Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Tuesday, 10 May 2022 at 10.00 am

Council Chamber - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings online, please click on this Live Stream Link.

In line with current Government advice, those attending the meeting are asked to consider wearing a face-covering.

Membership

Chairman - Councillor Jane Hanna OBE
Deputy Chairman - City Councillor Jabu Nala-Hartley

Councillors:	Nigel Champken-Woods	Damian Haywood	Dr Nathan Ley
	Imade Edosomwan	Nick Leverton	Freddie van Mierlo
District Councillors:	Paul Barrow	Sandy Dallimore	
	Jill Bull	David Turner	
Co-optees:	Jean Bradlow	Dr Alan Cohen	Barbara Shaw

Notes: ***Date of next meeting:*** *9 June 2022*

For more information about this Committee please contact:

Chair	-	Councillor Jane Hanna OBE Email: jane.hanna@oxfordshire.gov.uk
Interim Scrutiny Officer	-	*Helen Mitchell* *Email: helen.mitchell@oxfordshire.gov.uk*
Committee Officer	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *Email: colm.ocaomhanaigh@oxfordshire.gov.uk*

Stephen Chandler
Interim Chief Executive

April 2022

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 14)

To approve the minutes of the meeting held on 10 March 2022 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection. In line with current Government advice, those attending the meeting in person are asked to consider wearing a face-covering.

Normally requests to speak at this public meeting are required by 9 am on the day preceding the published date of the meeting. However, during the current situation and to facilitate 'hybrid' meetings we are asking that requests to speak are submitted by no later than 9am four working days before the meeting i.e. 9 am on Wednesday 4 May 2022. Requests to speak should be sent to colm.ocaomhanaigh@oxfordshire.gov.uk .

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

5. Access to Services - Primary Care (To Follow)

10.05

For the Committee to receive a paper from the Oxfordshire Clinical Commissioning Group on the current position of primary care services.

6. **Maternity Services** (Pages 15 - 46)

11.20

For the Committee to receive a report of the Chief Nursing Officer, Oxford University Hospitals FT, on the current position of maternity services.

12:40 Lunch

7. **BOB ICB Strategy for Working with People and Communities** (Pages 47 - 60)

13:15

(Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board)

To receive an initial draft.

8. **Update on Actions** (Pages 61 - 68)

13:45

To receive an update on the progress of actions arising from previous Committee meetings.

9. **Chair's Report** (To Follow)

14:00

To receive an update from the Chair of The Committee on work progressed in between meetings and future issues.

10. **Healthwatch Report** (Pages 69 - 74)

14:15

To receive a report of Healthwatch Oxfordshire.

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 email democracy@oxfordshire.gov.uk for a hard copy of the document.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 10 March 2022 commencing at 10.00 am and finishing at 3.00 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair
	Councillor Nigel Champken-Woods Councillor Imade Edosomwan Councillor Damian Haywood Councillor Nick Leverton Councillor Dr Nathan Ley Councillor Freddie van Mierlo District Councillor Paul Barrow District Councillor Jill Bull District Councillor David Turner
Co-opted Members:	Dr Alan Cohen Barbara Shaw (virtual)
Other Members in Attendance:	Councillor Liz Brighouse Councillor Jenny Hannaby
Officers:	
Whole of meeting	Ansaf Azhar, Corporate Director of Public Health; Helen Mitchell, Scrutiny Officer and Colm Ó Caomhánaigh, Committee Officer

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 additional documents are attached to the signed Minutes.

1/22 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

There were apologies received from City Councillor Jabu Nala-Hartley, District Councillor Sandy Dallimore and Jean Bradlow.

2/22 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Dr Alan Cohen declared a non-pecuniary interest as a Trustee of Oxfordshire Mind.

3/22 MINUTES

(Agenda No. 3)

The minutes of the meeting held on 25 November 2021 were approved and signed as an accurate record.

