Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 4 April 2019 at 10.00 am

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

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Neil Owen

Councillors:	Mark Cherry	Mike Fox-Davies	Laura Price
	Dr Simon Clarke	Hilary Hibbert-Biles	Alison Rooke
District Councillors:	Nigel Champken-Woods	Monica Lovatt	
	Sean Gaul	Susanna Pressel	
Co-optees:	Dr Alan Cohen	Dr Keith Ruddle	Barbara Shaw

Notes: ***Date of next meeting:*** *20 June 2019*

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 Arash Fatemian Email: arash.fatemian@*oxfordshire.gov.uk*
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*

Yvonne Rees
Chief Executive

March 2019

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes

To approve the minutes of the meeting held on 7 February 2019 (**JHO3**) and to receive information arising from them.

For ease of reference when considering the Matters Arising from the 7 February 2019 meeting, a list of actions is attached at **JHO3.**

4. Speaking to or Petitioning the Committee

5. Forward Plan

10:15

The Committee's Forward Plan is attached at **JHO5** for consideration.

6. Clinical Commissioning Group (CCG) - Key and Current Issues

10:20

This item provides a report (**JHO6**) on the key issues for the CCG and outlines current and upcoming areas of work. It includes a summary of the NHS Long Term Plan.

7. Regional PET-CT Scanning Service - Provision

10:50

To consider a report from NHS England (**JHO7**) which gives the following:

- an overview of the commissioning and procurement process which led to the award of the contract for the regional Positron Emission Tomography and Computed Tomography (PET-CT) scanning service to a private healthcare company, InHealth;
- A proposal for provision of services in Oxford.

A representative from the Oxford University Hospitals Foundation Trust (**OUH**) will be present will be present to discuss the implications of this decision for the delivery of PET/CT scanning for cancer patients' safety and good quality outcomes. A report is attached at **JHO7.**

8. Dental Services and Dental Health in Oxfordshire

12:20

The Committee will scrutinise the provision and capacity of NHS dentists in Oxfordshire (**JHO8**). It will include a look at the dental health of adults and children in the Oxfordshire population, including where inequalities exist; and programmes of work to promote dental health.

Public Health will lead on this item with input from Adult Social Care to link in with the needs of people in residential/nursing care.

13:00 – LUNCH

9. Update on Transition of Learning Disability Services: Benefits for Patients

13:30

The Committee will receive a report on the benefits of the changes to Learning Disability services for patients. The report is attached at **JHO9**.

There will be representatives attending for this item from a number of organisations – from the Clinical Commissioning Group, the Oxfordshire Family Support Network, 'My Life my Choice', Oxford Health and Oxfordshire County Council.

10. Update on Recommendations from the Health Inequalities Commission

14:00

Jackie Wilderspin (Oxfordshire County Council) and Dr Kiren Collison, Oxfordshire Clinical Commissioning Group) will attend to present the review of progress made (**JHO10**) in relation to the Health & Wellbeing Board's Health Inequalities Commission report.

11. OUH - Progress against Quality Priorities 2018-19

14:30

Dr Clare Dollery (Oxford University Hospitals Foundation Trust) will attend to present the annual report on key progress against OUH stated priorities. The Committee are asked to comment (**JHO11**).

12. Healthwatch Oxfordshire (HWO)

14:45

Rosalind Pearce, Chief Executive Officer of Healthwatch Oxfordshire (HWO) will be present to report on views gathered by HWO and its latest activities. (**JHO12**).

13. Chairman's Report

14:55

The Chairman's report is attached at **JHO13**. It includes and update on health and social care liaison.

15:05 Close of Meeting.

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.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 7 February 2019 commencing at 10.00 am and finishing at 2.00 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen (Deputy Chairman) Councillor Mark Cherry Councillor Mike Fox-Davies Councillor Hilary Hibbert-Biles Councillor Laura Price Councillor Alison Rooke District Councillor Nigel Champken-Woods District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Kieron Mallon (In place of Councillor Dr Simon Clarke)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle
Officers:	
Whole of meeting	J. Dean and S. Shepherd (Resources); and Rob Winkfield (Adult Social Care)

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

1/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Kieron Mallon attended for Councillor Simon Clarke and an apology had been received from Councillor Sean Gaul.

2/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Dr Alan Cohen declared an interest in Agenda Item 7 on account of him being a trustee of Oxfordshire Mind.

3/19 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 29 November 2018 were approved and signed as a correct record subject to the amendment of the phrase 'If money was not a problem' to 'Had funding been available' in Minute 57/18, page 6, paragraph 1, line 13

Matters Arising

With regard to Minute 57/18, page 6, paragraph 1, Sam Shepherd undertook to seek the result of the bid which had been submitted to provide additional capacity to support school health nurses in their ability to intervene and give them access to CAMHS, and to inform members accordingly.

4/19 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The following requests to address the meeting had been agreed:

- Didcot Town Councillor, Cathy Augustine, in relation to Agenda Items 5, 6, 8, and 10
- Julie Mabberly, on behalf of 'Save Wantage Hospital Campaign, in relation to Agenda Item 7
- Maggie Swain, 'Save Wantage Hospital Campaign' – in relation to Agenda Item 7
- County Councillor Jenny Hannaby, in relation to Agenda Items 7, 9 and 10
- County Councillor Jane Hanna, in relation to Agenda Items 5, 7, 8, and 12

5/19 FORWARD PLAN

(Agenda No. 5)

The Committee considered the latest Forward Plan, as amended since the last meeting (JHO5).

Prior to discussion at this item, the Committee was addressed by **Didcot Town Councillor Cathy Augustine**. Her view was that, in light of the new government guidance through the recently published national Long - Term Plan, and the introduction of new commissioning bodies, primary care networks and merged areas, there was a need for a new round of consultation to consider how it would affect Oxfordshire. She stated that its implementation would make the work of oversight and scrutiny more difficult for this Committee. Localised responses would be required. She added that no workforce planning had been included, leading to a risk that acute, short-term pressures would crowd out investment, which, in her view, was vital to putting local health services on a stable and sustainable footing. She urged the Committee to be aware of this bigger picture, as individual initiatives were scrutinised.

It was also her view that the effect of digital changes would be to reduce face to face primary care, threatening both the quality of care and continuity of care. It also went against the stated drive of the Oxfordshire long term plan to reduce inequalities.

With regard to primary care networks, she asked how would the growth of large primary care networks play out in rural Oxfordshire, where a lack of public transport impacted on the elderly, young families and those in poverty.

County Councillor Jane Hanna echoed Councillor Augustine's fears concerning the uncertainties about the role of this Committee, resulting from health and care plans at a national and local level. She also expressed her concern that there may be nothing placed in the public domain, thus affording little opportunity for the public to have its say. She added that there were urgent workforce issues around work planning which would impact on the public in a most impactful way. She asked what plans did this Committee have to view the contingency planning which is taking place, in a timely manner? Councillor Hanna gave the supply of medications as an example of an issue which related to the fundamental changes to the regulatory function, together with contingency planning for potential transfers away from doctors who were prescribing. She commented that in her view there was much to be said for the development of the role of pharmacy, in order to avoid mistakes being made, should events take place at great speed.

In response to the above, the Chairman commented that any transition was scrutinised readily by this Committee and it would continue to do so. He added that the long-term NHS Plan was to be covered by the Clinical Commissioning Group (CCG) at the Committee's 4 April meeting

The Committee added the long-term NHS Plan to the Forward Plan, together with with an expanded Primary care item to cover the divide between primary care and community health services.

Actions included the following:

- Committee training on the scrutiny of the integration of Health and Social Care to be looked into for possible delivery by the Centre for Public Scrutiny;
- Chairman to explore with the Chair of Performance Scrutiny Committee the question of which Committee was the most appropriate domain to perform the scrutiny of the outcomes-based Mental Health contract. There was a need to scrutinise integration properly.

6/19 CLINICAL COMMISSIONING GROUP (CCG) - UPDATE

(Agenda No. 6)

Prior to consideration of this item the Committee was addressed by **Didcot Town Councillor Cathy Augustine.** She asked the Committee to seek answers on how CCG's would be affected by the national Long-Term Plan, which, in her view would give considerable powers to a newly created network of joint NHS England and NHS Improvement regional directorates who would report upwards. Alongside this new centralised structure, there would be 44 'Integrated Care Systems by April 2019. She asked how transparent and accountable would those new organisations be? She

also asked if, given that each Integrated Care System would be working towards an Integrated Provider Contract, CCGs would only be strategic and not possess commissioning powers? If so, who would have these powers and how would HOSC oversee this?

The Committee considered an update (JHO6) from the Clinical Commissioning Group (CCG) on key issues. It also outlined current and upcoming areas of work, including the work on the primary care decision tree. In addition, Sam Foster, Head Nurse, Oxford University Hospitals NHS Foundation Trust (OUH), attended to give a verbal summary of the action taken in response to a recent Care Quality Commission (CQC) inspection of operating theatres.

The Chairman invited Catherine Mountford, Director of Governance, CCG, Dr Kiren Collison, Clinical Chair, CCG and Sam Foster, Chief Nurse, OUH up to the table.

Catherine Mountford and Dr Collison presented the report JHO6. Catherine Mountford pointed out that, with regard to the GP Practices Procurement Decision Tree, work would continue with this Committee and the public framework as before, but it would also be widened to encompass changes if a contract came to an end. The framework highlighted significant public and patient engagement. The work on the framework with the Primary Care Commissioning Committee would be a very useful and the CCG would ensure that it be made very transparent. It had been tested against some historical decisions. Comments received would be recorded on the flip charts on the wall where the draft version of the decision tree had been placed. Once progressed to a sufficient stage the decision tree would then be digitally produced to make it more accessible. This would not mean it was a static document; it would continue to evolve as learning took place, but the CCG did not want to take the step of producing a digital document (with the time and expense involved), until there was a good level of confidence in the process set out.

Catherine Mountford and Dr Collison gave a brief overview of the vision and main themes of the Long - Term Plan which had been published at the beginning of January. They commented that the CCG was pleased to see how it aligned with the integration of services and how it also addressed health inequalities. Reassurance was given that the Oxfordshire Health system was looking to addressing it with the public via the Oxfordshire Health & Wellbeing Board and this Committee. Under the NHS Plan, the current statutory bodies would remain, together with those providers who were a current statutory body. If any change occurred, then this would originate from the Government and would be discussed with this Committee. With regard to the Integrated Care System (ICS), there needed to be discussions with Buckinghamshire and Berkshire. Dr Collison added that work was ongoing with ICS which was complex, given the many organisations incorporated within it. Work was required with partners to identify the implications within the integration agenda for Oxfordshire.

Prior to questions from the Committee on the above, Sam Foster gave an update on the core service review by the Care Quality Commission (CQC) on OUH, which was the subject of a Section 31 Notice, details of which were on the CQC website. This related to an operating theatre block situated in the older estate on the John Radcliffe site. A refresh of the block had been included in the Trust's Capital Programme. A

refresh Action Plan was currently being drawn up that would ensure that the theatre block was fit for purpose, from a building (not surgical) perspective.

A member asked Sam Foster about procedure with the work – and what was being left on the theatre floors? She responded that the Trust planned to do the refurbishment. It was a question of timing and balance of the risk. Some theatres in the block needed to be closed. The CQC was happy for the closure to occur during April this year. She emphasised that the areas in question needed to be refreshed, adding that there had been too much stockpiling of equipment in the theatres and so there was also a plan to maintain the right stock, so that it was available at the right time. In response to a further question about whether the theatres were checked on a regular basis, she stated that OUH had a good record of infection control and surveillance across all of the sites.

Sam Foster reassured the Committee that patients were being risk assessed against those risks associated with the refurbishment, which was due to start on 1 April. The logistics associated with moving patients was a serious undertaking – and it was important to the Trust that the patients were treated in-house.

Questions from members of the Committee, and responses received, were as follows:

- How would the additional £25bn by 2023/24 be phased and would it be phased equally? Catherine Mountford responded that information had been received on this, and CCG would be allocated just over £43m, of which £20.56 would be for 2019/20. Some of the £43m would include money for pay awards. **She undertook to circulate to the Committee what was known of the allocation;**

- When would the Long-Term Plan be available for scrutiny? Catherine Mountford stated that a report would be taken to the next meeting of this Committee on 4 April. **The Chairman asked that it be presented in plain English and clearly labelled;**

- Given the many different patient pathways, how far are you away from discussion with the local authorities? Catherine Mountford stated that discussions were underway with regard to how to address data sharing with the different health providers. She added that the Clinical Commissioning Policies were on the CCG site for information on which procedures and treatments the CCG would not fund, or fund against set criteria for eligibility. The link could be shared with Committee members. There was also a national list. There had to be evidence of clinical cost effectiveness which for Oxfordshire, the Thames Valley Priorities Committee assessed and determined. **She was asked to circulate the list of procedures and treatments not funded by the CCG to Committee members, highlighting what had changed and to inform the Committee of any additions to the list each time**;

- A member commented that whilst the workshop looking at the Primary Care Decision Tree had thrown forth some innovative solutions, some

participants had some concerns. She asked if the Committee would be able to look at the finalised proposals? Catherine Mountford stated that she was happy to discuss with the Committee about how it wanted to comment. The proposal was to share the decision tree with the CCGs and NHS England and the more it was shown and tested through, the better it would be. The aim was to get it professionally produced, so that there was an electronic version, whilst still remaining a working document, in order to give members of the Committee the opportunity to see it as a whole. She offered to leave the only draft with the Committee for a few weeks to look at it. The Chairman declined but thanked her for the offer, commenting that the Committee felt that it could work with the framework, but warned against being 'wedded to it' and not to rush it;

- With regard to the Vasectomy survey, a member thanked the CCG for undertaking it, but asked for assurance that there were no plans in place to cease female sterilisation. She asked if OCC had been consulted on the plans, expressing a concern that there would be potential knock-on effects to the County Council's budgets. Catherine Mountford informed the Committee that the CCG was currently in an engagement period, which included engagement with Public Health in relation to the impact on services. A decision had not yet been taken, as there was a need to look at it fully. With regard to female sterilisation, which was not normally funded, the proposals were in line with those of other CCGs, in that there were more cost-effective ways of providing the service. **She undertook to highlight this service when sending the links through of procedures and treatments not funded by the CCG;**

- A member asked if there was a backlog in patients needing the vasectomy service and had the service caught up with seeing new patients? Catherine Mountford responded that new referrals were not being seen because it would take the service until the end of the contract to do so;

- A member asked how the decision to suspend all bariatric surgery referrals and clinics whilst the study on pathways was underway, impacted on OCC obesity services etc; and was the CCG consulting with OCC? Catherine Mountford responded that there were workforce shortages in this area causing pressures for those working with patients pre and post surgical. The CCG was working with OUH to find a short - term solution for those patients awaiting surgery. Work was ongoing with other Health authorities in the Thames Valley region on what a future service could look like, given the limited availability of clinicians, as it was a small service. She added that no decision had been made on a permanent change to date. She accepted that the temporary change in service should not be prolonged;

- In response to a question relating to the results of the Children & Adolescents Mental Health services (CAMHS) bid, Catherine Mountford reported that Oxfordshire had been successfully awarded £5.4m in extra funding until 2021 to bring services into all primary and secondary schools within Oxford City, where there was the highest need. A development plan was being worked up.

The Committee thanked all for the update and for their attendance

7/19 REVIEW OF LOCAL HEALTH NEEDS - WANTAGE PLANNING FOR POPULATION HEALTH NEEDS REPORT

(Agenda No. 7)

Maggie Swain cited a research paper undertaken by the University of Birmingham entitled 'Analysis of the profile, characteristics of patient experience and community value of community hopes' 2019 which echoed the patient experience of those living in the OX12 area. In this document people had stated that it felt different to be a patient in a community hospital than elsewhere. This was due to the environment and the atmosphere. It had found that patients received a holistic and personalised approach to care, together with a different patient experience of staff care. She also referred to the Save Wantage Hospital Campaign's Facebook request for accounts of patient experiences. A large response had emerged regarding the physiotherapy services provided by Healthshare, mainly focusing on travel difficulties for many patients journeying from Wantage to East Oxford and Bicester. She also highlighted problems experienced by patients leaving hospital being placed in care homes a long distance away from Wantage. She concluded by appealing to Health to carry out the repairs to Wantage Hospital so that people could receive their care in their own home town.

Julie Mabberly asked for an update on action in relation to the time frame presented by the CCG on Wantage Hospital at the September and November meetings of this Committee – and, furthermore, that it be presented in a professional manner. She circulated a chart which indicated that some of the promised actions were late. She stated that the campaign group had no confidence that the project would be brought to fruition. She also complained that the Terms of Reference for the project did not include representation from the Campaign Group.

Councillor Jenny Hannaby called for a wider vision to the project, to include all localities in the south of Oxfordshire. It was her view that the CCG was not progressing very quickly on the Wantage Hospital project. She pointed out that Wantage Hospital had not been included within the consultation under scrutiny at this meeting and this was not the correct manner in which to approach it, time had been lost. She urged the Committee to use its powers to refer the Wantage Hospital to the Secretary of State for Health.

Councillor Jane Hanna, commenting on this item and the next, made reference to the statement that there would be 'a consistent approach to health care across Oxfordshire and wider innovative progress.' She had found it difficult to see how the issue of governance and the experience of residents in the Wantage and Grove area connected with the work of the Integrated System Delivery Board (ISDB) and Government initiative. She asked where the funding would come from to fund a world class service, as expected. In her view, there was no transparency of funding contained within the local plan and decision making of the ISDB was not in the public domain. It demonstrated that local members had been excluded and not even given the opportunity to observe. She called for equity with health, and public scrutiny of decision making.

Dr Ruddle stated that the CCG had met with Wantage representatives on 19 December, and also on 13 February 2019 via their Stakeholder Reference Group. He asked if Councillors Hanna and Hannaby had been actively included and had engaged with both these meetings. Councillor Hanna responded that she had attended both meetings but could not be in agreement of what had been stated there, as there had been insufficient clarity. Councillor Monica Lovatt reminded them that she was both the Chairman of the Vale of White Horse District Council and the district council representative on this Committee, and that they could speak to her also. The Chairman observed that the Task & Finish Group had parity with the Horton HOSC, but the latter, by its very nature of its involvement with the IRP, was taking longer to reach its goal. The need for brevity was the reason why it had been decided that the best way forward for Wantage Hospital was via a Task & Finish Group.

The Chairman welcomed Catherine Mountford, Dr Kiren Collison and Jo Cogswell (OCCG) and Pete McGrane (Oxford Health Foundation Trust) to the meeting.

Jo Cogswell took the Committee through the key highlights of the report with regard to progress made with regard to Wantage Hospital. She reported that at the next meeting of the Stakeholders Group there would a test made of the timetable to ensure that there was transparency and meaningful engagement. She apologised if people felt that insufficient progress had been made in the direction they wished it to proceed, but stated that if it was executed faster, important aspects may have been missed. She added also that a response to the issues identified at the meetings, ie, that of GP services would be given in the near future. Furthermore, the CCG had been working hard behind the scenes with Oxford Health to address the requests made by the local community to reinstate the Physiotherapy services. She reported that a decision had been made to reinstate these services. Moreover, an update on this decision would be provided as soon as practically possible. Jo Cogswell also commented that CCG recognised the importance of elected members and this had been recognised within the membership of the Stakeholder Reference Group.

The Chairman expressed the Committee's appreciation for the amount of work which had taken place in this field. But, nine weeks on from the November meeting of this Committee at which this had been considered, he wondered if sufficient priority was being given to moving things forward in relation to the Hospital. Jo Cogswell assured the committee that a significant amount of work was taking place on the research side in relation to the population groups and health and social care need, and on how to draw out relevant information and best practice. Dr Collison was leading a group of clinicians, and knowledge from the Stakeholder Group was part of it. In response to questions from the Chairman, she gave her reassurance that this work would be completed by the May/June deadline.

In response to a question about how purdah might affect this deadline, Catherine Mountford reported that NHS England had taken Cabinet Office guidance which had been issued to the NHS. **She undertook to forward the links to this to members of the Committee.** She reassured the Committee that work would be ongoing during the purdah period. In response to a request for a commitment in relation to this, Catherine Mountford stated her expectation that the CCG would be in a period for developing options for the future provision of services in April/May/June. She added

that the CCG would also still be in the engagement phase, unless a decision had already been taken. There was therefore an expectation that they should be able to proceed.

Dr Ruddle informed the meeting that a draft paper for engagement with the plan would be presented to the Stakeholders Reference Group which was due to meet the following week. He made an appeal to the CCG for a clear and realistic approach to be followed, as there had been a three - month delay. He added that the Task and Finish Group was a scrutiny body, and the project was in need of a project manager and it also required an elected member. He reminded the Committee that this was meant to be a co-produced, local approach and needed clarity.

Jo Cogswell responded that Libby Furness, OCCG, was the project manager whose latest work was on the Older People's Strategy. She added that, on the face of it, some of the deliverables had slipped, but two informal meetings with representatives of the system had taken place. The CCG had looked at the demographics of the area – and had given some thought about how to ensure that the Stakeholder Reference Group genuinely represented all. Contained within the reference group were representatives from partner groups who would support the shaping of how it could be sure to represent the community as the project moved forward. Resources had been set aside to advance this work at a pace.

