increased flow through the ward, enabling patients to return home more quickly. Whilst there have been other whole system improvements, early indications are that patients are receiving more therapy in our beds than before, and this will continue to have a positive impact on outcomes. We will however continue to monitor this closely as more data becomes available. The co-location has allowed for a more sustainable workforce, albeit impacted by an unpredicted turnover requiring more cyclical recruitment than anticipated. A more settled staffing position and future plans will allow for continued service development improving quality of care further for the stroke patients of Oxfordshire.

.

This page is intentionally left blank

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21st June 2018

Title of Paper: Report into the transfer of Specialist Learning Disability Health Services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an overview of the transition of specialist learning disability health services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust.

The item will be introduced by the co-Chairs of the Oxfordshire Transforming Care Partnership Board, Gail Hanrahan (Oxfordshire Family Support Network) and Paul Scarrott (My Life My Choice). Gail and Paul represent people with learning disabilities and their family carers and will be able to provide a view of the transition from the perspective of people who use services.

The Oxfordshire Transforming Care Board is overseeing a programme of work which will improve services for people with a learning disability and / or autism, with a particular focus on reducing admissions to hospital for people with mental health conditions and / or distress behaviour which challenges services.

Senior Responsible Officer: Sula Wiltshire, Oxfordshire CCG

Report into the transfer of Specialist Learning Disability Health Services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust

1. Background

1.1 On the 1st July 2017, Oxford Health NHS Foundation Trust took over full management and service delivery of Oxfordshire's specialist adult learning disability health service from Southern Health NHS Foundation Trust.

1.2 This report provides an overview of the transition and considers whether learning from the previous transition of the learning disability service in 2012 (from the Ridgeway Partnership to Southern Health) was taken into account and appropriate mitigation put in place to manage the risks associated with such a transition. The report does not consider the transition of the Evenlode Learning Disability Medium Secure Unit (commissioned by NHS England Specialised Commissioning) which took place simultaneously and was managed by NHSE.

1.3 The "Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk" (Verita, 2015) considered in detail the acquisition processes adopted by Southern Health and commissioners in 2012. The review was structured around a number of key questions which provide the framework for this report.

1.4 The transition of the learning disability service was initially overseen by the Learning Disability Transition Board, a chief executive level group established in 2015. In February 2016 the Board evolved into the Transforming Care Partnership Board, which oversaw the transition and continues to deliver the transformation of services as set out in the Transforming Care Plan.

2. What did Oxford Health and their commissioners know about the quality and safety of services before the acquisition?

2.1 In July 2016 a Programme Director was recruited by Oxford Health (with funding from Oxfordshire CCG) to prepare the Trust for the transition of the learning disability service[1]. The Director played a crucial role in assessing the quality and safety of Southern Health learning disability services and ensuring that appropriate mitigations were in place pre transfer, during transfer and post transfer.

[1] The interview panel for the post included service user representatives and staff from Oxfordshire County Council, Oxfordshire CCG and Oxford Health.

2.2 The Programme Director devised a programme of assurance using 'peer review' methodology (used by Oxford Health) and information packs using CQC tools. Southern Health colleagues (led by a dedicated officer with responsibility for overseeing the service transfer) supported this process, providing significant data prior to service reviews which enabled visits to the teams to be completed successfully.

2.3 The peer review teams were comprised of colleagues from Oxford Health with wide ranging experience and expertise relevant to the services being reviewed, including staff with specific learning disability experience. All included the Programme Director and where possible the appointed Clinical Lead (an external psychiatrist specialising in learning disabilities and autism, also funded by Oxfordshire CCG).

2.4 Reports were completed for each service against the CQC five domains[2] and shared with Southern Health colleagues and the Oxford Health Director of Nursing. The reviews provided an assessment of capacity, workforce, staffing arrangements and any safety concerns identified by the review team. Participating Southern Health staff readily provided information verbally and through documentation as appropriate. The results were presented to the Oxford Health Board seminar on the 14th September 2016, summarised below:

Overall all service areas met the standards but with some areas identified for improvement:

- *Community learning disability teams (CLDTs)*
  Some areas to improve (governance / effectiveness / leadership), but broadly safe and caring;
- *Intensive Support Team (IST)*
  Intention to increase the team and its function and further develop as a service in line with best known practice;
- *Continuing Health Care (CHC) service*
  Commissioning intention is to review the whole service within the wider CHC / Oxford Health context.
- *Inpatient services*
  Patients were all placed out of area as there were no open local beds.