With regards to the Action List, the Chair noted two updates contained in the agenda published on the previous day for the meeting of Oxfordshire Health & Wellbeing Board on 17 March 2022:

- The Board will consider a Covid Recovery Plan to take effect from May 2022 onwards.
- The Pharmacy Needs Assessment has identified a need for improvement in provision in Oxford City and that a new pharmacy could satisfy that need.

4/22 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chair had agreed to the following request to speak:

Item 8 Community Services Strategy:
Julie Mabberley

5/22 EMOTIONAL WELLBEING OF CHILDREN & CAMHS

(Agenda No. 5)

The Committee received

- a report, as requested, summarising the work completed to date on the development of a shared strategic approach to children and young people's emotional wellbeing and mental health in Oxfordshire;
- a presentation on the Emotional Wellbeing of Children and CAMHS (Child and Adolescent Mental Health Service)
- a briefing paper providing the background information and data.

The presentation was given by Tehmeena Ajmal, Interim Executive Managing Director for Mental Health, Learning Disability and Autism, Oxford Health and Caroline Kelly, Lead Commissioner, OCC / OCCG.

Councillor Liz Brighouse, Cabinet Member for Children, Education and Young People's Services added that the Children's Trust Board was also discussing these issues. She believed that the safest place for a child was in school. However, the education system was fragmented now with only one maintained secondary school in the county. Many neuro-diverse young people were not achieving their entitlement of hours in school due to reduced timetables, exclusions, isolation and other reasons.

Tehmeena Ajmal noted that staff were tired after a couple of very difficult years and more staff were needed. She outlined a number of areas being looked at:

- the Neuro-developmental conditions pathway where assessment, treatment and support are all offered.

- the provision of more services online – some young people prefer it and it offers an opportunity to spread the staff base.
- working with the voluntary sector on in-reach into schools.
- examining if the outcomes-based contracts for services to 18-65 year olds could be expanded to 16-25 years olds where the offer is not quite right yet.

The Chair noted the tight timeline for engagement and asked if they were satisfied that the stakeholder group included the best possible representation. Caroline Kelly responded that there had already been engagement on the needs. They were working with the Council's engagement team and the list of possible initiatives will go to a stakeholder group to make recommendations.

Caroline Kelly added that the timescales were indicative and they can delay if they feel they need to in order to get sufficient engagement. The Health & Wellbeing Board had prioritised this strategy to be implemented this year. She noted that the voluntary and community sector was developing some really innovative services and Oxfordshire was also able to learn through the Integrated Care System what was working in Buckinghamshire and Berkshire.

Asked about additional funding for mental health teams in schools, Caroline Kelly confirmed that additional transformation funding from NHS England was available and that work was in-train on expanding the offer.

Dan Knowles, CEO, Oxfordshire Mind, highlighted some areas in need of focus and investment:

- the length of wait for an autism assessment
- the comorbidity of mental health and autism
- the way in which the pandemic had emphasised inequalities.

He noted that funding for mental health services in Oxfordshire has historically been below average and this was an issue in need of scrutiny. The voluntary sector shared the same workforce issues as the statutory services. What the sector does well was in providing non-clinical, person-centred, strengths-based, community-focussed recovery programmes.

Dan Knowles added that Oxfordshire Mind had communications with 13,000 people per year – about 20% of whom were young people or parents. They were interested to talk about how that resource could be used to benefit young people. There were also active discussions in train around cooperation between third sector organisations to break down silos.

Councillor David Turner asked if support was still being provided to young carers as Cabinet agreed some years ago. Caroline Kelly responded that support was provided through social work teams but they had identified a gap in relation to the provision of respite which they were looking to remedy.

Barbara Shaw asked what was being done to reduce waiting times for children with autism and ADHD which were having an enormous impact on schools. She noted that the proportion of children accepted with neuro-developmental conditions was less than half the number in 2019/20 and asked why.

Tehmeena Ajmal responded that she was concerned that many people were under the impression that they had to get a diagnosis to access support but this was not the case. However, it was correct to say that the current system was not working. There had been three workshops under the Integrated Care Board to discuss what could be done better.