Jo Cogswell was asked when there would be a decision about services provision in Wantage. She responded that there were other issues in Wantage which needed to be addressed and evidence of need gathered, but that she could confirm that MSK services would be commenced again from Wantage Community Hospital site. Councillor Lovatt commented that having MSK services at Wantage Hospital would be very helpful. Members of the Committee asked whether there would be the same number of plinths as there were before? Would the Vale area get the same number of plinths as before? And were services returning to Abingdon Hospital also?

Jo Cogswell responded that some facilities were available within the Vale area, but it had to be equitable within the county. Jo Cogswell agreed to respond on all the above issues.

It was **AGREED** to:

(a) to thank all for attending; and
(b) that the Chairman would write to NHS England to ask that it did everything in its power to assist in a quick resolution to this issue.

8/19 HEALTH & WELLBEING BOARD - MEMBERSHIP AND STRATEGY

(Agenda No. 8)

Prior to consideration of this item the Committee was addressed by **Councillor Cathy Augustine**. She thanked the Committee for challenging the lack of transparency and accountability of the Integrated Systems Delivery Board (ISDB), with some success. In terms of the Health & Wellbeing (HWB) Strategy, however, it was her view that consultation had been poorly publicised, causing participation to be low. She asked how input to the online survey was being encouraged and how could

Didcot residents participate? Who has been invited to the stakeholder meeting on 28 February and could the list be shared?

Councillor Jane Hanna requested that the Committee take a further look at what was constitutionally commercial. It was her view that all was of a confidential nature, which was not in keeping with the openness and transparency which local government endeavoured to capture. She also spoke about the need for contingency planning in the face of Brexit and the possibility of losing care workers.

The Chairman welcomed Councillor Ian Hudspeth and Kate Terroni, OCC; Catherine Mountford and Dr Kiren Collison, OCCG, up to the table. He clarified that the Committee was interested in two particular areas, namely, the question of how many elected members were on the Health & Wellbeing Board and the openness of the ISDB.

Councillor Hudspeth stated that the consultation in relation to the Board's membership began in November 2017. All were given the opportunity to put forward their views including the voluntary organisations of which there are 200 within the county, and providers also. It was felt that, in light of the new Long-Term Plan, the NHS needed to be in a position to influence local solutions. It was now felt that the Board had the appropriate balance of county/district councillors, NHS and OCC Chief Executives and the statutory representatives (eg. Directors of Adult Social Care, Public Health, Children's Services, Chief Officer and Clinical Chair of CCG, Chair of Healthwatch Oxfordshire, etc).

Catherine Mountford reported that a paper would be taken to the 14 March Health & Wellbeing Board on the use of different approaches to engage public and wider stakeholders, particularly in relation to the HWB Strategy. Healthwatch had agreed to provide the support for the development of a Stakeholder Reference Group, using people previously involved in the preparation of the HWB Strategy and then widening it to include the social media and online tools etc.

Kate Terroni stated that following the last system review on 20 November 2017, consideration was given to where the' engine' to deliver the work of the HWB was to come from. The recent CQC inspection had then given the impetus to go ahead with this in the form of the Integrated Strategic Delivery Board (ISDB). She pointed out that this is not a decision - making group, nor is it in a position of authority. Its views are fed into the HWB, or the respective organisations such as the Cabinet or a Trust Board(s) for those to decide the way forward. She added that in light of the concerns expressed about its transparency it had been decided to make available each month, a list of the discussions which the Board had been engaged in, if the Committee should wish it.

Questions from members of the Committee and responses received, were as follows:

- The voluntary sector comprised of many organisations which varied in size. Some were large providers of health care, some not. The very large providers were not actively involved in decision making in the same way as the Trusts. If the ISDB was to meet every 6 months, the voluntary organisations would have already met to consider their views. Therefore, what could they offer? Councillor Hudspeth responded that however large

or small/local/national they were, it was all about trying to reach a compromise. The paper outlined the outcomes of the conversation which had taken place with them. Catherine Mountford pointed out that discussions had taken place with Healthwatch Oxfordshire about how it would apply different means of gaining opinion for different issues, as part of the Stakeholder Reference Group. The Group could also meet at different times with different groups, depending on the issue;

- With regard to questions concerning the 'top heavy' membership of officers in relation to elected members on the HWB, Councillor Hudspeth compared the Board to that of the Growth Board which had grown organically from 2009. The key issue of difference was that the Growth Board comprised all elected members and the HWB did not. The HWB was set up as a statutory body with membership from key leading officers. He added, however, that the officers sitting on the Board would be fully aware of the views of the Council and would be representing members' views, thus giving a balance. He added that it was originally felt that the Board was too OCC 'top heavy' and this was an opportunity to try to get the best, seamless services for residents, the best for Health care, and the best democratic representation;

Draft Health & Wellbeing Board Strategy

The Committee had before them, for consideration, the draft Health & Wellbeing Strategy prior to its submission to the Health & Wellbeing Board on 14 March 2019 (JHO8).

Questions submitted and responses received were as follows:

- In the face of a lack of funding for public health and prevention, could it meet its targets? could it keep apace with rising need? And how would it be delivered? - Kate Terroni responded that the CQC inspectors had reflected that the Board had now got the right people around the table to tackle inequalities, the prevention agenda etc. The system leaders, pulling together, could direct the monies where needed and would be held to account by this Committee. Councillor Hudspeth agreed that cuts to public health (£531m nationally) were stringent and Oxfordshire was campaigning for this to be reversed. It was important to be lobbying hard in the spending review for Oxfordshire. The business rates outcome was unknown at present. He added that as far as district councils were concerned, all needed to be delivering on inequalities, not just Oxford City;

- Kate Terroni undertook to take back a comment about the 'close type' in the document making it difficult to read when imparting a lot of information;

- The issue of the need for a strategy for affordable housing for health workers was also taken back;

- In response to a question asking whether the lobby against cuts was also lobbying to keep these services ring-fenced, Councillor Hudspeth stated

that he saw no change in the current ring-fence, the key was to stop the cuts in public health which had been taking place since 2013;

- A member commented that there was a need to await the result of Brexit to see what the business rate threshold was before it is jumped to conclusions about the shift of services across Oxfordshire. Councillor Hudspeth responded that it was the goal of all of the Oxfordshire Councils to ensure a vibrant economy in Oxfordshire. Oxfordshire had a growth economy. Catherine Mountford commented that the NHS had been given national guidelines on planning for the EU. Moreover, workshops were being held, which was part of the usual business continuity. This was being addressed nationally.

All were thanked for their attendance and for responding to questions.

9/19 CARE QUALITY COMMISSION (CQC) SYSTEM REVIEW

(Agenda No. 9)

Prior to consideration of this item the Committee was addressed by Councillor Jenny Hannaby. She commented that she had been pleased that the CQC had recognised the work which had taken place on better working relationships with Health partners; and that it had been found that strategic development to be more robust in the usage of performance data. She suggested that this Committee should carry out an investigation into how far the voluntary sector would like more involvement/collaboration with the Health & Wellbeing Board, which could lead to better services. She also suggested that this Committee take steps to encourage more progress in relation to the recruitment challenge.

The Chairman welcomed Pete McGrane (Oxford Health), Sam Foster (OUH), Diane Hedges (OCCG) and Kate Terroni (OCC) up to the table.

Kate Terroni, in her introduction, stated that Oxfordshire was the only one chosen out of the three systems for the CQC to re-review. She observed that Councillor Hannaby had focused on the work which was still required as a result of the inspection. As an outcome of the re-review, the CQC had noted that:

- More work had been put into building trust between health and social care and thought given to how both could work together better, in order to improve the outcomes for patients and their relatives;
- Winter Planning had been executed well, bringing the delay statistics down from 81 to 60-80. More steps had been taken under a single leadership so that patients could leave hospital in a timely way;
- More thinking was needed on how to move away from the transactional working relationship with the providers;
- A comprehensive review of carers and self-funders was required; and
- Sufficient progress had been made on the tracking of patients.

Sam Foster stated that co-location was an important factor in terms of patients being treated in a seamless fashion. For those patients on pathway 1 (happy to be alone in between visits, there were co-located teams which could be scaled up in a place – related approach (‘Home First’). A range of pilots were taking place around therapy support, which was being driven by the A & E Delivery Board.

Questions from the Committee and responses received were as follows:

- Much time and effort has been put into filling the gap between services as best as possible, what actions have been employed to do this? – Kate Terroni listed a number of actions including:

- Health/Adult Social Care Chief Executives had a call a week to discuss any operational issues;
- 'Oxfordshire Pound' work by the provider Trusts within the community;
- Single team working in the John Radcliffe Hospital. This was successful as it was place-based approach to regulation as it required a place-based approach to regulation, which, in turn, required collective ownership of people and a joined-up approach.

Kate Terroni reported that a conversation was required on how to work with districts, HOSC's and the voluntary sector in the face of absence of a formal mandate from the Government.

Members asked whether there were plans in place to recruit people from all over the world? Sam Foster responded that they were and 51 new nurse/doctor recruits were coming from Cambodia, Ghana and India. The Trust was also now going out for therapists and other groups of staff. There were also some exciting apprenticeships planned, with a potential to make these roles attractive for career development. Kate Terroni reported also that talks were ongoing with the managers of 70 home care providers to discuss what the blocks were to the provision of more home care workers. In addition to this, work was ongoing on what technology and pilots were needed to provide a fresh look at this area. She added that more patch-based training could be offered and thought given into how to link with local primary care therapy. Mapping this out would begin soon to see how it would look and then, if proved possible, start in six to nine months.

The Committee then **AGREED** to **RECOMMEND** that the Health & Wellbeing Board, being the accountable body considers focusing on three or four topics, in an integrated, systematic manner, and it be held to account by this Committee. For example, its systematic approach to workforce issues, or continuity issues such as travel to the John Radcliffe for patients.

Diane Hedges commented that this was a very helpful suggestion. Picking the right topics was the key to ensure that there was sufficient 'joining together'.

10/19 REPORT FROM TASK AND FINISH GROUP ON MSK SERVICES

(Agenda No. 10)

Prior to the consideration of this item the Committee was addressed by **Town Councillor Cathy Augustine.** She expressed her disappointment that after initially accepting the report, the CCG was now, in her view, distancing itself from parts of it. As a Didcot Town Councillor, she was concerned that the Didcot Physiotherapy Unit did not become over-stretched due to closures of similar units nearby, and also in terms of service levels and information provided. She added that patients were still

reporting long waits and poor information. She concluded by stating that, as far as the residents of Didcot was concerned, this was not a task and finish group, but an ongoing issue.

Councillor Jenny Hannaby stated she had asked why services were not being brought back to Abingdon and Wantage. She reported that she had spoken to the Chief Executive of Oxford Health about Wantage Hospital not being allowed to take over facilities and he, as a result, contacted the CCG to offer the service at Wantage. Unfortunately, by this time, Healthshare had made other arrangements for the service to be provided at Faringdon. She hoped that Abingdon would receive the Service. Councillor Hannaby thanked the Committee for convening the Task & Finish Group, which in her view had opened the public's eyes to the situation.

Sharon Barrington, Ally Green and Diane Hedges (CCG) and Rob Walker, Healthshare were invited up to the table.

Councillor Monica Lovatt, Chairman of the MSK Task & Finish Group introduced the report (JHO10) from the Group. She paid tribute to her fellow Group members, Councillor Laura Price, Dr Alan Cohen and policy officer Sam Shepherd for all their hard work. She emphasised that the report presented was the culmination of eight meetings which had taken place between June 2018 to January 2019, to hear the views of interested parties, in response to concerns raised to this Committee by residents and patients. She stated that the recommendations made by the Group had been designed to be constructive in nature. They were intended to support and encourage performance improvements and solutions where needed. On behalf of the Group, she thanked all the people who came forward to give their views and the following organisations for their openness and co-operation:

Healthshare (Oxfordshire), Healthwatch Oxfordshire, Oxfordshire Local Medical Committee, OUH and the clinicians who participated in the process, OH and OCC.

She commended the recommendations to the Committee.

Councillor Laura Price echoed all that Councillor Lovatt had said, stating also that the recommendations were not the end for this Committee. There had been some very serious performance issues contained within it and the Group now wanted to see some plans put in place to resolve these issues.

Dr Cohen echoed all that Councillors Lovatt and Price had stated commenting that the Group had thought hard on the performance issues and had found the lack of outcome data for Healthshare disappointing. The way identified information was being collected was incorrect.

Rob Walker stated that the findings of the Task & Finish Group were very helpful, adding that Healthshare was always willing to learn. He stated that Healthshare had always collected and reported person-related outcomes to the CCG since the start of the contract – and, as a result, Healthshare had not found it necessary to alter the way these were looked at.

Questions from members and responses received were as follows:

- Why was the service in Chipping Norton not operating from the Hospital rather than the Health Centre? Diane Hedges responded that space was not available at the Hospital and the upstairs of the Health Centre had been given over to non-GP related services. The Service Level Agreement for all sites was subject to agreement of terms of use. A request had been made, and, as a result the Hospital had set accommodation aside for other purposes;

- In response to a question asking what savings could be achieved (page 24 of the report). Diane Hedges explained that at the outset, the target set for orthopaedic support and risk was at £20 per head. The CCG had to ensure that it focused this spend on people receiving the maximum amount of care in order to avoid an intervention in the form of an operation. The CCG had underestimated what was needed, which was £1.6m and £3m had been set aside;

- When asked about what quality assurance was in place, Rob Walker assured the Committee that Healthshare was satisfied that the levels were as one would expect;

- A member asked how and why had the target figures been changed? Sharon Barrington responded that there was only a certain amount of money available in Oxfordshire – and due to the 30% increase to make the contract viable, it had been important to benchmark the service against others in order to ascertain which areas could be more flexible. The contract team had agreed it and it had been signed off by the Director of Finance;

- A member asked if, going forward, the service now had the right balance in place to improve the service, as there were many people who could be in considerable pain if there was a delay in their treatment. Rob Walker stated that this was a very large service, the biggest in the country. The CCG had given Healthshare very definite targets, and he was confident that some would be within the key performance indicators. He added that more staff had been brought into the service and it had a 91% answering rate, which compared favourably with the national survey undertaken for the GP service which was 75%.

Diane Hedges made reference to the changes to the narrative of the report, where some of the more emotive language had been taken out. She also felt that there had not been sufficient recognition of the real efforts being made and lessons learned. She added that the CCG was working through how self - referrals to the service would work – and these points made would be picked up. She was asked if it could be run by a different organisation. Diane Hedges responded that the commitment was to work as one NHS and Social care system.

The Committee **AGREED** to:

(a) thank the Task & Finish Group for the report and the representatives from Health for their attendance at the meeting; and
(b) receive the report and to request all to return to the June 2019 meeting when an Action Plan was to be produced for consideration by Committee.

11/19 HEALTHWATCH OXFORDSHIRE (HWO)

(Agenda No. 11)

Rosalind Pearce attended for this item. She referred to the report (JHO11) which was on the Addenda for the meeting.

With regard to the Health Inequalities agenda, a member commented that she was pleased to see the information on outreach ESOL groups, asking if this would be written up? Rosalind Pearce responded that this would be pulled together in a report. It had been a steep learning curve as it was a question of finding ways to communicate and had taken a significant amount of time to build trust. She added that HWO had been very pleased to undertake this project and the report would be made public after a few weeks.

Rosalind Pearce was thanked for the report and for her attendance.

12/19 CHAIRMAN'S REPORT

(Agenda No. 12)

Prior to the consideration of this report, the Committee was addressed by Councillor Jane Hanna. She asked this Committee to consider a further step to build trust between the public and the CCG, the first being the request for Physiotherapy services to be provided at Wantage Hospital, to which assurances had now been given. The second related to the current proposals for two large GP practices to be provided This had raised concerns as the practices would have twelve thousand people on their books between them. She also asked for the words after 'sufficient openness and transparency' in paragraph 3:2, bullet point 3, of the Terms of Reference for the Task & Finish Group to be deleted. This would give an opportunity for the Group to consider addressing any contingency planning.

Councillor Alison Rooke moved, and Councillor Pressel seconded, a motion to amend the Terms of Reference to amend the membership to 'two further Councillors ***and one local councillor for Wantage and Grove, providing they are not a member of the Stakeholder Reference Group.*** This was **AGREED** unanimously.

A member highlighted the importance of clarity on the roles of the Task and Finish Group and the Stakeholder Reference Group. There was a need to ensure that this project had proper sponsorship. It was specifically a scrutiny task group set up from this Committee to ensure things happened. It's role was not to run the project. The right governance was required to ensure the project was properly established.

It was **AGREED** to receive the Chairman's report.

..... in the Chair

Date of signing .....

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HOSC Actions from 7th February 2019

Item no	Item	Action	Lead	Progress update
05/19	Forward Plan	Amend forward plan to include: a) Long term NHS Plan to be covered by the CCG in April b) Future item on integration. Date to be decided once HOSC training undertaken on integration c) Schedule primary care items on GP appointments and GP Federations on the same meeting date d) PET-CT Scan item to come to HOSC in April e) MSK report-back at HOSC in June	Sam Shepherd	Complete
05/19	Forward Plan	Discuss and determine the best route for scrutinising mental health with the Chair of Performance Scrutiny	Cllr Arash Fatemian	Complete- mental health scrutiny added to the Committee's forward plan for November 2019.
06/19	CCG Update	Share the link to the list of procedures within the CCG's 'Clinical Commissioning Policies' which are a low priority or have certain criteria for access because of the evidence around the clinical benefits and cost effectiveness. New additions to the list, complied through the 'Thames Valley Priorities Committee' to be highlighted.	Catherine Mountford	Link: https://www.oxfordshireccg.nhs.uk/professional-resources/policies.htm

HOSC Actions from 7th February 2019

Item no	Item	Action	Lead	Progress update
07/19	Local Health Needs Assessment in OX12	Request the answers to the following on the resumption of MSK at Wantage Community Hospital: a) Same number of plinths as was before? b) Will the Vale area get same number of plinths as before? c) Are services returning to Abingdon Community Hospital too?	Jo Cogeswell	**Update** • The MSK service in Wantage is planned to be offered from the same clinical area as used before, which is understood to accommodate 4 plinths. • Vale of White Horse will then have MSK services offered in Didcot, Wantage and Faringdon, this will provide a total of 8 plinths. However it should be noted that certain therapies including group programs also happen away from the plinth bays. • Services are not currently provided in Abingdon. The health facilities in Abingdon to date have been unable to make space available for MSK services. • Because of this Healthshare provide services in alternative premises in the surrounding areas, this includes exercise class only sessions in Milton Park

HOSC Actions from 7th February 2019

Item no	Item	Action	Lead	Progress update
07/19	Local Health Needs Assessment in OX12	Forward links to guidance to the NHS on purdah.	Catherine Mountford	Links: https://www.gov.uk/government/publications/election-guidance-for-civil-servants https://improvement.nhs.uk/documents/2523/Pre-election_guidance_for_NHS_organisations_2018.pdf
07/19	Local Health Needs Assessment in OX12	Write to NHS England to ensure a swift response on assurance for any proposed changes following work on the Local Health Needs Assessment in Wantage	Cllr Arash Fatemian	In train
08/19	Health and Wellbeing Board Governance	Share the list of invitees for a meeting on the 28th February	Kate Terroni	Contained within Appendix D of the Chairman's report (4th April 2019)
11/19	MSK	HOSC to receive a report (in June) to see how plans were in place to resolve performance issues.	Sharon Barrington	To come
12/19	Chairman's report	Amend membership of the new HOSC Task Group on Local health Needs Assessment in Wantage to include a further member- a County Cllr from Wantage who is not a member of the CCG Stakeholder Reference Group.	Sam Shepherd	Complete

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HOSC Forward Plan – April 2019

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
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	HWBB

Updated: 26 March 2019

Meeting Date	Item Title	Details and Purpose	Organisation
		Systems Delivery Board). • Report to include assessment of how revised governance arrangements are working • Plans for 2019/20.	
June 2019	Winter Plan 2018/19	• Evaluation of the Winter Plan 2018/19	CCG
June 2019	MSK Services	• Report back to HOSC on the progress made against the recommendations of the MSK task and Finish Group (reported in Feb 2019).	CCG
June 2019	GP appointments	• Scrutiny of GP appointments. • What are the numbers of GP appointments available in Oxfordshire and where? • What are the trends with GP appointments, nationally and locally? How long, how many, at what times and in what locations in the county. • What are the costs of GP appointments? • Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored?	CCG/ GP federations
June 2019	GP Federations	• The local GP Federation landscape. • How effective are Federations at delivering high-quality, accessible and sustainable services for residents across Oxfordshire? • What are the challenges and opportunities for Federations in Oxfordshire? • Federation funding and governance for public transparency and accountability.	Federations/CCG
Future Items			

Updated: 26 March 2019

Meeting Date	Item Title	Details and Purpose	Organisation
November 2019	Mental health	• To follow an item at November's Performance Scrutiny meeting which will scrutinise Oxfordshire County Council mental health activity and spend. • How are mental contracts being fulfilled and delivered? • How is money being channelled to deliver on outcomes for the people of Oxfordshire?	CCG/OH
	Adult Social Care Green Paper	• The potential implications of the ASC Green paper on the local health and social care system	System-wide
	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
	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
	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) • How District Councils and other partners link with and support social prescribing	
	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

Updated: 26 March 2019

Meeting Date	Item Title	Details and Purpose	Organisation
	Priorities in Health – Lavender Statements	• How the CCG manages competing priorities – Thames Valley Priorities Forum	CCG
	Commissioning intentions	• Committee scrutinises the CCG Commissioning Intentions	CCG

Updated: 26 March 2019

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 4 April 2019

Title of Paper: Oxfordshire Clinical Commissioning Group: Key & Current Issues

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

- Long Term Plan
- Gynaecology Outpatients
- Oxfordshire Vasectomy Service
- South Oxford Health Centre
- Judicial Review Appeal

Senior Responsible Officer: Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. NHS Long Term Plan

The NHS Long-Term Plan, published on 7 January 2019, builds on the policy platform laid out in the NHS five year forward view articulated the need to integrate care to meet the needs of a changing population.