2.5 The reports were also shared with the multi-agency Learning Disability Transition Task and Finish Group, which had been charged with overseeing the production of due diligence information and ensuring any safety and quality concerns were identified in advance of service transfer. The Group included Oxfordshire County Council and Oxfordshire CCG commissioners.

[2] Are services safe, effective, caring, responsive to people's needs and well led.

The Task and Finish Group had been constituted as a sub-group of the Learning Disability Transition Board which had been established in 2015 to oversee the transition of learning disability services. The governance arrangements for the transition are described further in 3.2.

3. <u>What processes did Oxford Health and the commissioners put in place to assess risk and mitigate any potential reduction in quality of care?</u>

Governance and Service User Engagement

3.1 Prior to December 2016 the commissioning of specialist learning disability health services was the responsibility of Oxfordshire County Council, who held the contract with Southern Health. Oxfordshire Clinical Commissioning Group assumed the role of lead commissioner on 1st December 2016, the date on which the Southern Health contract formally transferred (novated) from the Council to the CCG.

3.2 Oversight of the transition of learning disability health services was initially provided by the Learning Disability Transition Board, a chief executive level group with representation from:

- Oxfordshire County Council (as commissioner of adult learning disability health services to end November 2016);
- Oxfordshire Clinical Commissioning Group (as commissioner of adult learning disability health services from 1st December 2016);
- Southern Health NHS Foundation Trust;
- Oxford Health NHS Foundation Trust (as preferred provider);
- Oxfordshire Family Support Network (representing family carers); and
- My Life My Choice (representing people with learning disabilities).

Ian Winter CBE, formally Programme Lead for the Winterbourne View Joint Improvement Programme, was recruited to be the independent Chair of the Board in 2015. His appointment was intended to provide additional assurance for people with learning disabilities and family carers to ensure the views and interests of service users – including quality of care – would be central to the process of transition.

The Board evolved to become the Oxfordshire Transforming Care Partnership Board in February 2016. The Board's remit was to deliver Oxfordshire's Transforming Care Plan

(including the transition of learning disability health services), the local response to the national Building the Right Support strategy[3].

3.3 Oxfordshire CCG appointed a Senior Commissioning Manager to support the transition of the service and the development of the Oxfordshire Transforming Care Plan in January 2016. The post-holder worked alongside both the incumbent and intended provider and commissioners in the local authority to ensure a managed transfer of commissioning responsibilities was achieved.

3.4 The novation of the contract was overseen by the Learning Disability Transition Task & Finish Group. The service review process undertaken by Oxford Health and reported to the Group informed the CCG Board's decision to novate the contract, ensuring ownership and oversight at Board level.

Procurement

3.5 Oxfordshire CCG used a "Most Capable Provider" (MCP) process to assess Oxford Health's capability to both deliver the services provided by Southern Health at the point of transfer and to develop and implement a revised model of service in line with the Oxfordshire Transforming Care Plan and the national Building the Right Support strategy.

3.6 The MCP process sought to assess risk and mitigate any potential reduction in quality of care during and post transfer. It evaluated provider capability in the following areas:

I. Delivery of integrated healthcare that supports the health and well-being of people with learning disabilities (with or without autism), enabling them to develop capacity and capability to self-manage their care where possible;

II. An evidence based service delivery model which works now and over time to deliver integrated healthcare and which can be developed to deliver outcomes and quality performance in line with the Oxfordshire Transforming Care Plan;

III. A patient/user/carer focus that will inform both the design, implementation and future development of the care model and the individual experience of people who fall within scope of that model;

IV. A workforce sufficient to deliver the outcomes and quality expectations of commissioners over the length of the contract;

[3] The Oxfordshire Transforming Care Plan is the local plan to deliver the national Building the Right Support strategy, which aims to reduce reliance on inpatient beds and improve the provision of community services for people with learning disabilities and / or autism who display behaviour that challenges, including mental illness.

V. *A governance structure that provides leadership to support delivery in such a way that ensures the integrity of the service model across specialist and mainstream health services, in terms of patient/user accountability and management of business and clinical/quality risks;*

VI. *Robust implementation timescales and mobilisation and risk management.*

Oxfordshire CCG also stated that it was seeking assurance around the ability of Oxford Health to support those elements of the Oxfordshire Transforming Care Plan that were not within the current contract:

- The development of pathways for people with autistic spectrum conditions;
- The delivery of an all age approach to the care of people with learning disability and/or autism;
- The development of pathways aligned to secure beds commissioned by NHS England;
- To develop the capability of the wider health system to meet the needs of people with learning disability and/or autism in mainstream settings.