Vicky Norman, Service Manager, Oxford Health, added that they had a very good relationship with an online provider Healios and were agreeing another contract with them. Digital services had allowed them to provide 10,000 more appointments in the first year of the pandemic. There was more group work and one of the most popular groups was advising parents on how to help their children. There was a focus on how to provide support for people on the waiting list.

Jules Francis-Sinclair, Oxfordshire Parent Carers Forum, emphasised that they were very supportive of the good work by CAMHS when children get access the service. She believed that there were problems around communications and managing expectations that can be improved. There was often a lack of continuity with the loss of long-standing clinicians.

OPCF had a new survey which had just closed. They had some feedback that some links sent to parents when they accessed the service were not relevant, particularly for children with SEND. One had to be mindful too of the capacity of parents to deal with so many links. There was a need for more specialised support around self-injurious behaviour and school avoidance and refusal which can lead to more demands later if not dealt with.

The Committee heard an audio recording of the experiences of an 18-year-old woman who had attended sessions at the Mental Wealth Academy which she found very useful in developing strategies to cope better. She had found the CAMHS service frustrating because she had three different clinicians due to illness or leaving the service.

Councillor Damian Haywood asked for more detail on prevention – if Public Health or GP services were involved. Caroline Kelly responded that the strategy was being co-written between Children's Services and Public Health. The aim was that all professionals, in schools, nurseries etc would be trained in mental health to support children with emotional difficulties. NHS England were supporting a range of initiatives.

Ansaf Azhar, Director of Public Health, added that the needs assessment being carried out was also looking to understand the causes. Some conditions cannot be prevented but some can and in some cases conditions can be managed in existing settings such as schools. It was important not just to consider the situation for children but also for the families.

Ansaf Azhar also stressed the importance of having evaluation and lesson-learning built into the strategy to show the impact of the collaborative approach.

Councillor Nathan Ley noted that the figure of a 77% increase in mental health treatment was a national figure and asked if the statistic for Oxfordshire was available. He also asked what the target was for reducing CAMHS waiting times.

Officers responded that the figures for Oxfordshire would come out with the strategy. The target was four weeks and that is being achieved for urgent cases but the service was well outside that for non-urgent.

Dr Alan Cohen noted that mental health services were doing very good work but had been historically under-funded in this county and asked what was being done to identify new funding.

Diane Hedges, Deputy Chief Executive, Oxfordshire Clinical Commissioning Group, stated that the BOB-ICB (Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board) was examining what was being done in each area. Bucks and Berkshire West had already decided on greater investment in mental health services. The situation for Oxfordshire was that there was no doubt investment was needed but currently, to do that, funds would have to be diverted from some other service.

The Chair stated that the Committee would clearly support prioritising resources for mental health and that there should be parity of esteem between mental and physical health services.

Councillor Freddie van Mierlo asked officers what they would do if they had double the budget, if the extra money allocated in the Council's budget for 2022/23 would allow them expand services and for more information on geographic inequalities in the county.

Tehmeena Ajmal responded that, regardless of the money available, there were staffing issues that could not be easily overcome. The best way forward was to build on the partnerships between social care, health and the voluntary sector as well as learning from what works in other parts of the country.

Caroline Kelly added that the feedback from focus groups was that young people want more digital services, to be anonymous and more support in schools. Regarding geographic inequalities, services across the county were being mapped out to identify any gaps.

Councillor Brighouse noted that this all sat within the SEND review and its whole-system approach and was being worked into an overall strategy. She said that there was a real need for more trauma support. The positive was that we had great people working throughout the system and she welcomed the appointments of Matthew Taylor to lead the NHS and Javed Khan as Chair Designate of BOB-ICB.

The Chair thanked all the contributors to the reports and discussion. It was clear that the committee was very concerned at the sheer level of need facing services. They would be more reassured if the funding could be identified to provide the expanded services. She asked all the partners to reflect on the timescales involved in collaboration plans.