While it seeks to strengthen the NHS's contribution in areas such as prevention, population health and health inequalities, the plan is clear that real progress in these areas will also rely on action elsewhere. The Spending Review, which is due to be published later this year and will outline the funding settlement for local government including social care and public health, will therefore have an important impact on whether wider improvements in population health can be delivered, as will the Green Papers on social care and prevention when they are eventually published.

Overview

Key areas of the Plan include:

- Boosting out-of-hospital care, supporting primary medical and community health services with spending on these services £4.5bn higher in five years' time;
- Strong emphasis on prevention and health inequalities;
- More joined-up care in the community that has the potential to relieve pressure on hospitals and help to create a sustainable service in the face of rising demand;
- Improving outcomes for specific major diseases, including cancer, heart disease, stroke respiratory disease and dementia;
- Better access to mental health services, with an additional £2.3bn being invested in mental health by 2023/24;
- Ensuring all children get the best start in life by continuing to improve maternity safety, including halving the number of stillbirths, maternal and neonatal deaths and serious brain injury by 2025;
- Supporting older people through more personalised care and stronger community and primary care services
- Making digital health services a mainstream part of the NHS.

The full plan is available at NHS Long Term Plan

In addition the following organisations provide useful summaries and analysis:
The Kings Fund Kings Fund NHS Long Term Plan
NHS Providers NHS Providers Long Term Plan

Local Government Association LGA Long Term Plan

Alignment with the Oxfordshire Health and Wellbeing Strategy
The proposed Health and Wellbeing Strategy has a strong alignment with the main themes of the NHS Long Term Plan. Of particular note are the emphasis on prevention and health inequalities and the strong focus on integration of services.

The local NHS and partner organisations need more time to review the plan in full and to understand the requirements being placed on the system. At its next meeting, it will be proposed that this is taken forward through the sub-groups of the Health and Wellbeing Board.

2. Gynaecology Outpatient Waits

Oxford University Hospitals NHS Foundation Trust (OUH) has capacity challenges in gynaecology. Limited theatre capacity and difficulties recruiting appropriate staff have led to a build-up of the waiting list over the last two years.

Every effort is being made by the Trust to improve this situation. Progress has been made in reducing the number of women waiting long periods for surgery but outpatient appointment waiting times are still a significant challenge. Women are experiencing waiting times for gynaecology appointments of 40-plus weeks. This is unacceptable in terms of care and patient experience.

Having fully investigated all alternative options; it has been decided that for a period of three months (from 1 April 2019), women will be referred for some conditions (including general gynaecology and urogynaecology) to other out-of-county NHS hospitals and independent hospitals. A process has been put in place to consider referring to OUH in exceptional circumstances. It is anticipated that this short term action will enable OUH clinicians to bring outpatient waits down as much as possible and allow women to be seen more quickly.

OUH will continue to accept referrals for:

- Suspected cancer two week waits
- Recurrent miscarriage
- Fertility

Oxfordshire GPs are being asked to refer all other conditions to other providers:

- Buckinghamshire Healthcare NHS FT
- Great Western Hospitals NHS FT
- Royal Berkshire Hospital NHS FT
- South Warwickshire NHS FT
- Milton Keynes University Hospital NHS FT

- Independent hospitals providing gynaecology services such as the Foscote in Oxfordshire.

Some of these Trusts hold clinics in community settings e.g. the Royal Berkshire Hospital offers outpatient appointments in Henley and Newbury, which will be convenient for some Oxfordshire patients.

Patients are being advised that they may be eligible for help with transport or reimbursement of travel costs https://www.oxfordshireccg.nhs.uk/yourhealth/choose-the-right-service/patient-transport.htm

Whilst this diversion of referrals is expected to affect approximately 1,300 women during the three month period, the situation is being monitored weekly and if waiting times are reduced quicker than anticipated then the diversion will be lifted immediately.

GPs have been asked to support these measures in order to offer their patients the care they need within a reasonable timescale.

The providers listed above have been made aware they may experience an increase in referrals. NHS England's regional team is aware of this difficult situation and has supported the need for Oxfordshire Clinical Commissioning group and OUH to engage regional providers to provide this additional capacity as a one-off initiative.

3. Oxfordshire Vasectomy Service

We have previously updated HOSC of the issues relating to the Oxfordshire Vasectomy Service including OCCG considering decommissioning of the service except where there are exceptional circumstances. There is no consistency in Thames Valley (or nationally) for this service being available on the NHS; some CCGs no longer commission a vasectomy service whereas others have continued. Oxfordshire CCG has undertaken some further work to help frame opinion about this service.

A period of engagement has taken place to gather the public's views about stopping the service or introducing clinical criteria that would reduce the number of referrals for this procedure.

A survey has been available on the OCCG website (Talking Health) which has been open to all and two focus groups were organised to allow more discussion of the potential impact of changes to this service.

The survey ran for six weeks and was advertised through GP practices, sexual health clinics, CCG newsletter, social media and the local media.

An analysis of the survey and focus group discussions is currently being undertaken and a report will be published, later in April. We will then report back to HOSC with the results and next steps.

4. South Oxford Health Centre

South Oxford Health Centre (SOHC) is a small city practice with approx. 4,470 patients. One of the two partner moved abroad in October 2018, which increased its vulnerability with the remaining partner not wanting to remain the sole partner yet struggling to find other GPs willing to take on a Partnership.

Despite efforts by the Practice and the CCG working together to find a resolution, the CCG received notification from the remaining partner at the end of January that he was giving 6 months' notice to terminate his contract (effective end date 31 July 2019).

In line with our statutory responsibilities, the CCG has immediately commenced a process for developing service provision options when this contract expires.

SOHC is located in Lake Street, off the Abingdon Road. It has limited parking but many patients walk to the practice. The building is owned by NHS Property Services. Very little planned housing growth is expected to affect SOHC.

The practice has an active PPG which has previously discussed sustainability and lack of funding for small practices. The practice has already met with the PPG and explained that Dr Wooding was to give notice to the CCG to terminate his contract. The PPG are extremely supportive of the practice and are helping the CCG with communication to registered patients.

There are several possible options going forward:

- Option 1: Another Oxfordshire practice to merge with SOHC and provide a branch surgery from the Lake Street site.
- Option 2: Merge with a nearby practice and move GMS services away from SOHC.
- Option 3: Procure a new APMS contract for the SOHC area.
- Option 4: Disperse patients to neighbouring practices and close SOHC.

In Oxfordshire, we have co-produced with key stakeholders and agreed a local process for making decisions when an existing practice contract ends, or when significant population growth is planned (our Decision Tree). In applying this process, given the small registered population, the need to strengthen sustainability of practices and to ensure efficient use of Oxfordshire resources, our intention is to seek a local solution.

The CCG is following the same process as that used for Cogges Surgery (see here), including the legal requirements to publish a Public Information Notice (PIN). The CCG has written to all Oxfordshire practices to seek expressions of interest in holding a GMS or APMS contract to provide a branch surgery from the Lake Street site. The PPG is supportive of this action which aligns with Option 1 above.

If more than one practice is interested in running a branch surgery for SOHC, a light touch procurement will then be considered involving representatives from the PPG as part of the evaluation panel. It should be known by end of May if a local solution has been found.

As a precaution, work has started to prepare for if a local provider cannot be found. We are seeking to identify a possible interim provider from the NHS England Framework. The closing date for expressions of interest is 5 April 2019.

5. Judicial Review Appeal

The Keep the Horton General (KTHG) who were included in the Judicial Review challenge of the Transformation Consultation Phase 1, as an Interested Party, were granted leave to Appeal against the ruling made by Justice Mostyn in December 2017. The Appeal was heard on Thursday 14 March 2019.

Both parties presented their arguments at the Court of Appeal and we are now awaiting the judgement. We will update HOSC once the outcome is known.

REPORT FOR THE OXFORDHSIRE HEALTH OVERVIEW AND SCRUTINY COMMITTEE 04 APRIL 2019

Provision of PET-CT services

SUMMARY

PET-CT is a specialist imaging service. It is predominantly used in the staging and management of cancer, however, use in other areas is expanding. In England, PET-CT services are provided on a network basis.

Following a public procurement to select a provider of PET-CT scanning services for the Thames Valley area, NHS England has appointed InHealth Ltd as the Preferred Bidder. InHealth was selected as the Preferred Bidder because its tender response achieved a higher evaluation score against both the technical (service quality and patient access) and financial evaluation criteria included within the procurement.

Under InHealth's tender proposals for the Thames Valley, PET-CT will be delivered from a network of three new scanning locations. Each of these locations is based within an existing healthcare facility and situated within large population conurbations across the Thames Valley area, namely; Oxford, Milton Keynes and Swindon.

The proposals would have meant a change of service location in Oxford with the service being based at the GenesisCare facility in Littlemore, which is approximately four miles by road from the current scanning location at the Churchill Hospital site. However, InHealth's tender response also expressed a commitment to work collaboratively with Oxford University Hospitals NHS Foundation Trust (OUH) which would enable the current Churchill Hospital site to be retained. This was fully supported by NHS England, which does not want to remove access to PET-CT from the Churchill site.

The outcome of the procurement was communicated to both InHealth and OUH on 26 July 2018. The subsequent delay in implementation has allowed all parties to reach an in-principle agreement to work collaboratively. This means that OUH, working with InHealth, would continue to provide a service in Oxford from the Churchill site alongside new locations in Swindon and Milton Keynes. NHS England is committed to this course of action and aims to secure formal agreements with both parties during the course of April - May 2019.

NHS England recognises that OUH have expressed some concerns about the future service provision for Lot 4. These are dealt with in the body of the report. Importantly, all parties have agreed to develop the partnership based on four key service principles; with the prime focus being on the patient perspective, both access and experience. All parties believe that this approach will provide a path to resolve any residual issues and will help to clarify any remaining misconceptions about the provision of the service. These matters are set out within the body of the report.

It is NHS England's assessment that the in-principle proposals represent an improvement in access for people resident in Swindon and Milton Keynes and no change to service provision in Oxford. As such, it is considered that a moderate period (6 weeks) of public engagement across the whole geography of the lot would provide the opportunity to brief all stakeholders on the service improvements planned and secure valuable feedback about the proposed change to assist NHS England in the decision-making process. As part of the public engagement process, NHS England intends to publish an analysis of the impact on travel times, a summary of which is provided within the body of the report. In view of the District Council elections and taking into account Cabinet Office guidance, public engagement will not commence prior to 02 May 2019.

NHS England would welcome the advice of Oxfordshire's joint Health Overview and Scrutiny Committee (HOSC) as to whether the public engagement activities (as set out in Appendix 4) will now fully discharge our statutory duties relating to public involvement.

BACKGROUND

Clinical Service

PET-CT is a specialist diagnostic imaging service that is predominantly used in the staging and management of cancer. However, the modality is also used in a growing number of non-oncology indications, particularly neurosciences and infectious diseases. As with other diagnostic imaging services, PET-CT scans are predominantly delivered on an outpatient basis and form a discrete component of the clinical pathway. PET-CT scans are only accessible through secondary care referral.

PET-CT combines both a computed tomography (CT) scan with a positron emission tomography (PET) scan to provide highly detailed three-dimensional images of the inside of the body. The scanning process involves the injection of a mildly radioactive isotope (sometimes referred to as a 'tracer') into the body about an hour prior to the scan taking place. The tracer is detected by the PET-CT scanner, as it collects in different parts of the body. By analysing the areas where the tracer has and has not accumulated, it is possible to work out how well certain body functions are working which, in-turn, helps to identify abnormalities.

The most commonly used (circa 90-95% of all scans) tracer is 18F-flourodeoxyglucose, or 'FDG'. NHS England commissions several different tracers for use in specific clinical indications, these are generally referred to as 'non-standard tracers'.

A PET-CT service will typically serve a local catchment of referring secondary care providers, each delivering cancer services and hosting a range of cancer Multi-Disciplinary Teams (MDTs) and specialist MDTs. The majority of PET-CT services refer patients that require scans involving non-standard tracers to a small number of centres that are able to deliver these scans, historically based in either London or Manchester. Such referral arrangements also exist where patients need a PET-CT scans under general anaesthetic (GA), however, this is very rarely required because

most scans are undertaken on an ambulatory basis and, where required, sedation is preferable to GA.

NHS England's national Service Specification sets out that on receipt of a referral, the PET-CT service is responsible for patient booking, co-ordinating an appropriate supply of radioactive isotopes, sourcing previous scans, acquiring and reporting the PET-CT image and subsequent communication of the scan and report to the referring clinician. This process should normally be delivered within seven working days or specific time intervals as indicated by treatment plans. The service must also provide support to MDTs and ensure that 10% of all PET-CT scans must be 'double reported' by an independent external clinician as part of a national programme of audit and peer review. This approach is referenced by the Royal College of Radiologists Hybrid Imaging Guidance (2016).

Commissioning context

PET-CT services are nationally prescribed and since 2013 have been solely and directly commissioned by NHS England, using a national Service Specification and Clinical Commissioning Policy, the latter setting out both the clinical uses of PET-CT and the specific tracers that are commissioned.

The service has seen significant and rapid expansion over the course of the last two decades as the technology has moved out of a mostly research setting and into routine clinical use. This shift has resulted in rapidly rising activity levels. Despite the high level of growth, the overall scanning rate per head of population in England is considered to be generally lower than many European comparators. Access to local scanning capacity is a key factor in the scanning rate and therefore, increasing both capacity and ease of access are both seen as important enablers of satisfying what may be latent demand.

NHS England's assessment is that PET-CT services in England are yet to reach a steady state in terms of growth and, therefore, more capacity will be required over the coming decade. For this reason, the procurement, whilst not guaranteeing set activity levels, did forecast that growth would continue by circa 9-10% over the course of the next decade. Securing both increased capacity and access at an affordable price over the contract term are, therefore, important strategic objectives within the procurement.

Historically, the provider landscape for PET-CT services in England has been mixed, with independent sector, charitable organisations and NHS providers involved, either separately or in partnership. Indeed, NHS England completed a first phase of national procurement during 2014-15 which involved re-tendering contracts initially let by the Department of Health to two independent sector providers, Alliance Medical Ltd and InHealth Ltd.

The mixed nature of the landscape has undoubtedly benefited both patients and clinical teams, in the form of more local access, and commissioners because it has allowed for significant capital investment to be made over a relatively short timeframe, allowing scanning capacity to keep-up with rapidly rising demand.

Phase II Procurement

NHS England formally approved a second phase of procurement, covering the other 50% of the market, to commence in 2017. The procurement offered 11 lots to the market, including the Thames Valley geography (Lot 4), and a contract term of up to ten years (7+3).

The decision to procure PET-CT services was taken because, under the current legislative and regulatory framework, there was a compelling case to do so. This decision was informed by an assessment of competition in the market, comprising a Prior Information Notice, together with a period of public engagement about the procurement approach. A report of findings of public engagement, together with the changes that NHS England made to the procurement approach has been published.

The procurement approach was designed to secure long-term service sustainability, improve service quality and consistency and ensure that the benefits of scale and efficiency are appropriately shared with commissioners. These aims were captured in four strategic objectives for Phase II, which were reflected in both the design of the procurement and the evaluation criteria. These are:

- **Sustain integrated and reliable care pathways.** High-performing pathways are well-integrated and seamless for both patients and clinical teams. PET-CT service providers may change because of the procurement, but care pathways must not be adversely disrupted. Within the procurement, this led to a focus on referral and booking processes, the use of IT to transfer images and reports around the whole of the network and timeliness of the service. It also enabled referral and access arrangements to be put in place for non-standard tracers.

- **Secure a service that is high quality and value for money.** Maximising value from healthcare resources is important, in the context of PET-CT this led to a focus on ensuring compliance with the national Service Specification and Clinical Commissioning Policy. It also sought to secure greater service efficiency and, through this, improved value for money. Whilst research activity was not included within the procurement, all bidders were required to demonstrate that scanning equipment would meet technical specification accreditation requirements, such as those set by the UK PET Core Lab, to support research.

- **Ensure sufficient capacity to meet future needs.** Historic and forecast growth is significant and therefore the procurement was designed to secure optimal equipment utilisation, modern workforce practices and fair reimbursement mechanisms so that sufficient capacity is available over the contract term.

- **Avoid reducing competitive pressures in the market.** This was particularly the case in terms of the supply of radioactive isotopes, where the market is highly concentrated. As a result, phase II involved separate procurements to secure both scanning service providers and suppliers of radioactive isotopes. Similarly, lot limits were also included in both procurements.

Composition of Lot 4

Each of the eleven scanning services Lots was constructed based on an assessment of current patient pathways and existing networks of care. As such, each Lot was defined by a network of referring Trusts, reflecting that PET-CT is accessible only through secondary care referral, which were termed 'principal referring organisations'. The network of principal referring organisations in Lot 4 was defined, as follows:

- Buckinghamshire Healthcare NHS Trust, accounting for 9.16% of referral activity within the Lot;
- Great Western Hospitals NHS Foundation Trust, accounting for 5.76% of referral activity within the Lot;
- Milton Keynes University Hospital NHS Foundation Trust, accounting for 4.51% of referral activity within the Lot;
- Oxford University Hospitals NHS Foundation Trust, accounting for 65.46% of referral activity within the Lot; and
- Royal Berkshire NHS Foundation Trust, accounting for 13.27% or referral activity within the Lot[1].

Importantly, the procurement did not seek to disrupt or prohibit referring organisations from enabling individual patients to access PET-CT services further afield. Typically, such referrals are because a patient requires a scan involving a non-standard tracer or very specialist clinical expertise, including scans under general anaesthetic (GA). At present, very few centres offer the full range of commissioned tracers and only a handful are able to deliver scans involving GA.

At the time of data submission to NHS England in 2016, OUH did not undertake any scans involving commissioned non-standard tracers. Furthermore, OUH have also confirmed that any patients requiring a scan under GA would be referred to Leeds, stating that this has never been requested since the inception of the service in 2005.

PROCUREMENT OUTCOME

Evaluation of Tender Responses

Tender responses were assessed in accordance with the evaluation criteria contained within the procurement, as follows:

- Selection Questionnaire – Pass/Fail
- Invitation to Tender (Annex – ITT Questions):
    - Minimum Criteria – Pass/Fail;
    - Legal (Pass/fail);

[1] Activity proportions are based on the results of a 2015-16 data collection baseline exercise undertaken by NHS England will incumbent providers during 2016.

- Technical: Service / Quality – 9 questions attracting 50% of the overall score weighting;
- Technical: Patient Access – 1 question attracting 10% of the overall score weighting; and
- Finance – (i) 3 questions relating to the Bidding organisation's financial model, attracting 20% of the overall score weighting; and (ii) Price, attracting 20% of the overall score weighting.

The technical and financial questions were designed to test the ability of each bidder to deliver the national Service Specification and associated commissioning policy and were based around the four strategic objectives, i.e., integration, quality and value for money and capacity and access.

Each tender response was evaluated according to an agreed evaluation methodology, which included:

- Individual evaluation conducted by each evaluator and used an online system called "Award";
- Moderation, where evaluators discussed their individual scores to determine a final moderated score. The moderation meetings were structured by Lot and by area (e.g. Technical – Service / Quality, Technical – Patient Access, Finance).

Each evaluator met predetermined qualification and experience criteria (Appendices 1-3) and arrangements were put in place to prevent any actual or perceived conflict of interest. Each Moderation Meeting was independently chaired.

InHealth's Proposals for the Thames Valley (Original)

InHealth Ltd has been identified as the Preferred Bidder for Lot 4, having achieved a higher evaluation score against the technical (service quality and patient access) and finance criteria.

The InHealth service will be led by an experienced PET-CT doctor who holds an Administration of Radioactive Substances Advisory Committee (ARSAC) license and who will have managerial responsibility for delivery of all aspects of the service.

The proposed service locations included within InHealth's tender response are:

- GenesisCare, Sandy Lane West, Peters Way, Littlemore, Oxford, OX4 6LB;
- Great Western Hospital NHS Foundation Trust, Marlborough Road, Swindon, SN3 6BB; and the
- InHealth Diagnostic Imaging Centre, Milton Keynes, South Fifth Street, Milton Keynes, MK9 2FX.

InHealth planned to commence service delivery using mobile scanners based at the Oxford and Swindon sites, both within existing healthcare facilities and using existing mobile pads. Over the course of the first year of the contract, the Oxford site would become a static facility. The Milton Keynes service was planned to commence as a new static facility during the first year. The Swindon site was planned to transition into a fixed static unit during 2023/24.