3.7 Service user and family carer representatives from Oxfordshire Family Support Network and My Life My Choice were integral to the evaluation of the bid, both as members of the evaluation panel and in contributing to the development of the questions. The Oxford Health bid presentation was to an audience of people with learning disabilities and family carers, many of whose questions were related to patient safety.

3.8 The recommendation of the panel was for Oxfordshire CCG to enter into a contract with Oxford Health for provision of learning disability health services.

Service Transfer

3.9 The operational aspects of the transfer were managed through the Learning Disability Transition Project Board established by Oxfordshire CCG, with representation from Oxford Health and Southern Health. The Board was led by the CCG's Head of Mental Health & Joint Commissioning, placing accountability for the operational aspects of the service transfer with the commissioner.

3.10At the outset of the project outlines were created which described the membership and reporting arrangements, purpose and scope, key products and the approach to managing quality, change and risk for each of five workstreams:

- Finance and Estates
- People (staff and HR)

- IM&T (information management and technology)
- Communications
- Enablers (legal, regulatory and contracts)

3.11 The transfer was supported by a dedicated full time project manager post within Oxford Health, funded by Oxfordshire CCG. This provided dedicated resource to manage the pre and post transitional phases of the project. Reporting by the project manager ensured the CCG could monitor progress and react quickly to any risks and issues which might have compromised patient safety.

3.12 The CCG also made a small amount of additional funding available which could be deployed quickly to mitigate key risks, for example resourcing data conversion work that was critical to the safe and effective transfer of digital patient records between Southern and Oxford Health's different case management software platforms (RiO and CareNotes).

4. Did Oxford Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition?

Leadership

4.1 Executive responsibility for the transition was assigned to the Director of Nursing and Chief Operating Officer, with additional expertise provided by the interim Clinical Lead. Both the Director of Nursing and the Chief Operating Officer had previous experience of running services for people with a learning disability, which they declared throughout the process.

4.2 Throughout the transition process weekly calls took place between the Programme Director and the Head of Learning Disability at NHS Improvement, to provide support and challenge to the process and the models being worked up.

4.3 The Programme Director has remained in post since transition and is now the Service Director for Learning Disabilities. The postholder is also the Trust's lead for autism across the organisation. The majority of senior operational and clinical staff transferred to Oxford Health and remain with the service.

Staffing

4.4 A total of 127 staff transitioned from Southern Health to Oxford Health. Each member of staff was provided with an induction pack which addressed key areas such as

Safeguarding, Incident Reporting, Complaints, Care Notes (the Trust's case management software) and the Learning Disability Community Team Referral Recording Process.

4.5 A bespoke induction was put in place to address the needs of all of the teams, especially given the nuanced differences in policy, practice and culture identified in the quality reviews.

4.6 Emails from the Chief Executive and Programme Director were sent to all staff to welcome them and a newsletter was produced at intervals. Yammer (online networking) groups were set up to share and learn together and a 'meet and greet' between the adult Senior Management Team and the learning disability teams took place in the first month post transfer.

Business Transfer Agreement (BTA)

4.7 A critical element of the transfer process was the Business Transfer Agreement (BTA) negotiated between Oxford Health and Southern Health. The BTA proved critical as a process and offered assurance and indemnities to Oxford Health which were called upon post transfer. It covered a number of key areas including historical sub-contracts (including the provision of out of area spot purchased inpatient beds), cleaning and maintenance contracts and medical equipment.

The amount of work required in securing the detail for the BTA was considerable, but was considered a valuable investment by both Oxford Health and Southern Health.

Mobilisation

4.8 Post transfer, mobilisation plans were put in place which focused on the first 100 days and post 100 days. Both of these plans were developed as working documents to record 'live' dates encompassing both transitional and wider learning disability strategy and transformational work. The four risk themes of Enablers, Money and Buildings, IM&T and People were identified.

Risks remaining open at the point of transfer were either appropriately closed or transferred to the service based risk register and actively managed.

Following transfer the Trust's Executive were given weekly updates against the mobilisation plan during the first 100 days following service transfer.

5. Did commissioners ensure that the transition to a different provider addressed known safety and quality concerns?

5.1 Oxfordshire CCG made a significant investment in the learning disability service during the contract negotiation, increasing the contract value by 28%. This was principally to enable Oxford Health to mitigate specific risks identified during the due diligence and procurement processes described above.