6/22 ACCESS AND WAITING TIMES

(Agenda No. 6)

The Committee had received updates on

- Elective Recovery Plans,
- Midwifery Led Units,
- BOB-ICS Workforce and People Strategy and
- Re-opening of Temporarily Closed Specialties.

Sara Randall, Chief Operating Officer at Oxford University Hospitals, confirmed that the remaining specialties had reopened and they continued to work within BOB-ICS to manage the very long waiting lists.

Dr Alan Cohen asked for details of the waiting times for reopened specialties – in particular ENT and Ophthalmology – and how they were handling what must be an enormous surge of referrals.

Sara Randall responded that the overall waiting times were in the information pack but she could supply the specific information on those two. She confirmed that there would not be any patients waiting more than two years by the end of March and the numbers waiting more than a year had been steadily reducing. They had task and finish groups working on solutions across the BOB-ICS to ensure patients were seen in a timely way. Advice and guidance was being provided to GPs.

Councillor Freddie van Mierlo asked if there was now a two tier system with those who can afford it going to the private sector and others having to wait. He asked how many patients were leaving the waiting lists to be seen by the private sector.

Sara Randall responded that she could only speak for the NHS but referrals were being prioritised by urgency. She would know how many people left waiting lists but would not necessarily know where they went. She offered to get whatever information was available on that.

Councillor Nick Leverton gave an example where he had received a prompt service from an independent provider paid for by the NHS. Sara Randall agreed it was an example of effective cooperation with the independent sector.

The Chair asked when the Committee could see the recovery plan currently being developed. Sara Randall replied that there was an elective care board working on the issues on behalf of the ICS. She would ask them to advise on when that would be ready to be seen by the Committee.

The Chair asked for more information on the reasoning for the temporary closures of some local maternity units and the levels of absences through sickness. Sara Randall reported that the closures were being reviewed on a weekly basis. It was due to safety concerns around staffing levels during the latest Covid surge. It was a problem across the region and the country. Overall the numbers out with Covid had reduced from a high of 600 to around 200. She did not have figures for maternity but would get them for the Committee.

Councillor Damian Haywood asked about nursing recruitment rates. Sara Randall stated that international recruitment was going well but there were some particular areas of shortage. She agreed to get data on that.

James Scott, People Strategy Programme Director, BOB-ICS, summarised the ICS People Plan that includes five programmes and multiple projects such as recruitment, retention, apprenticeships and evaluation.

Councillor Damian Haywood asked what the local authority could do to help. James Scott responded that it would be good to have some follow-up meetings on it. There were gaps in the plan with regard to some social care and third-party services and the strategy was rather 'trust-heavy'. He offered to come back to the Committee when he had identified the gaps more clearly.

Barbara Shaw noted that there were a lot of abbreviations in the paper that many people would not understand. She asked if it was possible to see the impact on Oxfordshire – not just across the BOB region. James Scott agreed to provide that information and apologised that the paper had initially been intended for internal use.

Councillor Nick Leverton suggested that the council could help staff by ensuring they could have free parking on site at the various facilities.

James Scott also identified the cost of living in the BOB region as a difficulty and stated that a case was being put together to argue for a supplement similar to that operating in London.

Actions:
Sara Randall to provide information on

- **the waiting times for ENT and Ophthalmology;**
- **the number of patients who have removed themselves from elective treatment waiting lists;**
- **the new elective care access offer across the BOB footprint (the provider collaborative);**
- **vacancy and sickness rates across midwifery;**
- **nursing recruitment.**

James Scott to

- **meet Members separately to explore workforce challenges across Oxfordshire/the NHS**
- **provide information on impact in Oxfordshire**

7/22 INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD

(Agenda No. 7)

The Committee received an update on development of the Integrated Care System and Integrated Care Board. Catherine Mountford, Director of Governance, Oxfordshire Clinical Commissioning Group, summarised the report emphasising that many aspects were still subject to change as the legislation was still going through parliament. The final guidance was expected early April with the system aimed to function from 1 July.