Importantly, whilst the InHealth bid sought to quickly move towards a network of static sites, the use of mobile scanners is in-keeping with the national Service Specification and does not prevent the delivery of any commissioned uses of PET-CT. Linked to this point, all InHealth's PET-CT mobile scanners can safely accommodate in-patient activity.

InHealth's proposed PET-CT equipment is able to deliver intravenous (IV) contrast CT scans, as part of PET-CT scanning. The proposals included the arrangements for those patients that require emergency support, specifically that all scanning services would be delivered by staff with Life Support training and that there would be access to either a hospital-based resuscitation team, a Radiologist or a registered medical officer, i.e., a doctor. This is in-keeping with the requirements of the national Service Specification.

In-accordance with NHS England's Invitation to Tender requirements, InHealth also proposed to use a fully integrated RIS/PACs solution across Lot 4. This enables prior diagnostic images and PET-CT scans and reports to be safely and efficiently transported across the network.

InHealth's Proposals for the Thames Valley (Revised)

The in-principle agreement between NHS England, OUH and InHealth means that all parties are now working towards the following arrangements:

- The Churchill Hospital site;
- Great Western Hospital NHS Foundation Trust; and
- Milton Keynes University Hospital NHS Foundation Trust.

InHealth will commence service delivery on both the Great Western Hospital and Milton Keynes Hospital sites using a mobile PET-CT unit on each site for two non-consecutive days, each week. The operational days will be finalised with local clinicians to align with MDT's and out-patient oncology clinics. Each operational day will consist of 12 hours, scanning up to 20 patients, the patients being a blend of out-patients and in-patients. Each of these locations will transition to a fixed scanning facility:

- The Milton Keynes Hospital will have a fixed PET-CT scanning department in 2021/22; and
- The Great Western Hospital will have a fixed PET-CT scanning department in 2023/24.

Both Trusts are expanding their services to build their own dedicated Cancer Centre's, and InHealth have already begun discussions about locating the fixed PET-CT scanning departments within these centres. The move to static scanners will be aligned with these developments and therefore the move to static scanners may happen earlier.

This ensures that the services will be delivered from a network of acute hospital sites and will enable inpatients on all three sites, rather than solely at the Churchill site, to

benefit from PET-CT scans without the need of hospital transportation. This approach will retain and preserve OUHs research portfolio.

Under the in-principle arrangement, InHealth's clinical lead will work collaboratively with OUH's PET-CT clinicians, who will continue to provide clinical reporting for the service and meet, as a minimum, the requirement that 10% of scans should be double reported. The joint service will also benefit from the proposed RIS/PACS arrangements and will be supported by a local Medical Physics service.

As part of reaching an in-principle decision to work collaboratively, all parties have agreed to develop the partnership in accordance with four key principles:

- To build on the service that already exists in Oxford – retaining the Churchill Hospital site, in terms of both equipment, including the new scanner, and staffing.
- To focus on the patient perspective – access and experience – when undertaking the more detailed work to support the partnership.
- To involve the cancer clinicians/network in discussions about PET/CT scans in cancer pathways.
- To be as flexible as possible to sustain the Oxford service as a centre of excellence.

By working in accordance with these principles, all parties have committed to resolving any residual issues, such as the need to maintain OUH ways of working at the Churchill site, in a constructive and patient-focussed way.

Travel time analysis

Following completion of the tender response evaluation, an assessment of the impact of the proposed Lot 4 outcome on travel times was made. This found that the proposal to deliver PET-CT services from InHealth's network of three sites would significantly improve access compared to the existing single site model.

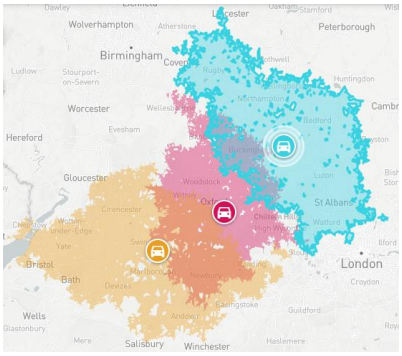
The analysis was conducted using an online tool called TravelTime Platform for each site in each configuration, using the postcode as the reference. The resulting maps show the areas that can reach the site in question within a 30, 45 and 60 minute timeframe, using either car or public transport. Because the Lot covers a large geography, 60 minute driving time is considered to be the most useful comparator (Figure 1).

InHealth's proposed three-site service configuration, with each site being closely situated to large populated hubs, offers clear patient access improvements with whole population able to access services within the 60 minute driving time measure (Figure 1). This is particularly the case for people resident in Milton Keynes, Swindon and Newbury.

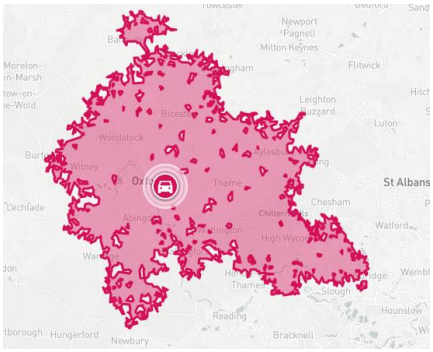
The in-principle service configuration retains the benefits of the InHealth proposals for the populations of Milton Keynes, Swindon and Newbury and means that there is no impact for Oxford population.

Figure 1: 60 minute drive time access

InHealth



OUH



NEXT STEPS

NHS England, OUH and InHealth have already discussed what will be the next steps to develop the detail of the partnership agreement and the supporting contractual and financial arrangements. There will be further meetings taking place in the next two months to progress the work, involving two parallel workstreams: clinical and contractual/financial.

The leads from each organisation have been identified and there will be senior officer oversight to ensure the work progresses at pace and reaches a conclusion. There will also be joint discussions about the overall phasing of implementation to factor in the timetable for opening-up the new services in Milton Keynes and Swindon.

CONCLUSION & RECOMMENDATIONS

NHS England is committed to ensuring that the Thames Valley population benefit from high-quality PET-CT services. It is our view that the partnership arrangements provide distinct benefits in terms of expanded access in Milton Keynes and Swindon, whilst also preserving the Churchill Hospital site.

It is therefore recommended that the Oxfordshire joint Health Overview and Scrutiny Committee:

- Support the partnership plan; and
- Support moderate public engagement to be undertaken in-parallel with progressing partnership discussions as set out in Appendix 4.

Appendix 1: Lot 4 Technical – Service / Quality Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores and rationale are compliant with the published scoring methodology.
2 X Radiologist / Nuclear Medicine Physician	Required to be currently employed as a radiologist / nuclear medicine physician at consultant level in the NHS and to have at least 5 years direct experience at consultant level in clinical PET-CT in the UK.
Medical Physics Expert	Required to be currently employed as an MPE supporting nuclear medicine and PET-CT services. Must have at least five years' (within the last ten years) experience of supporting the delivery of PET-CT services in the UK.
NHS England Commissioner	Required to be employed by NHS England in a specialised commissioning role and be expert in the commissioning of healthcare services. Must have at least five years' (within the last ten years) experience of health service management in the UK.

Appendix 2: Lot 4 Technical – Patient Access Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores and rationale are compliant with the published scoring methodology.
NHS England Communications and Engagement Specialist	Required to be directly employed by NHS England in a specialised commissioning role and be expert in patient engagement and communications.
NHS England Commissioner (X2)	Required to be employed by NHS England in a specialised commissioning role and be expert in the commissioning of specialised commissioning services.

Appendix 3: Lot 4 Financial Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores

	and rationale are compliant with the published scoring methodology.
NHS England Qualified Accountant (X3)	Qualified Accountant expert in health care finance and directly employed by NHS England in a specialised commissioning role.

Appendix 4: Lot 4 Proposed Engagement Activities

The following engagement activities will be undertaken to support implementation of the procurement outcome.

- Publication of the proposed approach to delivering PET-CT services in the Thames Valley including the new arrangements for access on the NHS England website. Contact details will be provided for members of the public, staff, patient groups and other interested stakeholders to comment by email or in writing.

- A briefing will be provided (similar to this one) for other HOSCs in the Thames Valley to alert them to the proposals and give them the opportunity to comment on the proposals and invite NHS England and InHealth to future meetings if required.

- A briefing will be prepared and sent to all Thames Valley MPs and local Health Watch's giving them the opportunity to comment on the proposals.

- Hold a face to face or online meeting for local patient groups and relevant local healthcare charities affected by the proposals in Oxford. We welcome suggestions from the HOSC and Health Watch as to which organisations should be invited.

- Briefing on the proposed change to be sent to NHS England's cancer clinical reference groups and their registered stakeholders. Members of the public and other stakeholders can register on the NHS England website to receive these updates.

- Analysis of the outcome of the engagement along with a summary of responses and any changes made to the proposals as a result will be shared electronically with all the key audiences engaged and all those who submitted comments at the end of the engagement period.

Appendix 5: Weblinks

Cabinet Office Pre-election period guidance:
https://www.gov.uk/government/publications/election-guidance-for-civil-servants

Engagement report:
https://www.england.nhs.uk/publication/pet-ct-phase-ii-design-of-procurement-engagement-report/

Stakeholder registration page:
https://www.england.nhs.uk/commissioning/spec-services/get-involved/crg-stake-reg/

Oxford University Hospitals
NHS Foundation Trust

REPORT FOR OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE THURSDAY 4 APRIL 2019

OXFORD UNIVERSITY HOSPITALS (OUH) NHS FOUNDATION TRUST REQUEST FOR HOSC SCRUTINY OF FUTURE PROVISION OF THE THAMES VALLEY REGIONAL PET-CT SERVICE, CURRENTLY PROVIDED BY OUH AT THE CHURCHILL HOSPITAL

Background
Oxford University Hospitals (OUH) NHS Foundation Trust currently provides the Thames Valley regional Positron Emission Tomography and Computed Tomography (PET-CT) service in the Cancer & Haematology Centre at the Churchill Hospital in Oxford.

This service is commissioned by NHS England – this means that NHS England is responsible for any decisions about the contract to provide this service.

OUH has held the contract since 2005 and carries out 5,000 scans per year on 2 PET-CT scanners which are owned by the Trust.

OUH request for HOSC scrutiny
OUH Chairman, Dame Fiona Caldicott, wrote to the HOSC Chairman on 24 January 2019 because we understood that he was likely to be contacted by NHS England in connection with its intention to award the contract for the regional PET-CT scanning service to a private healthcare company, InHealth.

NHS England had indicated that it would be contacting HOSCs in Oxfordshire, Berkshire, Wiltshire and Buckinghamshire about this significant change in treatment for patients with cancer.

We requested an opportunity to give evidence at the next available Oxfordshire HOSC meeting about the implications of this decision for the quality and safety of patient care.

We are grateful to be given this opportunity at the HOSC meeting on 4 April 2019.

In her letter to the HOSC Chairman on 24 January 2019, Dame Fiona Caldicott wrote:

"We are concerned about the impact of this proposed change on the quality and safety of PET-CT treatment for cancer patients for a number of reasons.

"For example, it would mean that very sick patients at the Churchill would need to travel off site for a scan which could have a negative impact on their health.

"And it would have a negative impact on multi-disciplinary working because the reporting radiologist would not be attending multi-disciplinary meetings where patients' care and future treatment plans are discussed.

"As a regional centre of excellence for cancer treatment, our clinical teams take a holistic and individual approach to their care of people living with cancer – treating the whole person and taking a broad overview of each patient's care pathway – and this would be put at risk by separating PET-CT treatment from the rest of the pathway."

Our concerns for the quality and safety of patient care – and for training and research – if the PET-CT service is no longer provided at the Churchill Hospital

Our Trust Board, Council of Governors, clinicians and patients are all concerned about the impact on the quality and safety of patient care if we no longer provide the PET-CT service.

We have raised these concerns with NHS England which commissions this service.

The Trust Board is committed to working collaboratively in partnership with both NHS England and InHealth in order to maintain and improve the quality and safety of care for patients requiring PET-CT scans in the Thames Valley region.

This commitment includes face-to-face meetings involving the Trust's Chief Executive and Medical Director – and other Directors as required – as well as senior clinicians from the PET-CT service.

We asked our senior radiologists, oncologists and surgeons to summarise their concerns in order to provide clinically-led evidence to HOSC.

These concerns are grouped under the 3 headings of quality, safety, and training and research.

1. **Quality issues**

- OUH is at the leading edge of PET-CT imaging quality and has led the world in defining the role of PET-CT scans for sarcomas and oesophogal cancer
- OUH provides a longer uptake of FDG (the radioactive drug, or tracer, used in scanning to show differences between healthy and diseased tissue), longer scan time and better image reconstruction – in short higher quality scans – than the proposed service
- All Thames Valley scans are currently reported by two consultants whose training and specialist interest is PET-CT – the proposed service would see scans sent out to reporters elsewhere in the country who would not be available in the same way to the multi-disciplinary team (MDT)
- 20% of patients having a PET-CT scan at the Churchill have a CT scan using intravenous (IV) contrast dye at the same time, which reduces patients' exposure to radiation (and thus their risk of developing a further cancer) and also reduces travel costs because they don't need to come back to hospital for the CT scan separately – we do not believe the proposed new provider can provide this service
- On average 5 patients a week have their PET-CT scan carried out as part of planning for radiotherapy treatment, which means radiation can be targeted more effectively to cancerous tumours and therefore is safer for patients – using PET-CT for radiotherapy planning is the gold standard in all major cancer centres but we understand the proposed new provider is not intending to provide this service
- If the PET-CT service is no longer provided by OUH at the Churchill Hospital, the reporting radiologist will not be at MDT meetings to discuss and plan patients' care – this will reduce the effectiveness of these meetings and impact on quality of care
- OUH is installing a new digital PET-CT scanner following a successful bid for funding by the University of Oxford to the Government's Industrial Strategy Challenge Fund – this would give patients scanned in Oxford access to one of the most advanced PET-

CT machines in the world but this opportunity will be lost if the regional PET-CT service is no longer provided by OUH at the Churchill

2. Safety issues

- Patients having a scan at the Churchill have on occasion fallen ill and required an immediate intervention, for example being transferred to the Emergency Department (A&E) at the John Radcliffe Hospital or to an inpatient ward
- If the PET-CT service is no longer provided by OUH at the Churchilll, inpatients would have to be transferred off-site by ambulance for scans
- The PET-CT service at the Churchill is able to scan immobile patients who require a hoist and children (6+) – because the proposed service uses mobile scanners, it will not be possible to scan patients who require a hoist or children
- It is imperative that there is a doctor on site when scanning is performed, if the staff carrying out the scans have queries which require medical input or if patients are ill – the Churchill service has doctors specialising in PET-CT on site but the proposed service does not

3. Training and research issues

- All patients having a PET-CT scan at the Churchill are given the opportunity to take part in world leading research which is improving cancer care – these are technically complex scans, often with new drugs, and this opportunity will not be available if the PET-CT service is no longer provided at the Churchill
- Oxford has led the world in research to push forward PET-CT scanning, for example we helped to develop and optimise a new, improved PET image reconstruction – we were the first centre in the world to do so, it has now been adopted globally
- If the PET-CT service is no longer provided by OUH at the Churchill Hospital, this would have a negative impact on PET-CT research and training in Oxford
- OUH prides itself on being a teaching hospital trust, and indeed has trained many consultants who are now working all over the country – this opportunity will be lost for the future as it is not possible to train consultants outside a recognised and approved centre, using fixed and not mobile scanners

Listening to patients

Following recent media coverage both nationally and locally, there has been significant concern expressed by many different parties including cancer patients past and present; clinicians; publicly elected governors who represent our local communities on our Council of Governors; local MPs who have been contacted by concerned constituents.

While much of this public debate has focused on issues such as the outsourcing of clinical services to private companies – and the lack of consultation or engagement with patients and key stakeholders about a significant change to services – our focus remains our concerns about the impact on the quality and safety of patient care.

These concerns are exemplified by a letter written by a cancer survivor to the *Oxford Times* which he copied to the Trust for information.

“A few years ago I had the bad luck to contract cancer of the bowel. I had the good luck to be treated at the outstanding Churchill Hospital.

“One of the many bad sides of cancer is the time you spend having scans. For me it made a great deal of difference that the PET-CT scans I had were carried out in the Churchill, by highly skilled (and always kindly) staff working closely with the oncologists.

“Whatever the other issues are in the proposal to outsource this service in the future, it simply doesn’t take into account the feelings of patients. When you have cancer, it matters a lot to your state of mind to know you are being treated by a single established team.”

Dr Bruno Holthof
Chief Executive
Oxford University Hospitals NHS Foundation Trust

Mr Nick Maynard
Trustwide Cancer Lead & Consultant Upper GI Surgeon
Oxford University Hospitals NHS Foundation Trust

Oxfordshire Joint Health Overview & Scrutiny Committee- 4th April 2019

Dental Services and Dental Health in Oxfordshire.

1. **Introduction**
   This paper will discuss the following
   - Provision and capacity of NHS dentists in Oxfordshire
   - Dental health of adults, older adults and children in the Oxfordshire population, including where inequalities exist
   - Programmes of work to promote dental health
   - Dental needs and health in nursing and residential homes

2. **Exempt Information**
   There is no exempt information contained within this report.

3. **Oral Health and the impact of poor oral health**
   Oral health is an integral part of overall health. A significant proportion of the population in England experience very good levels of oral health. Successive oral surveys have shown that child and adult oral health has been improving over the past 30 years. However, the vulnerable, disadvantaged and socially excluded groups are at a greater risk of oral diseases affecting their teeth, gums, supporting bone and soft tissues of their mouth, tongue and lips.

   Oral disease is largely preventable by addressing risk factors common to general health, such as smoking, alcohol misuse, poor diet and high sugar intake.

   Maintaining good oral health throughout life and into old age not only improves our general health and wellbeing but plays a part in helping us to stay independent for as long as possible. However vulnerable older people may require special care due to age, disability or risk of abuse or neglect

   Dental decay among young children remains an important public health issue Poor oral health can affect a child's ability to eat, speak, play, sleep and socialise with other children. Poor oral health also causes pain, infections, and impaired nutrition and growth.
   When children have toothache or need treatment it can mean school absence and that families and parents must take time off work. Oral health is an integral part of overall health. When children are not healthy it affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness.

   Whilst more adults are keeping their teeth for life many still suffer from periodontal disease and tooth decay with the number of adults aged 56 with no teeth being higher than some EU countries. Evidence shows that poor oral health in older people can lead to pain and discomfort, which can lead to mood and behaviour changes, particularly in people who cannot communicate their experience. It can also cause speech problems; reduced ability to smile and communicate freely;

problems chewing and swallowing which limit food choices and can lead to impaired nutritional status; reduced self-confidence and increased social isolation; impaired well-being and mood; poor general health and premature mortality.

4. Oral health in children

Local data for Oxfordshire is based on national surveys whose sample size is at district level. Looking at the national data it is possible to see that tooth decay is linked with other measures of social disadvantage and so is a source of inequality in the County. The data available from the 2017 oral health survey of 5-year-old children showed that 80.2% of 5-year-old children in Oxfordshire are now free from any dental decay which is higher than the national average of 76.7% and an improvement from 67% in the 2012 survey. While the improvement is welcome there are still 19.8% of 5-year-old children who have experienced decay, which is an avoidable condition. There is an inequality in the number of children with decay between Districts. The number of children who experience decay is higher in Oxford City than the other districts at 23.5% as shown in Figure 1.

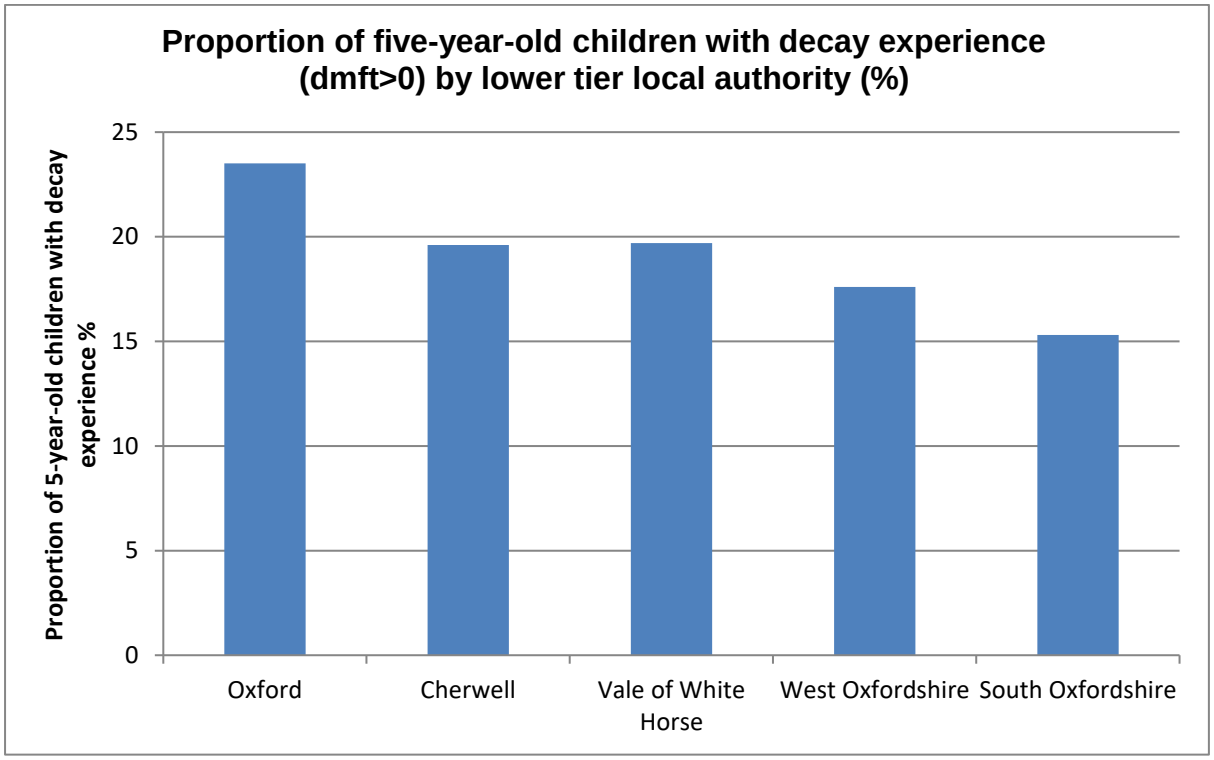


Figure 1 Proportion of 5-year-old children with decay by district in 2017

Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million.