5.2 The service is subject to Oxford Health's corporate quality systems with ongoing contract management incorporated into existing arrangements for the Trust's mental health and community services contracts. This ensures equity and consistency of process and evidence of how well the service is embedded within the Trust.

5.3 Since the transfer the CCG's Senior Commissioning Manager for learning disability has been in regular contact with the Oxford Health Programme Director to discuss any risks, issues and service development. Patient complaints and serious incidents are monitored alongside business as usual contract monitoring returns and regular updates to Contract and Quality Review Meetings.

6. Conclusion

- Significant joined up work was completed by system partners to support Oxford Health to understand and corroborate evidence in regards to the quality and safety of services;
- Oxfordshire CCG took Oxford Health through an assurance process which enabled both parties to gain a shared understanding of the services, their immediate quality and safety and assurance in regards to the capability of the Trust to transition the services, with direct reference to the 2015 Verita report;
- Additional leadership and management resource was agreed by Oxfordshire CCG and Oxford Health and put in place to ensure safe transition and transformation;
- Oxford Health local leadership remained and has continued to be an active part of this process post transition;
- Additional external oversight of Oxford Health was provided by NHS Improvement and welcomed by the Trust;
- Board to Board discussion between Oxford Health and Southern Health close to transition proved useful and informed further actions and the indemnities within the Business Transfer Agreement;

- Additional internal contract arrangements that enabled better contract management (including quality assurance) of out of area inpatient placements was put into place at the time of transfer following joint work between Oxford and Southern Health;
- Taking responsibility for delivering the transfer of the service allowed the CCG to closely monitor progress and manage risks and issues;
- Oxfordshire CCG provision of targeted resources in advance of and during transfer (funding posts and providing a small budget for unforeseen transition costs) made a significant contribution to the successful transfer of services;
- The Verita framework provided a useful objective measure to ensure safe transition of a service for some of our most vulnerable adults.

Health Overview and Scrutiny Committee.
21 June 2018

Chairman's Report

1. Health Board Chairs meetings

1.0 A meeting was held with the Chairman of HOSC and the Chairs of the Health and Wellbeing Board (HWBB) (Cllr Ian Hudspeth) and the Health Improvement Board (HIB) (Cllr Anna Badcock) on the 15th of May. The meeting was scheduled following an action from HOSC in February to clarify, discuss and determine the appropriate roles of the different health-related Boards and Committee in Oxfordshire when considering cross-cutting, public-health issues.

1.1 Notes of the meeting are in Appendix A of this report, but the actions agreed as a result were aimed at improving links between the work of the Boards and scrutiny:

a) HOSC to receive an annual report from HIB/HWBB on progress.
b) Write to District Council Leaders and Chief Executives informing them their functions will be scrutinised through the annual reporting process and they make like to participate and attend the meeting in question.
c) For the letter from HOSC (as above) to be discussed at Oxfordshire Leaders/CEO's meeting.

2. The Horton HOSC

2.0 In August 2017, Oxfordshire CCG made a decision to permanently close consultant-led obstetric services at the Horton General Hospital. This decision was referred to the Secretary of State by Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). Following advice received by the Independent Reconfiguration Panel (IRP) and the Secretary of State in March 2018, the Committee agreed a proposal to establish a 'Horton Joint Health Overview and Scrutiny Committee' at its meeting on the 19th of April.

2.1 The new Committee was agreed to be established with relevant authorities covering the patient flow area for obstetric services at the Horton; Northamptonshire and Warwickshire County Councils. To achieve this, all three of these upper tier authorities needed to agree at a meeting of its Council to delegate health scrutiny powers to this new joint Committee for the express purpose of scrutinising proposals on consultant-led obstetric services at the Horton. Oxfordshire County Council and Warwickshire County Council considered and agreed these proposals on the 15th of May. Northamptonshire met to agree the same on the 17th of May.

2.2 Following final confirmation of the appointments to the new Committee, the Horton HOSC will be convened at the earliest opportunity.

3. Task and Finish Group

3.0 The Task and Finish Group to look in detail at Musculoskeletal Services (MSK) met for the first time on the 13th of June. The agenda for the first meeting is attached in Appendix B of this report. Due to timing of the publishing of papers for HOSC, a verbal update will be given to the Committee on the 21st of June regarding the outcomes of this meeting.