In 2017/18 six hundred and twenty children in Oxfordshire aged 0-19 years had teeth extracted under general anaesthetic. This number has remained relatively stable for the last five years, as shown in figure2.

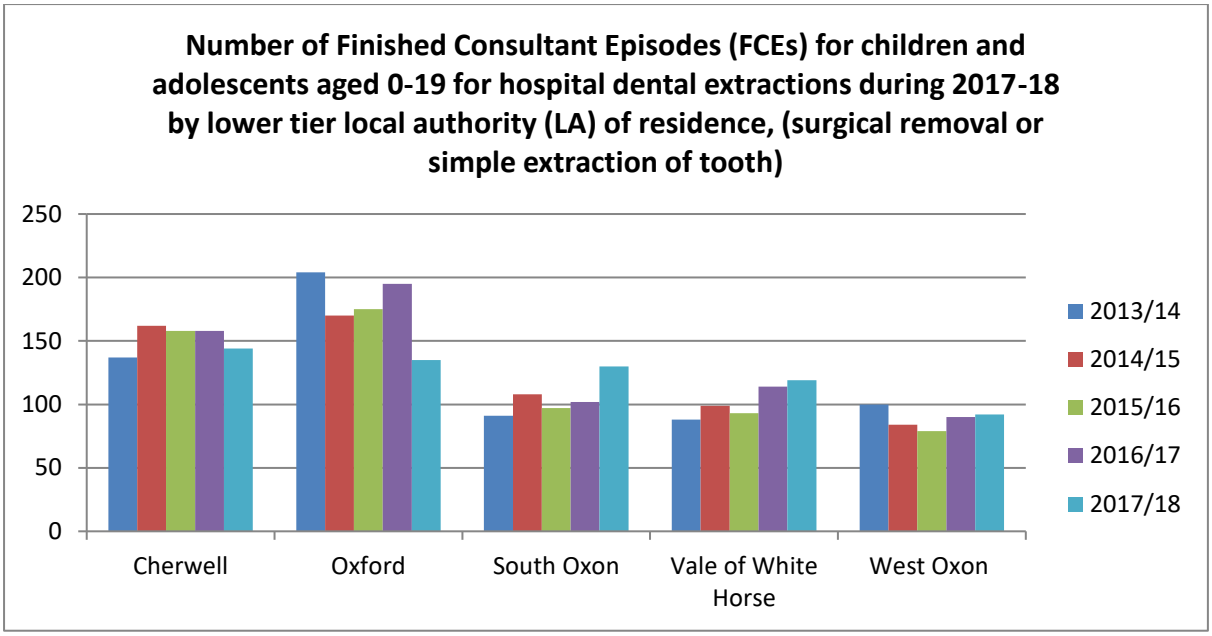


Figure 2. Number of Hospital Episodes for children 0-19 for dental extractions 2013/14 – 2017/18

5. Oral health in adults

Current local data on oral health in adults are not available. A report on a 2018 survey of the oral health of adults attending dental practices is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS). These surveys collect data on clinically defined ('normative') and patient defined ('perceived' or 'felt') oral health needs. It is an accepted convention to use Strategic Health Authority (as was) data as a proxy for local data with the caveat that it will be a precise estimate and will not fully reflect local variations. South Central England comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial survey can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods.

During the post-war years, the nation's oral health was poor, dental disease was rife and there was little expectation that teeth would last a lifetime. This expectation has now changed, with the majority of adults having teeth for life. We have seen dramatic improvements in the last 50 years with the percentage of adults in England with no teeth falling from 37% in 1968 to 6% in 2009. In South Central England, only 2% of adults had no teeth in 2009.

Reasons for improvement in oral health in adults are thought to be:

1. Changes in social norms and behaviours, including body hygiene, smoking rates, use of fluoride toothpaste, increasing public engagement in oral health and rising expectations. Oral hygiene behaviours have substantially improved: 75% reported brushing twice daily in the most recent adult survey and levels of plaque and calculus have steadily improved over the last 40 years.
2. Changes in diagnosis and treatment of oral diseases mean that dentists are more likely to restore teeth than in the past where full dental clearances were commonplace.

While oral health has improved generally, it is not all good news. Population averages for adults hide oral health inequalities and a 'social gradient' exists whereby higher levels of disease can be seen at each lower level of the social hierarchy. Data shows that adults from the most deprived areas, in most age groups, are more likely to have:

- Decayed teeth
- No teeth
- Gum disease
- Oral cancer
- Suffer from urgent conditions

It is well established that absolute deprivation has a significant impact on health status, but the social gradient illustrates the importance of relative deprivation. This is significant for Thames Valley where there are pockets of deprivation in a broadly affluent area.

As the population ages and people are increasingly retaining their teeth into later life, the restorative problems experienced by adults have become more complex. In addition, the prevalence of periodontal disease and root caries increases with age, as does the medical complexity of patients. The most recent ADHS found that almost 1/5 adults were found to have complex oral health needs with multiple management issues, particularly in those over 45 years old.

6. Oral health in older adults

At the moment local data on oral health in older adults are not available. A 2016 survey of the oral health of adults in supported living settings is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS) and from surveys conducted in other areas. The national surveys collect data on clinically assessed ('normative') and subjective (public view) oral health needs.

The most recent (2009) decennial national survey (Adult Dental Health Survey, ADHS) collected data at a Strategic Health Authority (as was) level. These data can be used as a proxy for local data with the caveat that it will not be a precise estimate and will not fully reflect local variations. The SHA, when the survey was carried out, which relates most closely to Thames Valley, was South Central. South Central comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial surveys can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods, for example, adults living in care homes are excluded from the survey population.

Good health is central to improving outcomes for older adults and good oral health is a key part of that. The consequences of oral diseases in older adults can be considerable. Pain, discomfort and sleepless nights are all common impacts of oral diseases.

The number and position of a person's natural teeth affects their ability to chew. Difficulty with chewing affects the nutrient intakes of older people. There is evidence that people who cannot chew or bite comfortably are less likely to consume high fibre

foods such as bread, fruit and vegetables, thereby risking reducing their intake of essential nutrients such as fibre, iron and vitamin C. In older adults, this can lead to dehydration and malnutrition. Age UK report that it is estimated that 1.3 million people over 65 suffer from malnutrition, the vast majority of whom (93%) live in the community.

Poor oral health can have a negative impact on a person's ability to socialise and can reduce a person's self-esteem. This can increase the problems of loneliness and isolation. Poor oral health therefore can impact on a person's quality of life and their ability to live independently. A survey carried out with residents of care homes found that 40% of the residents reported that poor oral health affected their daily life.

Good oral health is therefore important for an older person to be able to lead an independent life with good general health and quality of life.

In general, the oral health of older people has improved in recent decades. For example, more older people are now keeping their teeth into old age. In 2009 the ADHS found that in England the proportion of the population aged between 65 and 75 with some natural teeth was 84% with over half of the people aged over 85 having some natural teeth. This compares with 26% of adults aged 65 to 75 with some natural teeth in 1978.

The 2009 ADHS found that the number of natural teeth is related to age. 86%of all adults with some natural teeth (dentate) had 21 or more teeth. This proportion fell significantly as age increased. For example, 100% of dentate adults aged 16 to 24 had 21 or more natural teeth compared with 40% of dentate adults aged 75 to 84. Among adults aged 85 and above only 26% had 21 or more natural teeth. These older dentate adults with enough natural teeth remaining to enable functional dentition represents 14% of all adults aged 85 and over.

The number of teeth a person has an impact on their general health. For example, older people with a need for dentures are more likely to be frail than those without a need and older people with 20 or more natural teeth are less likely to be frail than those with no teeth. This would suggest that improving the oral health of older people can have an impact on their ability to live independently.

Tooth decay is not distributed evenly throughout the population; inequalities exist. Older adults, for example, are more likely to experience tooth decay than younger adults. Studies carried out in other parts of the country have found that older adults living in care homes are more likely to experience tooth decay than the general older adult population (Figure 3). The 2009 ADHS found that those older people with tooth decay had a considerable number of teeth affected by decay with an

average of 2.5 teeth affected.

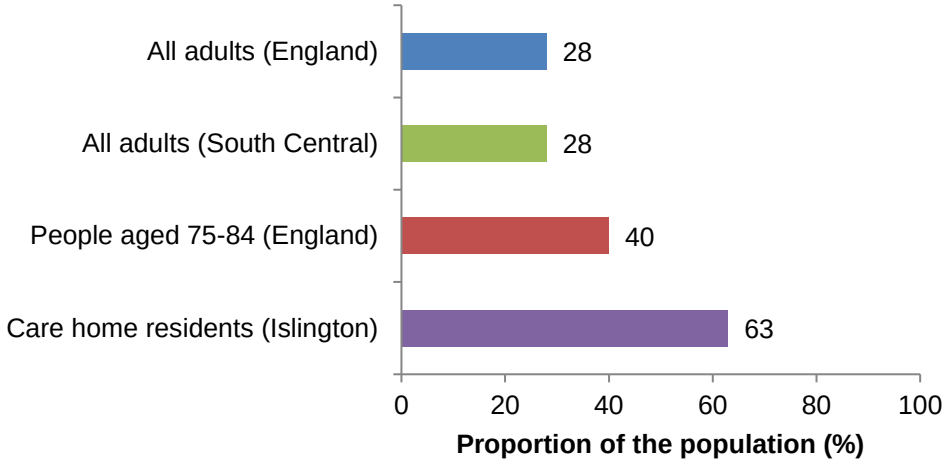


Figure 3. Proportion of the population with tooth decay. Source: ADHS 2009, UCL

7. NHS dental care in Oxfordshire

NHS England commissions all dental services including primary, community and hospital services and urgent and emergency care.

NHS England has a legal duty to commission dental services to meet the needs of a local population. It commissions local oral health needs assessments in partnership with local authorities and other organisations and decides subsequently how best to use its resources to meet this need. NHS dental services are commissioned through contract with independent providers which take account of the access to local dental services and the dental health of the local population.

Everyone is entitled to NHS dental services, and registration with a dental practice is not required, as it is with GP practices, because they do not operate in the same catchment areas. Some dental practices offer emergency treatment and will provide care if it is clinically necessary. The NHS Choices website advises only to visit A&E in serious circumstances:

- Severe pain
- Heavy Bleeding
- Injuries to the face, mouth or teeth.

NHS dental services provide care and treatment for adults and children alike, but dental care for children under the age of 18, or young people under the age of 19 and in full time education, is free of charge.

8. NHS Dental services in Oxfordshire

i. Primary Care

Services are provided by 'High Street' Dentists under the NHS (General Dental Services/Personal Dental Services) Regulations 2005. Treatments are delivered within NHS treatment bands which include check-ups, fillings, dentures and crown

and bridge work. Dentists also monitor patient oral health with health promotion advice and early intervention to maintain oral health. Patient Charges apply to these services. Patients are free to attend any dental practice of their choice; they are not registered with the practices.

Practices see patients on a planned and urgent basis. In 2015, the local office has established arrangements with NHS 111 and a number of dental practices for patients to be seen urgently on the day. These are normally patients who do not attend the Dentist on a regular basis. Many of these patients then form an on-going relationship with the dental practices concerned.

Services are provided via cash limited non-time limited General Dental Services (GDS) contracts with 'Unit of Dental Activity' targets. Providers paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Dentists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics (includes 2 week waits for potential cancer cases)
- Level 2 oral surgery and restorative dentistry – specialist but does not require treatment in hospital
- Community Dental Services – special care and paediatrics for patients with more complex management needs
- Orthodontic services

Table 1 below details primary care provision in the county 2018-19:

Local area	Population	Practices	UDAs commissioned	UOAs per head	'Full' NHS practices	Numbers over 96% 17-18	% over 96%	Referrals from NHS 111
Cherwell	145,600	16	261,048	1.79	12	5	31.25%	3
Oxford	154,600	20	283,434	1.83	14	9	45%	4
South Oxon	137,400	21	143,731	1.05	10	8	38.1%	3
Vale of the White Horse	126,700	15	137,693	1.09	10	8	53.33%	1
West Oxon	108,600	18	159,638	1.47	14	13	77.78%	1
Oxfordshire	**672,900**	**90**	**985,544**	**1.46**	**60**	**43**	**71.67%**	**12**
Thames Valley	**2,124,175**	**282**	**2,775,796**	**1.31**	**191**	**202**	**71.63%**	**40**

Table 1. Primary dental care provision for Oxfordshire 2018/19

ii. Access to primary care services

In 2009 the government commenced a programme of improving access to NHS Dental Services (as measured by the number of patients attending an NHS Dentist in the previous 24 months). Since April 2009 the number of patients attending an NHS Dentist in the Thames Valley has increased by 243,899 from 852,516 to 1,096,415; a growth of 28.6%. The local office is set a target for the % of patients attending an NHS Dentist. The target is that 51.50% of the population attend an NHS Dentist; the position at the end of January 2019 is that 51.62% of the population had attended an NHS Dentist in the previous 2 years. This compares to 43.64% of the population in 2009.

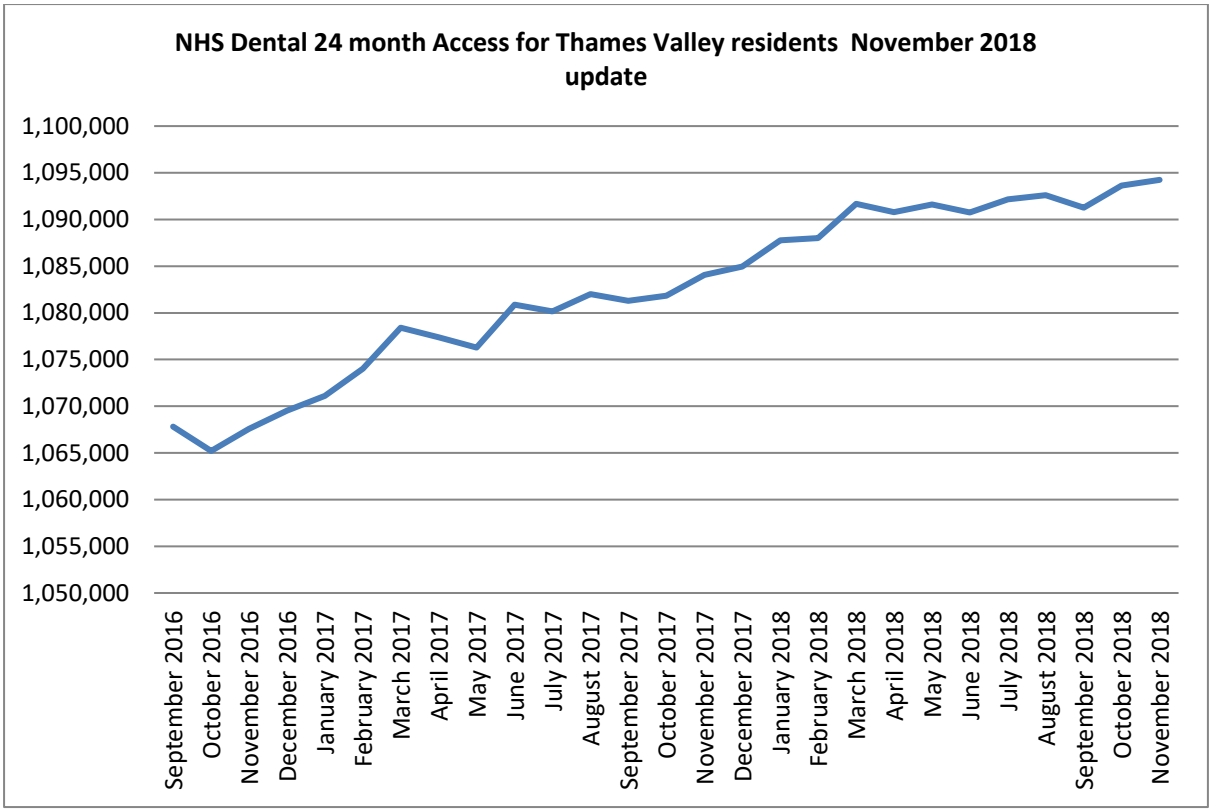


Figure 4. NHS Dental 24 month access for Thames Valley residents Sept 2016- Nov 2018

In Oxfordshire the information available is about the number of patients attending over one-year period. The latest available information is for October 2018; detailed below:

Local Authority	Population	Patients attending Oct 17	Patients attending oct 18	Change	% attending Oct 18
Cherwell	145,600	90,511	92,807	2,296	63.7%
Oxford	154,600	99,069	99,917	848	64.6%
South Oxon	137,400	58,248	59,240	992	43.1%
Vale of the White Horse	126,700	48,918	46,955	-1,963	37.1%
West Oxon	108,600	59,881	61,229	1,348	56.4%
Oxfordshire	**672,900**	**356,727**	**360,518**	**3,791**	**53.6%**
Thames Valley	**2,124,175**	**1,029.400**	**1,040,150**	**10,750**	**49.0%**

Table 2. Oxfordshire patients accessing primary dental services over a one-year period Oct 2017- Oct 2018

iii. Orthodontics

One of the peak ages for people to attend High Street Dental services is between the ages of about 10 and 14. This is due to possible Orthodontic (braces) treatment under the NHS. If patients are identified as having an Index of Treatment Need (IOTN) of 3.6 and above, they are eligible for NHS treatment. Patients are in treatment for an average of 21 months with a year retention period to monitor the outcome of treatments. In the Thames Valley there are usually about 24,000 patients either starting treatment; mid-treatment and in-retention. Patient charges apply to these services, but it is rare for them to be collected as most patients are children aged under 16 and are in full time education and so exempt from dental charges.

Services provided via Orthodontic specialist led cash limited time limited Personal Dental Services (PDS) agreements with 'Unit of Orthodontic Activity' targets. Providers are paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Orthodontists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics
- Dental Services – special care and paediatrics for patients with more complex management needs

These services have recently been subject to a procurement exercise across the south of England with new arrangements to be implemented from April 2019. New contracts for 7 years have been awarded. The level of activity to be commissioned in Oxfordshire will be very similar to levels commissioned prior to April 2019 (49,925 UOAs post April 2019 v 50,310 pre-April 2019). But there will be some redistribution of the activity, in line with need, with reduction in the Cherwell area, but increases in South Oxfordshire, the Vale of the White Horse and West Oxfordshire. This will provide more local access for patients.

Some providers will be those who had contracts pre-April 2019, and some will be new to the area. For providers who submitted unsuccessful bids or who did not bid there are arrangements in place for them to complete treatments over a 2-year period. For patients who have been assessed as eligible for NHS treatment but who have not yet started treatment or who have yet to be assessed and their current provider cannot start treatment before their contract expires, arrangements are in place to transfer these patients to new providers from April.

The local office has also written to all dental stakeholders about referral arrangements post April 2019.

iv. Community Dental Services

For patients whose management needs cannot be met in primary care (possibly due to learning disabilities or mental health issues) there is the Community Dental Service. This Special Care and Paediatric service is provided by the Oxford Health NHS Foundation Trust via a cash limited time limited PDS contract. The service has a number of clinics across the county and is led by Dentists who have training in Special Care Dentistry. Patient charges apply for these services, but many of the patients attending fall within the charge exempt categories.

In addition to routine care, the service provides urgent care and treatment under Sedation and General Anaesthetic.

v. Secondary care (hospital) services

If patients have more complex treatment needs that cannot be met in primary care then referrals are made to the hospital services, as described above. The hospital services are provided by the Oxford University Hospitals NHS Foundation Trust from various sites across the county. Services are commissioned via NHS standard contracts and patient charges do not apply.

vi. Tier 2 services

Over the last few years across the country, the NHS has commissioned services that are deemed to be outside the expertise of primary care but do not need hospital treatment. An example is Orthodontics, but in addition to this there are Oral Surgery (extraction) and Restorative (complex root canal fittings and crown and bridge work) services. These have been subject to review over the last few years and work is about to start on the procurement of these services across the Thames Valley. This will be with the aims of ensuring these treatment pathways are available to patients with equity of access, patients are not referred to hospital if they don't need to be and services are commissioned in line with the relevant NHS England Commissioning guides.

9. Challenges facing NHS Dental services in Oxfordshire

i. Improving oral health

Dental access and oral health have improved substantially in recent years. However, for more deprived communities the rate of improvement has been more challenging. These groups are less likely to attend the Dentist regularly and urgently when they have dental pain. There is also national growth in the number of children having teeth extracted. There are arrangements in place to ensure they can access services either in or out of hours, but this is not ideal in terms of oral health improvement.

In order to try to address this, the NHS England Chief Dental Officer has led a national programme called 'Starting Well' with a focus on improving the oral health of young children. The scheme is designed to support dental practices in identifying children more at risk of poor oral health with early interventions and also for them to engage with local communities to encourage regular attendance at the Dentist.

The scheme led by the NHS England Chief Dental Officer has identified the 13 local authorities with the poorest oral health in the country with Starting Well to be implemented in these areas. Slough has been identified as one of the areas and the scheme has been running there since early 2018. The project is being carried out in partnership between the Dental practices taking part in the scheme, NHS England and the local authority. The local office has now agreed to roll out this scheme to other areas where oral health has been identified as challenging. From April 2019 the Starting Well scheme will go live in Oxford and High Wycombe. Two practices in Oxford have applied to take part in the scheme and the applications are currently considered by the local office.

ii. Access for hard to reach groups

Recent Healthwatch reports in Oxfordshire and Reading have highlighted the challenges of access to dental care for residents of care homes. If residents of care homes are unable to visit dental practices and have an urgent dental need, they can be referred to the Community Dental Service who carries out domiciliary visits.

Since the current NHS contract was introduced in 2006 very few dental practices now visit care homes, as it is not included as part of the standard national contract. Their contracts relate to the sites from which they provide services; the dental practice. Legislative changes since 2006 in terms of issues such as infection control have also made it more difficult for dental services to be taken to care homes.

A number of local offices have carried out pilots into providing dental care in care homes. These reports tend to highlight some of the challenges of providing services; such as legislative constraints, facilities in care homes to enable dental care to be delivered and turnover of staff in the homes.

The Care Quality Commission (CQC) has been carrying an investigation into the management of oral health in care by care homes. A report on this is due to be issued shortly.

The local office is investigating whether some of the identified barriers to care home provision can be addressed in practical ways to enable provision in care home settings.

iii. Population growth

When the Dental Access Programme began in 2009, the population of the Thames Valley was 1,953,500. It is now estimated to be 2,124,175; a growth of 170,675 people (8.7%). Much of the growth relates to new housing with Oxfordshire facing significant pressures in the Banbury, Bicester, Didcot and Wantage areas.

In order to address these pressures, the local office does offer dental practices non-recurrent uplifts to their contracts (in each of the last 3 years) to enable them to deliver more activity. A new practice was opened in Bicester in January 2019 to help address pressures in this area.

The local office is working on the development of a 5-year plan with the aim of achieved a planned increase in provision in that time, with a focus on areas with housing growth.

10. Resources

When the Dental Access Programme was established in 2009 ringfenced monies were identified to support delivery. This has proved to be very successful and access to NHS Dentistry continues to improve. However, the ringfence was removed in 2012 and the use of monies for dental services has to be considered alongside other services.

If dental practices fail to deliver their contracted activity targets, then monies are recovered by NHS England; for that year only. These monies are then used on a non-recurrent basis to commission additional activity from practices with a history of contract delivery. In developing the 5-year plan, the local office aims to develop an investment plan to ensure resources are maximised both to support on-going improvements to dental access and the oral health of the people of the Thames Valley.

11. Oral Health Promotion and Dental Epidemiology

On 1st April 2013 the statutory responsibility for the commissioning of dental public health functions transferred to local government (oral health promotion and dental surveys). The dental public health functions of local authorities are described in

regulations and include a statutory requirement to provide or secure provision of oral surveys.
The statutory instrument states that:

A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area-

I. The assessment and monitoring of oral health needs
II. The planning and evaluation of oral health promotion programmes.
III. The planning and evaluation of the arrangements for the provision of dental services as part of the health service, and
IV. Where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.
V. The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.) so far as that survey is conducted within the authority's area.

Oxfordshire has had longstanding dental epidemiology and oral health promotion services delivered in the county. The current contract for these services commenced 1st April 2015 and ends on 31st March 2019. This contract was delivered by Community Dental Services (CDS), a community interest company based in Bedfordshire. They had an office based in Upper Heyford as base of their operations for Oxfordshire.

At time of writing this report the commissioners of these services are currently out to tender for a new dental contract which will commence on 1st May 2019. This contract will be for 4 years and 3 months with an option to extend for a further two years. At time of writing this report, due to procurement regulations the commissioners are not able to identify who the provider of this new contract is.

i. Dental Epidemiology Services

The dental epidemiology service is a mandated function of the County Council. It involves the collection of oral health data through conducting dental surveys. The information that is obtained from the service will contribute to the wider intelligence on the oral health of the population and help inform the future commissioning of dental services which are commissioned.

The service conducts surveys in accordance with the national Dental Public Health Intelligence Programme (DPHIP). The DPHIP is a national programme of dental surveys and are co-ordinated by Public Health England (PHE). The DPHIP surveys are conducted annually, usually over academic years and are carried out on randomised stratified samples or commissioning organisations can opt to conduct wider surveys e.g. census surveys. The surveys are conducted according to a national standard protocol and examiners are trained and calibrated to a national standard. The sampling procedure conforms to the national standard and is agreed with the DPHIP survey co-ordinator before fieldwork is carried out. DPHIP epidemiology co-ordinators are employed by PHE. They work on a regional basis and are responsible for the quality assurance of the fieldwork carried out in their area. This quality assurance and standardisation allows local, regional and national

comparisons of the data. Participation in DPHIP enables commissioners to collect meaningful, comparable data which has been collected, analysed and validated to the highest standards.

The current survey being conducted is of 5-year-old children in Oxfordshire.

ii. Oral Health Promotion Services

The Oral Health Promotion Service aims to coordinate, facilitate, support and provide a range of evidence-based interventions to improve oral health and reduce oral health inequalities in Oxfordshire by:

- Improving oral health promotion
- Improving diet choices
- Reducing consumption of sugary food and drinks, alcohol and tobacco
- Improving oral hygiene
- Collaborating with NHS England, dental practices, other healthcare professionals, early years settings, schools, community groups and other organisations to increase access to and improve patient awareness of NHS dental services
- Identifying and targeting vulnerable groups
- Providing training to frontline professionals

The service delivers information and advice on oral health in line with Commissioning Better Oral Health and Delivering Better Oral Health (two key guidance documents published by PHE), whilst being flexible to the varying needs of the population.

The model is based around providing a range of services for children and adults in a range of locations.

The health promotion activities provided by the service include:

Oral health promotion interventions aimed at children;
This includes:

- Direct oral health education and outreach oral health promotional work in high risk, vulnerable child groups.
- Training the trainers about oral health strategies (including hygiene, primary prevention, and first aid response to dental trauma or emergencies) amongst health and non-health professionals working with children.
- Accreditation in oral health of settings for early years and primary school age children, prioritising setting based on need and deprivation.

Oral health promotion interventions aimed at vulnerable adults with additional needs.
This includes:

- Direct oral health education and outreach oral health promotional work for identified adult priority groups.
- Training the trainers about oral health strategies amongst health and non-health professionals working with adults with additional needs.

- Accreditation in oral health of residential care homes with the development and use of an oral health care assessment tool as recommended by NICE

The ethos of the service is to train and develop the wider workforce to become knowledgeable in oral health issues and how to use this knowledge to improve oral health in the service users they regularly engage with – public health commissioners are trying to make every contact count for oral health.

In 2017/18 CDS working to the agreed work plan delivered the following:

- Training of health and non-health professionals who work with children and adults.
- The service trained 460 local staff in oral health, how to maintain good oral hygiene and how to access dental services.
- Supervised toothbrushing programme in primary schools. Five-year-old children brush their teeth under supervision of their teacher.
- The team worked with 5 schools who signed up to take part in this programme. Overall 191 children took part in this pilot scheme.
- Training for carers in care homes.
- CDS trained 53 members of staff who work in care homes in older adult oral health.
- Direct oral health sessions and outreach oral health promotion aimed at children and adults.
- CDS attended, in total, 149 different groups, sessions and events throughout the year. They made contacts with over 2500 people.
    - Adults
      Some of the groups the team worked with; Age UK, RVS, Macmillan, Healthy Hospital Days, Here4Health, Solutions4Health, OSJCT, Day centres, CSS centres and Maggie's Oxford.
    - Children
      Some of the groups the team worked with; JR and Horton outpatients, Toddler/baby groups, primary schools, libraries, Play Bus, OCC stay and Learn sessions and OPA days.
- Promotion of oral health related national campaigns.
- CDS Took part in events for National Smile Month (May) and Mouth Cancer Action Month (November)
- Involvement in public health groups, events and workplace health fairs.
- CDS discussed oral health with 918 contacts at events during the 2017/18 period.

iii. Older adults and oral health promotion

A Healthwatch report last autumn highlighted the issues and concerns regarding oral health of residents of care homes in the County. This is an issue that colleagues in adults social care and public health have been aware of and had been working to address prior to publication of the report.

Since 2016 CDS have been working with care home providers to pilot an oral health accreditation programme. This pilot programme enabled care home providers:

- To be accredited as an oral health promoting environment
- Support elderly care home to oral health friendly practices
- Help improve the oral health of residents in their care

Five care home took part in the pilot and CDS has maintained contact with these homes to continue supporting the training need for staff in these homes.

The public health team are currently developing an oral health assessment tool and training which will help care home staff assess the oral health of residents in line with NICE guidelines. Using the learning from the pilot programme, commissioners will be working with the new provider, Adult Social Care colleagues and care home providers in developing a programme to introduce use of the assessment tool as a standard practice and create healthier oral health promoting environments in care homes.

12. Recommendation

The Oxfordshire Joint Health Overview & Scrutiny Committee is recommended to note the oral health of the local population, the current dental services provided to address oral health issues in Oxfordshire.

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April 2019

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 4 April 2019

Title of Paper: Update report on transition of LD services: benefits for patients

Purpose:
To provide an update for HOSC on the key developments that have taken place since the transition of specialist learning disability health services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust on 1st July 2017, and the associated benefits for patients.

Senior Responsible Officer: Sula Wiltshire, Director of Quality/Lead Nurse, Oxfordshire Clinical Commissioning Group

NHS
Oxfordshire
Clinical Commissioning Group

Update report on transition of LD services: benefits for clients

1. Introduction

Since the transition of specialist health services for people with a learning disability on the 1st July 2017, both anticipated and developed improvements to services have been delivered, for the benefit of service users with learning disabilities and autistic people.

Initiatives have taken place both system wide and internally within Oxford Health NHS Foundation Trust. These have improved the internal offer for clients with learning disabilities across the Trust's service areas, as well as delivering more joined up provision across mainstream secondary healthcare and social care.

The Trust and the CCG continue to work on the development and implementation of a revised Trust autism strategy and associated implementation plan. This work aims to improve the service offer for autistic people with or without a learning disability, and covers the Trusts main service areas (beyond the specialist learning disability service).

2. Governance

The Oxfordshire Transforming Care Partnership Board has overseen the development and evolution of services across health and social care from April 2016.

The developments outlined below all fit within various workstreams which report to the Board.

The Board has equal voting numbers of service users and service user representatives and statutory sector representatives. It is currently co-chaired by a person with a learning disability and a service user representative. To our knowledge it is the only Board in the country which is led by people with lived experience.

3. Internal changes within Oxford Health NHS Foundation Trust

2.1 Improvements to mental health provision for people with learning disabilities and / or autism

The Green Light Toolkit (GLT) is a national guide to auditing and improving mental health services so that they are effective in supporting people with learning disabilities and / or autism who have co-morbid mental health conditions.

A mental health liaison nurse pilot role has been developed to lead on implementation of the GLT. The initial benchmarking of mental health services was completed in January 2018, with a follow up review in January 2019.

Evidence of improvement was identified in 16 out of the 27 areas assessed, with a further 11 areas audited remaining consistent with baselines.

Strengths highlighted in the review included personalisation, physical health, service user involvement in governance of the service, psychological therapies and local plans.

As a result of these developments access to local acute mental health inpatient services has improved for people with learning disability and autism. While these services will not be appropriate for all people requiring an admission, they have delivered care closer to home, reduced the need for out of area admissions and reduced lengths of stay for a number of individuals who would not previously have had access to these services.

Learning has been taken from these local admissions, with associated priorities highlighted for 2019-20.

Oxford Health remain in discussion with NHSE England regarding the provision of capital funding to develop two single person services for people with more complex and specialist needs which cannot be met in mainstream mental health inpatient services. The design for these services has been developed in partnership with families of young people who have spent time in Assessment and Treatment Units (specialist hospitals for people with learning disabilities detained under the Mental Health Act 1983).

Oxford Health's involvement in an NHSI discharge collaborative, combined with closer joint working with Oxfordshire County Council and Clinical Commissioning Group colleagues, has led to a reduction in the number of out of area inpatients from six to three. Lengths of stay have reduced from over 500 days to under 100 since the contract start date.

In 2018 the CCG commissioned Oxford Health to expand the remit of the Intensive Support Team (the crisis support function within the specialist LD health service) to all age, meaning children and young people can now access the specialist behavioural support this service offers.

2.2 Training and Workforce Development

Oxford Health staff across the Trust can currently access communication (including intensive interaction), epilepsy and learning disability awareness training (delivered by staff in the specialist service), to support people with learning disabilities access generic services.

A three tier training programme is planned which will complement this bespoke training. Three tier-one training resources are currently being developed in partnership with local user led organisations. The expectation is that these will be mandatory for all staff within OHFT, in line with the requirements of the NHS long term plan.

Oxford Health led on the development of a STP BOB-wide Workforce Development Strategy covering learning disability and autism across health and social care services. The strategy was a requirement of NHS England and was agreed in January 2019. It is expected that the final report will be incorporated into the BOB workforce development strategy.

4. System wide improvements

4.1 Health and social care

Several initiatives have improved the seamlessness and quality of the offer from health and social care to people with learning disabilities.

Oxfordshire County Council have provided three senior social work practitioners to provide links and expertise between the generic council offer and the specialist health service.

Joint team building between the team managers and leaders enabled a set of joint commitments to be agreed which teams now work to, when supporting people with learning disabilities.

The Oxfordshire Family Support Network (OxFSN) has delivered joint training to both health and social care team members on working with families, which further improved both the offer to people with learning disabilities and joint working across health and social care.

4.2 Primary Care

Oxford Health have developed a revised primary care liaison offer, with advice and guidance provided by Dr David Chapman (OCCG clinical lead for learning disabilities and autism) and the GP localities.

This work has included the development of a physical health strategy and implementation plans for each of the CCG's GP localities.

The offer is now live, with the impact to be evaluated by the CCG in 2019-20.

4.3 Secondary Care

Joint work with Oxford University Hospitals NHS Foundation Trust (OUH) is underway to improve the co-ordination of health care for clients with the most

complex physical health needs. The two Trusts are also developing an improved system wide mechanism for service user feedback, which is more fit for purpose and accessible for people with learning disabilities.

A senior nurse from the Oxford Health specialist learning disability service is currently on secondment to the OUH neurology department to develop a pathway for people with learning disabilities and neurological conditions.

System wide mortality reviews are leading to learning and proactive work to address causes including sepsis and pneumonia. In conjunction with the Oxford Patient Safety Academy a Look@Me project has developed the use of technology to ensure people are safe when they eat.

5. Contract Performance

Oxford Health are consistently delivering performance at or above required levels in the majority of key performance indicators and there are no specific areas of concern at present.

Remedial actions are in place to address any areas of underperformance. These are detailed in the CCG's IPR reports.

6. Validation of impacts

6.1 User feedback and involvement

Patient experience reports to OCCG's quality review meetings indicate that during the first year of the specialist learning disability health service there were 43 compliments and 7 complaints received by PALS in relation to the Oxford Health service.

Service user involvement in business as usual activities (e.g. interviewing for staff posts, development of accessible care planning and the mental health crisis pathway) was identified during the service's CQC inspection in 2018:

> *"The service promoted meaningful co-production and worked actively alongside patients to enable them to influence the running of the service"*

6.2 External validation

CQC visited the specialist learning disability health service in March 2018. The service received a rating of good overall (in all five domains) seven months post-transfer. In addition to the quote provided above, the report stated:

> *"All patients and carers we spoke with described ways in which they had been emotionally supported by the staff team. Patients talked about staff having an in-depth understanding of their individual situations, and the type of emotional support they found most helpful when they were finding things hard. We*

observed staff interacting sensitively with patients who were experiencing difficulties in coping with specific issues."

The CQC:

"*observed a culture across the service of treating people with learning disabilities as unique individuals with their own strengths and goals as well as needs, and of a strongly held belief in their right to access the same standard of care and treatment as the general population. We found staff and managers were committed to not pathologising learning disability, which means not treating the disability as an illness that requires treatment in itself*."

Oxford Health has piloted the NHSI Provider improvement standards and completed the national bench marking exercise which included service user questionnaires. Provisional results indicate that the 12 users that responded felt they were treated with respect 100% of the time and that the majority of respondents agreed or strongly agreed that they were happy with the care they received.

Following a visit from the NHSI Chief Executive in late 2018 the service was declared 'a centre of excellence'.

The learning disability team have won and been runners up in consecutive years at the Oxford Health Staff Awards, including winning the patient nominated award following a carer stating that a staff member had "given her daughter a voice".

A joint speech between a patient experience group member and the service director at the Trust AGM indicated the positives and challenges of the transition and their joint hope for the future of the service.

7. Conclusion

The transition of specialist learning disability health services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust has delivered a number of benefits for people with learning disabilities in Oxfordshire, with some of the most impactful changes outlined above.

Oxford Health have played a key role in the development of wider system changes which have enabled Oxfordshire to deliver against key Transforming Care targets, particularly maintaining adult inpatient numbers at nine or less.

Oxfordshire is currently well placed to deliver against the NHS long term plan and its aims of reducing health inequalities for people learning disabilities and / or autism, with a number of requirements either in place or in active development.

In relation to particularly health services 2019-20 is a transitional year for learning disability and autism, bridging from the Transforming Care Programme to the NHS long term plan.

Work remains ongoing in a number of key workstreams, particularly the development of specialist inpatient services in Oxfordshire and more specialist services for autistic people who do not have a learning disability. It is intended that these programmes of work will be incorporated into implementation plans for the forthcoming Adults Strategy, to ensure the health and social care offer is joined up and meets the needs of people with learning disabilities and autistic people, now and in the future.

Future progress will be reported via the Health and Wellbeing Board.

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Oxfordshire Joint Health Overview and Scrutiny Committee, April 2019

Update on implementation of recommendations from the Oxfordshire Health Inequalities Commission

Summary

In the last report to this Committee from the Health Inequalities Commission Implementation Group (June 2018) details were given on the breadth of activity to implement the 60 recommendations from the Commission report in 2016. It was reported that much of this work has been completed.

Since that last report the Health and Wellbeing Board has approved a new approach to the work of the Implementation Group. This paper sets out the changes in approach which are now being adopted. In summary the Implementation Group is now focussing on:

1. Adapting and developing existing systems and processes
2. Furthering the Prevention Agenda
3. Building on Existing Projects
4. Leading on sharing good practice

In addition, the Implementation Group has run a very successful event called the "Health Inequalities Good Practice Exchange". Details of this event are also described below.

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 multi-agency Implementation 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, Oxfordshire County Council Public Health, Cherwell District Council, Oxford City Council, West Oxfordshire District Council, South and Vale Councils, Oxfordshire Mind, Oxfordshire Healthwatch and Active Oxfordshire.

New priorities

A paper to the Health and Wellbeing Board (HWB) in November 2018 set out new ways of working for the Implementation Group. These were approved by the HWB. The paper can be seen here:
http://mycouncil.oxfordshire.gov.uk/documents/s43919/HWB_NOV1518R19%20-%20Health%20Inequalities%20Commission%20Implementation%20Group%20-%20Update.pdf

The new way of working that was approved is set out in 4 main areas:

a. Adapting and developing existing systems and processes

The original Commission Report highlighted that one way to do this is to take the Health in All Policies approach. All partners need to take the opportunity to renew and further develop their focus on health equity of outcomes across the population. Ideas for making sure that services address identified health inequalities of access and outcome include:

- **Continuing to develop detailed intelligence on health inequalities**
- **Equality impact assessments** –to identify health inequalities and ensure services are available and appropriate for those who experience worse outcomes.
- **Equity audits** –to make sure there are no barriers to particular groups in accessing services
- **Better reporting** – for example including more reports of variation in outcomes in the JSNA and in needs assessments for commissioning.
- **Setting targets to reduce variation** – e.g. targets for improving the worst outcomes can be added to ambition for overall improvement for the whole population.
- **Shifting the focus** –by looking at the needs of people in particular places or for specific groups rather than assuming a universal service will meet all needs.
- **Using the levers of Contract management** – for example to gather evidence of "reasonable adjustment" for people with additional needs.

b. Furthering the Prevention agenda

- **In the Joint Health and Wellbeing Strategy** and all related work of its sub-groups.
- **Implementing the NHS Long Term Plan,** building on the prevention agenda in the Five Year Forward View for the NHS. This means setting out a clear agenda at each level from Primary Care Networks, County or "Place" level and through the Integrated System.
- **Healthy Place Shaping,** building on the learning from the NHS Healthy New Towns in Barton and Bicester. This includes embedding the principles of Healthy Place Shaping in all aspects of the Growth Deal and ensuring the policy context set out in Oxfordshire 2050 includes a range of principles for health improvement.

c. Building on Existing Projects

- **A focus on inequalities in bids for funding** and development of programmes.
- **Refreshing plans for existing programmes** – such as Stronger Communities in the City and Brighter Futures in Banbury

d. Leading on sharing good practice

It was agreed that this work could be brought together by

- Asking project leads to report on the ***impact*** of their work so that this can be collated

- Setting up opportunities for project leads to report on what they have learned from their work and to ***share good practice*** e.g. an annual Knowledge Exchange event.
- Complete the work of making grants available through the Innovation Fund / Good Exchange.