4. Care Quality Commission (CQC)

4.0 The CQC Inspection Manager for Oxfordshire and Buckinghamshire has written to the Chairman HOSC to suggest a meeting. The meeting will be specifically in relation to inspection services for mental health and primary medical services and will discuss heath provision in Oxfordshire and particularly any concerns the HOSC may have in this regard.

4.1 The Chairman will scope this work with the CQC and a further discussion will take place with HOSC Members at the next meeting of the Committee in September.

Appendix A

Notes of Chairs meeting:
Oxfordshire Health Joint Health Overview and Scrutiny Committee, Health & Wellbeing Board and Health Improvement Board

Date of meeting: May 15th 2018
(County Hall Oxford)

In attendance:

HWBB Chairman: Cllr Ian Hudspeth
HIB Chairman: Cllr Anna Badcock
HOSC Chairman: Cllr Arash Fatemian
Nick Graham, Head of Legal and Governance
Jonathan McWilliam, Director of Public Health
Julie Dean, Principal Committee Officer
Sam Shepherd, Senior Policy Officer

Aim:
Clarify, discuss and determine the appropriate roles of the different health-related Boards and Committee in Oxfordshire when considering cross-cutting, public-health issues.

Objectives:
- Chairmen and their support officers are clear about the remit and scope of each of the health-related Boards and Committee.
- The relationship between each of the Boards and Committee is understood- both in governance terms and the routes of communication.
- Chairmen and their support officers are able to ensure that forward plans for each of the relevant meetings are appropriately focused.
- Relevant forward plans maximise the respective Board or Committee examination of

Notes
Welcome and outline of meeting Cllr Fatemian stated that following discussions regarding HOSC's forward plan and important issues which are potentially beyond the remit or role of the Committee, it is helpful to align work across HOSC/HIB/HWBB to give appropriate and due consideration

the issues and avoid unnecessary duplication.

to the issues in Oxfordshire.

The official position

It is understood that for all the Boards and Committee's working around health and public health, that it is everyone's responsibility to work on health improvement for the population of Oxfordshire. The roles are:

- HWBB deliver the HWB Strategy. They set the plan.
- HIB is a sub-committee of the HWBB working on wider determinants of health. The job of HIB is to bring together partners to work on this.
- HOSC scrutinises all activity. They scrutinise plans.

Communications and forward plans

An annual report to HOSC on the activity of the HWBB and HIB was discussed. This would cover what each Board has done over the year, how it performed against what it aimed to achieve and what its plans are for the coming year. This would enable HOSC to be aware of all activity and add value through scrutinising and challenging past performance and future plans.

ACTION: HOSC to receive an annual report from HIB/HWBB on progress. Sam Shepherd to schedule on Forward Plan.

Cllr Badcock raised a concern that without Leader and Chief Executive sign up to all health improvement outcomes, it was difficult to ensure HIB can get ownership over its actions because the improvements they are aiming for are not always the statutory function of each organisation involved.

ACTION: Cllr Fatemian to write to District Council Leaders and Chief Executives informing them their functions will be scrutinised through the annual reporting process and they make like to participate and attend the meeting in question.

ACTION: Cllr Hudspeth to ask for letter from HOSC Chair (as above) to be discussed at Oxfordshire Leaders/CEO's meeting.

How to maintain an overview of business between the Boards and Committee was discussed. A scan of each meetings' agendas and minutes was proposed and that this may be something the Policy Officer with responsibility for scrutiny Chairman may usefully pick up and flag issues accordingly to the relevant Chairman.

Meeting close
Cllr Fatemian thanked the participants for their support and closed the meeting.

Appendix B

Oxfordshire HOSC Task and Finish Group: MSK Services

Date and venue: 10.00am-12.00pm, 13th June 2018, Members Boardroom.

Attendees:

HOSC Members:
Cllr Monica Lovatt (Chairman)
Cllr Laura Price
Dr Alan Cohen

Organisational representatives:
Ally Green, Head of Communications, CCG
Sharon Barrington, Head of Planned Care, CCG
Rob Walker, Healthshare

Agenda:

Time	Item	Lead
10:00	Welcome and apologies	Chairman
10:05	Terms of Reference for the Group	Chairman
10:15	MSK Services overview: • Process and timeline for the development and transition of MSK Services to existing provider • The Services now available to Oxfordshire residents • Outstanding issues which need addressing	CCG/ Healthshare
11:15	Proposal for a review to meet the aims and objectives of the Group	CCG
11.55	Next meeting: date and focus of meeting	Chairman
12:00	Meeting close	