Reports on progress on this new set of priorities

1. **Adapting and developing existing systems and processes**

This section includes 2 examples of recent good practice in partner organisations to illustrate this strategic approach to embedding good practice.

a. **Health Equity Audit** – Public Health, Oxfordshire County Council

A comprehensive health equity audit has been completed by the Public Health Team at the County Council, analysing the uptake of NHS Health Checks for all five years that they have been provided in Oxfordshire. The analysis included identifying whether any particular sections of the invited population were less likely to take up the offer. The conclusions were that, overall, Oxfordshire residents are among the best in the region at having their NHS Health Checks but that men aged 40-55 are under-represented. The commissioners in Public Health are currently targeting this group with campaigns and marketing information to encourage them to attend.

b. **CCG Equality Analysis -** Oxfordshire Clinical Commissioning Group (OCCG)

Under the Equality Act 2010, the NHS and other statutory bodies must show 'due regard' to eliminating discrimination. OCCG has applied this 'due regard' principle in the form of an Equality Analysis (also known as an Equality Impact Assessment). An Equality Analysis must be undertaken for any new service; service re-design; decommissioning a service or a new policy. This process helps us make fair, robust and transparent decisions based on a sound understanding of the needs and rights of the population, and to ensure our priorities demonstrate meaningful and sustainable outcomes for protected groups. The nine protected characteristic groups are: Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion or Belief; Sex; Sexual Orientation.
In addition to the statutory groups, OCCG also applies this process to other disadvantaged groups e.g. homeless people, Carers, veterans and people living in areas of socio-economic deprivation. Once final, an Equality Analysis is a public document and is published on the OCCG web site – you will find examples here.

OCCG commissions face to face Equality Analysis training annually for all new staff members, which is in addition to the statutory and mandatory online Equality & Diversity training. This has resulted in Equality & Diversity being embedded across the organisation and being 'everyone's business'. Through conducting Equality Analyses, staff have more awareness of due consideration of the needs of the population.

c. **Basket of inequalities indicators** - Joint Strategic Needs Assessment.

The publication of the Basket of Inequalities Indicators last year has been well received and shows that access to information on inequalities indicators is improving. The Implementation Group want to drive continuous improvement on the quality and range of inequalities data available and promote use of that data in service planning and review. The latest version of the Basket of Inequalities Indicators supplements the newly published Joint Strategic Needs Assessment and can be found here: https://insight.oxfordshire.gov.uk/cms/annex-inequalities-indicators-jsna-2018

2. Furthering the Prevention Agenda

There are national and local strategic drivers for furthering the prevention agenda and these have helped maintain the momentum on this area of work. The HIC Implementation Group want to ensure that all this work addresses inequalities issues. Some examples of recent developments include:

a. The Joint Health and Wellbeing Strategy

As part of the Health and Wellbeing Board's leadership on tackling health inequalities they have recently approved the new Joint Health and Wellbeing Strategy. This has cross cutting themes of embedding prevention and tackling health inequalities. The members of the Health Overview and Scrutiny Committee had the opportunity to comment on this strategy as it was developed.

Implementation of the strategy will need to prove that inequalities are being addressed and that the impact can be measured. The performance framework which was approved at the last HWB meeting already includes some measures which focus on inequalities by targeting specific identified or disadvantaged groups, such as:

- Reducing the number of looked after children and addressing persistent absence from school for children on Child Protection Plans
- Reducing the number of adults who are physically inactive
- Increasing the number of smoking quitters
- Increasing the number of people who have a learning disability who receive an annual health check.
- Targeting social prescribing initiatives to disadvantaged localities

b. Healthy Place Shaping

The principles of "Healthy Place Shaping" have been adopted by the Growth Board and included in the Joint Health and Wellbeing Strategy. This is also part of the work of the Safer Oxfordshire Partnership which makes sure that all the major strategic partnerships in Oxfordshire are playing their part.

Healthy Place Shaping is a collaborative approach which aims to create sustainable, well designed, thriving communities where healthy behaviours are the norm and which provide a sense of belonging, identity and community. https://www.youtube.com/watch?v=BcWnQlBTpAA&sns=em Oxfordshire is in the

vanguard of implementing this place based approach having developed and tested it through the Healthy New Town programmes in Bicester and Barton. Through the work of the Growth Board this approach is being embedded in future development, ensuring that growth is inclusive, that it addresses the current health inequalities in the county, and that it results in the creation of healthy communities which enable people to become more active, healthier and happier.

3. Building on Existing Projects

To date this area of work for the HIC Implementation Group has focussed on making grants available. In future the emphasis will be on influencing to ensure relevant projects take inequalities into account.

a. Innovation Fund bids

These bids are being administered by Oxfordshire Community Foundation (OCF) through their grant award scheme. The funding available was from partners in the Growth Board (£2,000 pledged from each local authority) matched by £12,000 from the CCG. This money was augmented by other funds available to OCF as detailed below.

Phase 1 - The first phase of the funding awards were combined with the Tampon Tax round in November 2018. The organisations receiving a funding contribution have included:

- Aspire Oxfordshire – Gym Bus

Aspire Oxfordshire are an employment charity and social enterprise supporting disadvantaged people in Oxfordshire into and towards employment, to break the complex cycles of homelessness, poverty, re-offending or disadvantage.

The funding will contribute to the launch of Oxfordshire's first ever "Gym Bus" to take sports and physical activity sessions to disadvantaged women across the county to provide them with essential early intervention support and help them take their first steps towards positive life changes such as work experience, training, employment, volunteering and secure housing.

- Ark-T

Ark-T deliver creative programmes to enable people to learn practically how to raise self-esteem and build healthy relationships, also developing essential life skills and supporting progress into education, training, volunteering and employment.

The funding will contribute to their self-care retreats during school holidays, and HerSpace term-time workshops for 12 to 18 year old teenage girls where participants develop practical art and design skills which could lead to employment opportunities, build arts and social leadership skills, project management, communication skills, time-management skills and learn about physical and nutritional health creatively.

- Home Start Oxford

Home Start Oxford provide training, matching and support of volunteers who offer support, friendship and practical help to families with under-fives, who are vulnerable, isolated or under stress. They work with families with multiple disadvantages and complex needs, including domestic abuse, substance abuse, mental health, learning difficulties, and the greater risks around safeguarding and exploitation that can follow.

Weekly home visits are made to build trusting relationships and provide practical support; help access other specialist services; build social networks; improve skills and confidence around parenting, attachment, play, routines, nutrition, budgeting and debt management; improve mental and physical well-being; support victims of domestic abuse; manage the impact of disability, illness, or trauma. The contribution of funding will be towards the Family Support Worker and Co-ordinator costs

Phases 2 and 3 - The second phase of funding was combined with the 'Loneliness and Isolation' grant round in February 2019 with funding contributions currently being awarded. The third phase is expected to be delivered when the last few contributions are received and will either be combined with another Oxfordshire Community Foundation grant round or will be dispersed on our behalf by OCF through the Good Exchange funding platform.

4. Leading on sharing good practice

The HIC Implementation Group decided that there is a need to learn from each other in the effort to develop and embed good practice across Oxfordshire. The first Good Practice Exchange event was held recently and is reported in brief here:

a. Health Inequalities Commission: Good Practice Exchange

This event took place on March 7th at The King's Centre with 62 people attending. The aim of the event was to showcase and share examples of good practice of projects that address health inequalities, their reach and what the impact has been.

Three different presentations highlighted projects that address health inequalities. These were:

- how an embedded mental health worker in Oxford City Council's Tenancy Sustainment Team is helping to address tenant's issues and numerous interactions with the team which can result in them being at risk of losing their tenancy;

a project identifying the health needs of men from various Black and Minority Ethnic groups and why they aren't accessing the NHS Health Check programme. This project was carried out by East Oxford United football club and was supported by Healthwatch Oxfordshire and NHS England. The video can be seen here: https://youtu.be/GcDG7wKMZ40

- The third project took place in Banbury and was tackling 'holiday hunger' through food provision at recognised community venues throughout the lengthy school Summer holiday, as well as providing a range of activities.

Delegates also had the opportunity to learn about a range of other projects in themed workshops on physical activity; employment and food / tackling food poverty. A full report will be disseminated soon.

Kiren Collison, Oxfordshire Clinical Commissioning Group
Jackie Wilderspin, Public Health, Oxfordshire County Council
Maggie James, Oxfordshire Clinical Commissioning Group
On behalf of the Health Inequalities Commission Implementation Group

Oxford University Hospitals NHS
NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust: Progress against Quality Priorities described in the Quality Account 2018-19 and feedback from 'A Quality Conversation' event January 2019

The Joint Health Overview and Scrutiny Committee For Information April 2019

Oxford University Hospitals NHS
NHS Foundation Trust

'A Quality Conversation' event January 2019

- Approximately 75 patients, Foundation Trust governors and members, and staff took part in an event on Tuesday 15 January 2019.
- A showcase of the achievements of the quality priorities was held in Tingewick Hall prior to table discussions of possible future quality priorities.
- The three priorities the audience chose to carry forward to next year were:
- a) Partnership working - including avoiding patients being stranded in hospital and the Home Assessment Reablement Team (HART)
- b) Preventing patients from deteriorating
- c) Safe surgery and procedures
- The feedback from the event was very positive with 86% finding the event useful or extremely useful.
- 98% of attendees felt they were able to contribute to decisions about the future quality priorities.

Oxford University Hospitals NHS
NHS Foundation Trust

Did we achieve the 18/19 Quality Priorities?

2018/19 Priorities- a reminder

- Preventing patients deteriorating: Cardiac arrest reduction and Sepsis.
- Safe surgery and procedures.
- Right patient every time.
- Go Digital.
- Lean Processes for patient pathways.
- Partnership working: avoiding patients being stranded in hospital and Home Assessment Reablement Team (HART).
- End of Life care.

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Preventing patients deteriorating

Cardiac arrest reduction and antibiotics delivered within one hour of a sepsis flag		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was the one of the 2017/18 priorities that stakeholders voted to continue into 2018/19 at our Quality conversation public event in January 2018.	**Cardiac Arrest Reduction** Our goal is a 25% reduction in general ward areas and a 15% overall reduction (which would include areas within the Heart Centre).	• The overall progress against the target set out in the Quality Priority is an 2.8% decrease overall with a 9.3% increase in general ward areas when the period Apr-Jan 2017/18 is compared with the same period in 2018/19. • The resuscitation team continue to observe a number of patients who are subject to a 2222 call and for whom a decision regarding resuscitation status would have been appropriate prior to the point of cardiac arrest. These cases are reviewed and highlighted to the patient's consultants who share the learning with their respective teams. ***Not achieved***.

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Preventing patients deteriorating

Cardiac arrest reduction and antibiotics delivered within one hour of a sepsis flag		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was the one of the 2017/18 priorities that stakeholders voted to continue into 2018/19 at our Quality Conversation public event in January 2018.	We will improve upon our 2017/18 achievement of 65% patients receiving antibiotics within one hour of alerting for sepsis, and set the target of >90%. We will develop and deliver a sepsis training package to >50% of regular clinical staff working in the emergency departments by 31 March 2019.	• Overall, since April 2018, 412/580 (71%) acute admissions and 1009/1363 (74%) inpatients with sepsis have received antibiotics within 1 hour. ***We have improved to 74% but have not fully achieved this.*** • Training has been delivered to 197/319 (62%) of regular clinical staff in the Emergency Department (target 50%). • Outcomes of patients with sepsis at OUH: Dr Foster data demonstrates a sustained fall in Summary Hospital-level Mortality Indicator (SHMI) for sepsis since Trust sepsis work began in July 2015. • The Oxford Sepsis Team strategy has been shortlisted for the British Medical Journal 2019 Award for Innovation in Quality Improvement. ***We have fully achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Safe surgery and procedures

Safe surgery and procedures		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
National Safety Standards for Invasive Procedures (NatSSIPs) have been produced to address many of the underlying causes of Never Events (events that should be wholly avoidable due to the consistent application of specific safety checks e.g. WHO surgical safety checklist). The aim is to produce Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had eight Never Events in 2017/18 and that is why focus on these standards has been chosen to be a Quality Priority.	Establish a new Safety Standards for Invasive Procedures group (SSIPG). Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to the eight Never Events that occurred in 2017/18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.	• The SSPIG group has been established and meets regularly. • The remaining key overarching policies from which the specific LocSSIPs will develop are all either complete or nearing completion. • An implementation plan for LocSSIPs has been developed and reviewed at SSPIG. A small number of LocSSIPs have been completed with work on the others currently underway. • The scoping work for LocSSIPs is expected to be completed before the end of March 2019. FY2s (junior doctors) are supporting clinical areas with the creation of LocSSIPs as part of their Quality Improvement Projects (QIPs). ***We have partially achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Right patient every time

Right patient every time		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
This Quality Priority is key to ensuring safe diagnostic tests, procedures and treatments are identified with the correct patient every time. We chose this priority following a number of incidents, particularly in Radiology where the wrong patient received a test or procedure in the previous year. We are committed to learning from these events.	Positive patient identification (PPID) Delivery of a campaign to promote PPID across the Trust. Questions on PPID will be rotated through the new Matron's Assurance App during 2018/19. The app is being launched for Matron's assurance audits. Achieve a 50% reduction in PPID incidents in Radiology compared to 2017/18	• Final sign off for the revised PPID policy happened at clinical policies group on 5th March 2019. New 'at a glance' documents will be circulated following this sign off. • 'Wristband Wednesday' continues however the audit tool is being updated for March 2019 and an associated document "What good looks like" is being produced for the audit. • There has been 1 PPID incident in radiology (in February 2019). This was presented at the serious incident requiring investigation (SIRI) forum and a local investigation is now underway. Learning will be shared once this investigation is complete. ***We have fully achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Go Digital

Go Digital		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
Oxford University Hospitals NHS Foundation Trust is one of the UK Global Digital Exemplar Trusts and Go Digital is one of our strategic priorities. This was also one of the 2016/17 priorities that stakeholders voted to continue into 2018/19 at our Quality Conversation public event.	**Global Digital Exemplar programme - patient portal** The patient portal will be live in Q4 2018/19 (January-March) for use by OUH staff. During Q4 (January-March) 2018/19 a phased release across different departments will allow patients to view appointments, results and contribute information to their health records via the portal.	• An eight-week pilot of the patient portal is in progress as of 30th January 2019 with the diabetes service and will help understand how best to engage with users and provide a baseline prior to roll out to the rest of the organisation throughout 2019. ***We have partially achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Lean Processes

Lean processes		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
We chose this because we want to increase efficiency within the directorates in order to eliminate waste (including respecting patients' time) and improve patient experience. This will include consideration of streamlining administration processes that meet the needs of patients.	The Transformation Team will train a core team of Divisional staff in lean processes. Each directorate will then complete a lean pathway exercise for at least one patient pathway.	• From September 2018-February 2019 we will have had 172 staff participate in Quality Service Improvement and Redesign (QSIR) fundamental courses run by the Transformation Team. • Feedback has been outstanding with the most describing the course as "Inspiring." • Directorates the Transformation team are supporting, incorporating 'Lean' as one of the improvement tools include: Gynaecology, Trauma and Orthopaedics, Specialist surgery, Children's, Renal transplant and urology and Oncology and Haematology. ***We have fully achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Partnership working

Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
This was the one of the 2017/18 priorities that stakeholders voted to continue into 2018/19 at our Quality Conversation public event.	A Systematic Stranded Patient Review process will be embedded to ensure critical clinical decision-making prevents harm from deconditioning and patients leave hospital for their next destination in a timely way. Use outcomes of Systematic Stranded Patient Review process to advise joint funding priorities and to advise 2018/19 winter plan.	• Patients who are ready for discharge are discussed at 12:00hrs Monday to Friday to identify actions that will further support their discharge. This is to reduce their overall length of stay in hospital. • In addition we are working with the community locality teams to provide further support for 'discharge to assess'. • Partners we are working with include the North locality teams, The Order of St John and the continuing healthcare team (CHC). ***We have fully achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

Partnership working

Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
This was one of the 2017/18 priorities that stakeholders voted to continue into 2018/19 at our Quality Conversation public event.	Actively participate in the **End Pyjama Paralysis campaign** and report progress in the 2018/19 Quality report. **Home Assessment Reablement Team (HART)** We will maintain our 2017/18 achievement of 50% direct face-to-face contact time with patients. In addition we will aim for the stretch target of up to 55% by 30 September 2018 which we will thereafter aim to maintain.	• All inpatient areas actively participated in the campaign to end pyjama paralysis. This work continues through the wards particularly within the general medical wards. ***We have fully achieved this.*** • HART's February 2019 contact time percentage was 47%, a slight decrease on previous performance. • However the drive to achieve the 55% will continue as HART have recently entered into a subcontract agreement with Oxford Health who are supporting patients in 4 agreed postcodes across a wide geographical location. ***We have not achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

End of life care

End of life care		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2019**
This was one of the 2017/18 priorities that stakeholders voted to continue into 2018/19 at our Quality Conversation public event.	An electronic care plan will be in place to document end of life care to ensure clear communication and continuity of end of life care across the Trust.	• There has been learning from the two areas of OUH that have trialled the care plans. • Following review, the care plan will be rewritten into the electronic patient record (EPR) in the next 3 months. • An advice sheet for staff has been written. • The EOLC care plan is likely to be rolled out initially at sites that are confident with care at the end of life and where there is a strong level of daily support from the Hospital Palliative Care Team. • Continuation of the work has been incorporated into the EOL work plan for 2019/20. ***We have partially achieved this.***

Oxford University Hospitals NHS
NHS Foundation Trust

2019/20 Priorities

Safety First

- A. Preventing Never Events- particularly around safe surgery and procedures.
- B. Patient safety response teams.
- C. Reducing still births.

Partnership working

- A. HART services.
- B. Reducing the number of stranded patients.
- C. Care of patients with mental health issues.

Preventing deterioration

- Sepsis care – antibiotics within 1 hour.
- Launching NEWS 2.

Digital

- Patient portal to support better interaction with hospital services.
- Roll out of the Surginet module in Cerner Millennium to support best care for patients undergoing surgery and procedures.

Oxford University Hospitals NHS
NHS Foundation Trust


John Radcliffe Hospital


Nuffield Orthopaedic Centre


Churchill Hospital


Horton General Hospital

FOUR HOSPITALS, ONE TRUST, ONE VISION

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Your voice on health and social care

Healthwatch Oxfordshire Report to Health Overview Scrutiny Committee April 2019.

DENTISTRY

Healthwatch Oxfordshire carried out two pieces of research in 2018 focusing on NHS Dentistry. This focus was as a result hearing concerns about access to NHS dentistry in Bicester in 2017, leading to Healthwatch Oxfordshire highlighting the problem to NHS England Commissioners, who have since commissioned more NHS dentists in the area.

Our subsequent reports 'Filling the Gaps; Access to NHS Dentistry in Oxfordshire' and 'Treatment only when needed- dental services for care home residents' included conversations with more than 400 people across the county, 172 questionnaire responses, and 26 care home responses.

Reports can be found here - https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/

Overall, we found:

- Concerns about access to NHS dentistry in some areas of the county experiencing population growth, with services not keeping up with demand (Thame, Faringdon, Bicester Wantage** (also highlighted in Wantage Town study)
- Gap in awareness of importance of oral health among some adults and children
- Room for improved information on what is available on the NHS including clear communication about pricing.

Our main findings highlighted by the **care home** study were:

1. A significant number of residents in care homes did not use dental services at all.
2. Healthwatch Oxfordshire found that there were significant gaps in provision of dentistry services to residents of care homes.
3. Some care homes struggle to obtain NHS dental services for their residents.

Barriers faced meant that many residents at care homes received no dental treatment at all, or only in an emergency. Barriers included:

- Lack of NHS dentists to visit a home.
- Poor physical access at dentists' surgeries.
- Lack of transport and staff time to take residents for appointments

- Some homes felt that dentists were unwilling or unhappy to treat patients with dementia or learning disability.

We asked care homes what could be done to improve access to dental services for their residents, and the following were suggested:

1. Better access to dentists at the care home for residents who cannot easily visit dental surgeries
2. Dementia training for dentist treating residents with dementia. This would also improve the experience of people living with dementia in the community
3. More information available to care homes about dental services that can be accessed by their residents.

Stakeholder meeting

Healthwatch Oxfordshire convened a stakeholder meeting to discuss the findings of the report in **September 2018**. This enabled discussion and support for a collaborative approach to tackling some of the issues. We are currently following up with attendees to identify outcomes.

Whilst NHS England South were unable to attend the meeting, they gave a written response to our reports saying that:

'We recognise there are growing challenges around oral health for older patients, particularly as a much higher proportion of older people still retain their own teeth nowadays."

In terms of key issues raised in the report:

Access to High Street Dental practices

NHS dental practices provide access to a full range of services for patients of all ages. Their contracts are site-specific, which means they can only provide services from sites identified in their contracts. Their services have to meet all the necessary requirements for Care Quality Commission registration and with regard a number of other legal requirements, such as infection control.

There are challenges for dentists in terms of going into care homes in terms of the limitations it places on treatment that can be provided if the necessary equipment and facilities are not available. Dentists also have to ensure compliance with infection control regulations and CQC registration for any site from which they provide services.

If patients are unable to attend High Street services on medical grounds, they can attend or be referred to Community Dental Service clinics with staff and facilities more adapted to their needs. In Oxfordshire, this service is provided by Oxford Health NHS Foundation Trust and it has a number of clinics from which it provides services. The Trust has three domiciliary teams (North, Oxford City and South and West). The Trust has provided a domiciliary service for many years and is happy to see patients with a range of needs, both routine an urgent. The service has

experienced staff willing to provide support to the care homes. Access to High Street dentistry is under review at the moment with the aim of ensuring there are no gaps in provision. This is both in terms of High Street access and access to more specialist services.

The Oxfordshire Community Dental service has advised us that it has been unusually quiet recently in terms of contact with care homes and that it was looking to do work to ensure the care homes are aware of this service. We are aware that some care homes experience high turn-over of staff and this may impact on the local awareness of available services. We would also like to share that guidelines were recently published about maintaining good oral health in care home settings (i.e. helping residents brush their teeth twice a day). This is the responsibility of the home, but the Community Dental Services could advise and support staff if needed'.

Rose Hill Primary School - Healthy Eating Consultation. This HWO Project Fund report carried out by researchers associated with Rose Hill Primary School focused on engaging parents, children and teachers in exploring development of healthy eating guidelines for the school. It highlighted some issues around oral health including:

- Many felt that information about dental care is scarcer, that knowledge about keeping teeth healthy is low, and as a consequence, many children have dental caries (tooth decay).
- Challenges of the wider food environment to healthy eating related to oral health, including access to foods high in sugar, higher cost of fresh fruit and vegetables, food poverty and confusing labelling systems on foods.
- Some parents spoke of efforts to find a 'child friendly dentist'
- Schools can be a powerful vehicle in efforts to improve public health. They can create a healthy environment by encouraging and modelling healthy behaviour, educating children about healthy options, harnessing the power of positive peer influence, and reaching out to families, carers and the wider community

As a result of the report, Rose Hill school has had ongoing conversations with the Community Dental Service.

Wider 'service review' comments on our Feedback Centre (78 reviews from April 2018-March 2019) about individual dentists on infographics. Overall positive about treatment, but include comments on access to NHS dentists, waiting times, and communication/ information given by dentists about treatment, costs and care, pressure to go private, high staff turnover.

OXFORD UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

We continue to visit hospitals monthly – 2019 has seen visited to the Nuffield Orthopaedic and Horton General hospitals. Parking continues to be a major theme of concern.

An Enter and View visit took place at the A&E Urgent Care Centre – full report will be published in April.

HEALTHWATCH OXFORDSHIRE ACTIVITY UPDATE

- **Men's Health Film;** focused on the work with Healthwatch Oxfordshire and East Oxford United to reach men in East Oxford, funded through NHS England, presented at Health Inequalities Commission Good Practice event. Film can be viewed on our website https://healthwatchoxfordshire.co.uk/
- **Report on changes to Adult Daytime support (2017-18)** completed and presented to Oxfordshire County Council's Performance Scrutiny Committee. Recommendation accepted to review its approach to major changes to services specifically:
    - communication with service users and their carers
    - and the impact on service changes on carers be addressed through the change process.
- **Patient Participation Group events** - two events with 106 delegates representing 34 practices across all six localities. Purpose was to share experiences, learn from other groups, and hear about the future of primary care from Locality Leads. We plan to hold two more forum meetings in the summer and autumn this year. The full report is available here https://healthwatchoxfordshire.co.uk/what-we-do/supporting-patient-participation-groups-and-locality-forums/
- Enter and View activity
    - We spent New Year's Eve with the South Central Ambulance Service NHS Trust SOS Bus
    - All Enter & View Reports can be found here https://healthwatchoxfordshire.co.uk/enter-and-view-reports/

Future activity includes:

Healthwatch England funding to support stakeholder engagement across BOB footprint, to gain insight into local priorities for NHS Long Term Plan. We are holding two focus groups to discuss mental health services in Oxfordshire.

Focus on mental health in 2019

Enter and View with an aim to visit the Warneford Hospital in April.

Oxfordshire Joint Health Overview and Scrutiny Committee
4 April 2019

Chairman's Report

1. Co-opted members

1.0 In addition to Councillors the Joint Health Overview and Scrutiny Committee (HOSC) includes in its membership up to three non-voting co-opted members. Co-opted members are appointed because of the valuable personal contribution they make to the work of the committee.

1.1 Co-opted members normally serve for a period of two years and may serve for one further consecutive period of two years before reapplying. In line with this, a review of the terms of the co-opted members of the committee was due and therefore undertaken in February 2019. An advertisement, application shortlisting and interview process then followed for co-opted members.

1.2 There was significant interest from some excellent candidates in the co-opted role and following shortlisting, four people were interviewed and offers made to join the committee immediately to Mrs Barbara Shaw and for a deferred (September) start date to Mrs Anita Higham.

2. The Horton HOSC

2.0 A meeting of the Horton HOSC took place on the 25th of February. All papers are published for these meetings on the Council's website at:

http://mycouncil.oxfordshire.gov.uk/ieListMeetings.aspx?CId=1070&Year=0

2.1 The main points covered during the meeting on the 25th of February were updates on the following:

- Public and stakeholder engagement
- Service description
- Activity and population modelling
- Travel and access data/information
- Option appraisal
- Recruitment and retention of staff at OUH.

2.2 The next meetings of the Horton HOSC are scheduled for:

- Thursday 11th of April 2019
- Monday 24th June 2019 (provisional)

3. Task and Finish Group on Local Health Needs Assessment in the Wantage Locality

3.1 At the HOSC meeting on the 7th of February, the committee agreed a Terms of reference for a Task and Finish Group on Local Health Needs Assessment in the Wantage Locality. The first meeting of this Group will be held on the 3rd of April 2019 and a verbal update will be provided at the committee's meeting on the 4th of April.

4. Committee briefings

4.0 The committee received three written briefings since its meeting in February 2019. They are in the Appendix of this report are on:

Appendix A: Mental health funding
Appendix B: South Oxford Health Centre
Appendix C: Gynaecology outpatient appointments.

5. Actions from February HOSC meeting

5.0 During the HOSC meeting on the 7th of February 2019, the committee requested a list of those attending the Health and Wellbeing Board workshop at the end of February be shared. This is attached in Appendix D.

5.1 On the 7th of February, the committee agreed to explore training for HOSC members on scrutiny of integrated health and care arrangements. Such training would be delivered by the Centre for Public Scrutiny (CfPS). CfPS is the leading national body promoting and supporting excellence in governance and scrutiny. As a charity, they provide training, consultancy and conferences; they are also respected and provide independent and impartial advice in a wide range of health and social care scrutiny projects nationally.

5.2 The training in question will take place in late April or May, in a workshop format and will cover:

- The changing world of integrated health and care
- The importance of strategic focus in scrutinising health partners
- Assist the understanding of the various provider roles and to consider how each can be effectively scrutinised and held to account
- Building and understanding of the overview and scrutiny framework within an integrated social care and health setting.

Briefing on behalf of Oxfordshire Clinical Commissioning Group and Oxford Health NHS Foundation Trust: Mental Health Funding – February 2019

Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health NHS Foundation Trust (Oxford Health) are committed to seeing the best services to support and care for patients' and service users' mental health needs now and in future. That is why we have jointly commissioned an independent review into the funding of mental health services in the county. The review found that investment in mental health services in Oxfordshire is considerably lower than comparator areas.

Relative to other similar clinical commissioning group (CCG) areas, the county spends less on mental health – 70 per cent of the average - with the potential funding gap ranging from £16 to £28 million (but only if the CCG were to receive its full allocation).

The Oxfordshire CCG has the lowest funding allocation per person of any CCG in the country, meaning the county spends around 80 per cent of the average on all other services for the Oxfordshire population. The allocation is worked out centrally on a formula based on the expected needs of our population, and while reviewed periodically it is unlikely to result in OCCG being funded close to national or regional averages in the near future.

Oxfordshire CCG and Oxford Health recognise that the proportion of spend on mental health services should increase, at least to the 80 per cent level of other services within the county and we are working together to manage and address this along with partners in the wider system locally and nationally.

The position on mental health investment in Oxfordshire also sits within the context of a national view that mental health services overall are relatively underfunded and a recognition of the need to invest more proportionately in them for 'parity of esteem' with physical healthcare and to meet national targets to address population needs. For example, the Mental Health Five Year Forward View sets specific targets for improved access to Child and Adolescent Mental Health services, but even when these are achieved they will only have increased access to treatment from 25 per cent to 30 per cent of those who would benefit from it.

The independent review, also looked at how well current resources are spent and concluded that mental health resources in Oxfordshire are used efficiently, eight per cent more efficiently than the national average according to NHS Improvement reference costs data. That efficiency is helping to somewhat offset the effects of relative underinvestment in mental health services, but current funding levels have implications for the sustainability of services, patient access, experience and outcomes as highlighted in the recent Care Quality Commission inspection of Oxford Health. At the same time these services were overall rated 'good' for now, which is a testimony to the commitment and dedication of staff.

Both local organisations recognise that if Oxfordshire is to spend a proper and significant share of its resources on mental health, it will need to spend proportionately less on something else. The overall allocation of resources to OCCG is a factor, as is the county's relative gap in funding of mental health services specifically.

Oxfordshire CCG and Oxford Health have written to Oxfordshire's Health and Wellbeing Board (HWB) to highlight this and to begin discussions about examining the relative prioritisation of resources in relation to need. This has implications for reducing health inequalities and for other parts of the public sector, for example housing, policing and the criminal justice system.

Both organisations want this issue to be a major area of focus for our county's health and care system over the next year.

We are working together to address this and by the end of March we will have developed the first phase of a plan to get mental health services in Oxfordshire on a sounder more sustainable footing. The things we're looking at include: the development of crisis resolution teams, strengthening community mental health services and reducing the numbers of patients being treated outside their areas, in recognition of the ambitions of the NHS long term plan.

It is important to note that latest figures from NHS England rate the performance of health services in Oxfordshire for people with dementia, mental health problems and learning disabilities as 'outstanding' or 'good'.

NHS
Oxfordshire
Clinical Commissioning Group

Briefing on future of South Oxford Health Centre

Dear Stakeholder

South Oxford Health Centre (SOHC) is a small practice in Lake Street, Oxford. It currently has one partner who has been under pressure and facing challenges in maintaining services due to difficulties in recruiting new doctors, increasing workloads and rising costs. The practice has a patient register of approximately 4,700 people. Despite the practice's best efforts the remaining partner, Dr Nick Wooding, has decided to end his contract to provide primary care services with effect from 31 July 2019.

South Oxford Health Centre will be open as usual throughout the notice period, and patients have been reassured that they need do nothing at this stage. They will continue to continue to receive high quality care and support until at least 31 July 2019.

Patient Participation Group:

The practice Patient Participation Group (PPG) is keen to work with Oxfordshire Clinical Commissioning Group to explore the options for the future of services at the practice. Its representatives met with OCCG on 19 February 2019 to discuss the position. The PPG has offered to meet patients and answer questions and concerns as they come for appointments at surgery and will distribute letters from the practice outlining the decision to hand back its contract and plans for the future.

Actions by the CCG:

OCCG was made aware of the decision by Dr Wooding to hand in his contract with six months notice, effective from 1 February 2019.

OCCG has undertaken background work preparing a thorough options appraisal, looking at the commercial case, strategic vision, service needs assessment, new models of care, state of the workforce and the feedback from the PPG. This will be published on our dedicated page for South Oxford Health Centre (see below)

Summary

We continue to work with SOHC and local providers to seek a resolution to the issues and support SOHC patients.

Work continues to develop options, including a procurement process to find a new provider or look to local practice willing to provide primary care to the registered patients, running SOHC as a branch surgery. .

As OCCG works through the process, we will take the same approach to engaging with

patients as was undertaken last year at Cogges Surgery in Witney, and which was commended by patients and stakeholders alike.

Together with SOHC staff, we will continue to meet with the PPG and keep them up to date with developments. We will provide regular updates through the practice and the OCCG website which already has a dedicated page https://www.oxfordshireccg.nhs.uk/about-us/south-oxford-health-centre.htm

This page will provide regular updates including Frequently Asked Questions and letters to patients as appropriate.

Julie Dandridge
Deputy Director. Head of Primary Care and Localities
February 2019

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NHS
Oxfordshire
Clinical Commissioning Group

Briefing: Gynaecology outpatient wait

March 2019

Oxford University Hospitals NHS Foundation Trust (OUH) has capacity challenges in gynaecology. Limited theatre capacity and difficulties recruiting appropriate staff have led to a build-up of the waiting list over the last two years.

Every effort is being made by the Trust to improve this situation. Progress has been made in reducing the number of women waiting long periods for surgery but outpatient appointment waiting times are still a significant challenge. Women are experiencing waiting times for gynaecology appointments of 40-plus weeks. This is unacceptable in terms of care and patient experience.

Having investigated all alternative options fully, OUH has proposed to divert referrals for certain conditions to other out-of-county hospitals and independent providers for three months, starting on 1 April until 30 June 2019. These include patients being referred for general gynaecology, urogynaecology, endometriosis, menopause, pelvic pain. It is hoped this short term action will bring outpatient waits down as much as possible and allow women to be seen more quickly.

OUH **will continue to accept** referrals for:

- Suspected cancer two week waits
- Recurrent miscarriage
- Fertility

Oxfordshire GPs are being asked to refer **all other conditions** to other providers:

- Buckinghamshire Healthcare NHS FT
- Great Western Hospitals NHS FT
- Royal Berkshire Hospital NHS FT
- South Warwickshire NHS FT
- Milton Keynes University Hospital
- Independent hospitals providing gynaecology services such as the Foscote in Oxfordshire.

Some of these Trusts hold clinics in community settings e.g. the Royal Berkshire Hospital offers outpatient appointments in Henley and Newbury, which will be convenient for some Oxfordshire patients.

Patients will be advised that they may be eligible for help with transport or reimbursement of travel costs https://www.oxfordshireccg.nhs.uk/your-health/choose-the-right-service/patient-transport.htm

This diversion of referrals is expected to affect approximately 1,300 women during the three month period.

GPs have been asked to support these measures to offer their patients the care they need within a reasonable timescale. They have been asked to ensure all practice clinical and administrative staff are aware of the OUH referral diversion so they do not send patients with one of the restricted conditions to OUH, which would result in a delay to those patients**.**

The providers listed above have been made aware they may experience an increase in referrals.

NHS England's regional team is aware of this difficult situation and has supported the need for Oxfordshire Clinical Commissioning group and OUH to engage regional providers to provide this additional capacity as a one-off initiative.

If you would like to discuss any issues arising from this, please contact 01865 334638 or email OCCG.talking.health@nhs.net

Organisations whose representatives were invited to Health and Wellbeing Reference Group Event – Thursday 28th February 2019

Attendees – 35 people representing 27 organisations with 15 apologises.

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All HAWB Board members

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Cherwell District Council - councillors

West Oxfordshire District Council - councillors

South Oxfordshire District Council - councillors

Oxford City Council - councillors

Vale of White Horse District Council - councillors

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Jacqueline Wright - Shared Healthy Communities Officer, West Oxfordshire & Cotswold District Councils

Heather McCullough - Shared Healthy Communities Manager, Cotswold and West Oxfordshire District Councils

Community Information Network

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Abbeyfield Sheltered Housing

Abingdon Carousel

Abingdon Food Bank

Abingdon Green Gym

Abingdon Street Pastors

Abingdon Stroke Club

Ace Training

ADHP Oxfordshire

AE-SOP

African Families in the UK

Against Breast Cancer

Age UK Abingdon

Age UK Oxfordshire

Age UK Oxon

Al Anon

Ami

Archway Foundation

Aspire

Assisted Reading for Children

Asylum Welcome

Autism at Kingwood

Autism Family Support

Autism Oxford

Balsam Family Project

Banbury Branch Parkinsons

Banbury Breath Easy Group

Banbury Carers Support Group

Banbury Dementia Café

Banbury Stroke Club

Banbury Young Homelessness Project

Be Free Young Carers

Beacon Centre, Banbury

Bicester Green

Blackbird Leys Adventure Group

Blossom Arts

Bookfeast

Breakaway Club Oxfordshire

Bridewell Gardens

Carers Oxfordshire

Charity Mentors

Charlbury Day Centre

Cherwell Partnership Network

Chiltern Centre for Disabled Children and Young Adults

Chipping Norton Green Gym

Cholsey Church

Clear-Sky

Climate Outreach

Combe Mill

Community First Oxon

Connection Support

Contented Dementia Trust

Creative Dementia

Crisis

Cruse Bereavement Care

Cutteslowe CCA

Daybreak-Oxford

Dementia Friendly Abingdon

Dementia Friendly Charlbury

Dementia Oxfordshire

Diabetes UK Banbury

Didcot Railway Centre

Didcot Volunteer Centre

Donnington Doorstep

Dorchester Abbey

Dovecote Community Children & Family Project

Earth Trust

East Oxford Good Neighbours

EMBS Community College

Emmaus Oxford

Enrych

Ethical Property

Family Links

Farmability

Film Oxford

Flexicare

Florence park community centre

FND Hope

Folk Weekend Oxford

Footsteps Centre

Generations Games (Age UK)

Getting Heard

GP Federations

Guideposts

Harwell Village Hall

Headway

Healthy Abingdon

Healthy Bicester

Helen and Douglas House Hospice

Hill End

Hinksey Sculling

Holistic Massage

Home Farm Trust

Homeless Oxfordshire

HomeStart Banbury and Chipping Norton

HomeStart Oxford

HomeStart South Oxfordshire

Hummingbird Centre

Island Farm Donkey Sanctuary

Jacari Home Tutoring

Katharine House Hospice

Kidlington & District Good Neighbour Scheme

Leukaemia Care

Life at No 27

Life Carers

Locality Forum Chairs

Low Carbon Oxford North

Macmillan

Magdalen Road Church

May Messy

Mctimoney Trust

Mencap

MHA

Minthouse Oxford

Mobis Consulting

Modern Art Oxford

Monument Park Chalgrove

MS Society

Muzo Akademy

My Life My Choice

My World Autism Support

North East Abingdon Good Neighbour Scheme

OCD-UK

OCLT

OCVA

OMEGA

One-Eighty

Order of St John

ORFC

OSARCC

OVADA

OWR

Ox Breastfeeding Support

Oxeyes

Oxford Against Cutting

Oxford CAB

Oxford Civic Society

Oxford Council of Faiths

Oxford Cruse

Oxford Friend

Oxford Health NHS Foundation Trust

Oxford Hindu Temple

Oxford Mencap

Oxford Methodist

Oxford Quakers

Oxford University Hospitals NHS Foundation Trust

Oxford Women Swahili Community

Oxfordshire Care Homes Association

Oxfordshire Credit Union

Oxfordshire Mind

Oxfordshire Outdoor Learning

Oxfordshire Parenting Forum

Oxfordshire South and Vale CAB

Oxon Association for the Blind

Oxon Association of Care Providers

Oxon Family Support Network

Oxon Red Cross

Oxopendoor

Oxorinoco

OXPIP

Oxtrag

Parasol Project

Quest for Learning

Red Kite Family Centre

Reducing the Risk of Domestic Violence

Refugee Resource

Relate

Response

Restore

Rethink

Riverside Counselling Service

Root and Branch

Royal Voluntary Service Oxfordshire

SAFE Supporting Young People Affected by Crime

Samaritans

Season Senior Living

Seesaw

Shed Oxford

Sinodun Players

Smart CJS

SOHA

Smart CJS

South Central Ambulance Service

South Oxford Community Centre

Special Effect

Spelling School

St Ethelwold's House

St Matthews Church

St Mungo's

Steeple Aston Good Neighbour Scheme

Stewart Village Hall

Stonehill Gardens

Stroke Association

Styleacre

Sunrise Multicultural Project

Sustainable Health Care

Talking Newspaper

Tandem Befriending

Tetsworth Memorial Hall

Thame and District Day-Centre

Thame Barns Centre

Thame Players

The Abbey, Sutton Courtney

The Berin Centre

The Kings Centre

The Listening Centre

The Porch

The Sunshine Centre

UGACOX Community Development Initiative

Unison Retired Members

Universify Education

University of Oxford

Vale House

Villager Community Bus Service

Volunteer Link Up

Wallingford Sports Park

Wantage Advice Centre

We Own It

Wendy Spray Coaching

WI Henley

Wilts & Bucks Canal Trust

Windrush Bike Project

Witney Foodbank

Wolvercote Young People's Club

Woodstock Youth Club

Yellow Submarine

Young Dementia

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