Members noted the new positions to be appointed and national reports of management consultants being engaged to work on elements of ICS's and asked if this was introducing another layer of administration and costs.

Catherine Mountford responded that it was not expected that the running costs of the ICB (the new NHS statutory body) would be larger than the combined costs currently for the three separate organisations. A number of the positions were required under the legislation. Consultants were providing advice on governance which was helpful. Any such contracts were subject to NHS approval and had to be within the budget envelope.

Dr Alan Cohen noted that there was to be engagement around local determination and asked who made the final decisions on that. He also asked why there was no mention of scrutiny in the draft constitution.

Catherine Mountford responded that there were currently a Chief Executive designate and Chair designate who would make those decisions subject to approval by NHS England. They would expect to have a review of Board membership within the first year. The draft constitution used the NHSE template and there was a reference in that to compliance with local authority scrutiny arrangements but without any detail on that.

The Chair noted that there was some anxiety around the situation where the ICB was going to be an NHS body dealing with social care. Questions remained about how the local authorities were to be involved and how the cultural differences would be addressed. There was also a lot of concern that many of the meetings were not to be held in public. She asked if there was still scope to deal with these issues.

Catherine Mountford welcomed the points being raised. She said that it was clear that care will remain managed at Place with local input.

Stephen Chandler, Chief Executive, Oxfordshire County Council, responded that he recognised and understood the concerns being expressed. He believed that the Committee should look, not just at how the Board would work, but also how the local structures will operate. He was aware of a recent report that was critical of the NHS culture but he had seen no evidence of it in the people he had dealt with on the ICS.

Councillor Freddie van Mierlo asked to focus on how services were going to change for the people of Oxfordshire. He gave the example of differing policies on In Vitro Fertilization across the three counties and asked how that would be resolved.

Diane Hedges responded that work would have to be done to identify the differences in services across the region. The priorities committee would be involved in advising on solutions.

Councillor Nick Leverton asked if this Committee was safe under the new structures. Catherine Mountford responded that the local authorities decided on scrutiny and it was their decision to set up a HOSC at BOB level in addition to the local HOSCs.

Actions:
Members will engage with Catherine Mountford and OCC about the evolution of the ICS/ICB from a governance perspective and how/where democratic references can influence how the ICB/ICS operates in practice.

The convergence of service offer across BOB is to be placed on the Committee's work programme.

8/22 COMMUNITY SERVICES STRATEGY

(Agenda No. 8)

The Committee had before it a paper providing a brief update on the Oxfordshire Community Services Strategy which proposed a way of working with members of JHOSC, the public and other key stakeholders to ensure engagement was as effective as possible.

Before considering the report, the Chair had agreed to a request to speak on this item:

Julie Mabberley welcomed the appointment of Helen Shute as Programme Director and hoped that this will enable a detailed timeline to be produced for the Strategy. She asked for more information about the way that this project will be scrutinised by HOSC and repeated a number of questions that she said had not yet been answered:

- More clarity was needed on what the Strategy was intended to do.
- While it was anticipated new services for mental health in Wantage could see a potential 300 people a month being assessed, it wasn't clear if this will be 300 in Wantage or across Oxfordshire.
- If birthing does not reopen in March when does this become a "substantial change" subject to public consultation?
- How will the changes taking place in the direction and content of the strategy affect the future of in-patient beds at Wantage?
- Was a minor injuries unit in the hospital being considered?

Helen Shute, newly appointed Programme Director, Community Services Strategy, Oxford Health, summarised the Strategy as providing the people of Oxfordshire with the right care at the right time in the right places supported by the right resources. She planned to put in a programme structure to make it clearer what they intend to do and the progress they are making along the way. She would provide timescales once she had scoped what was required.

On an issue such as a minor injuries unit, they will look at the county as a whole, the needs and what is currently available and other issues such as transport, parking etc. They will also consider what care can be delivered at home given new technologies available.

Dr Ben Riley, Executive Director, Primary, Community and Dental Care, Oxford Health, added that the principles of the strategy, which were updated following the public engagement work last year, had been adopted by the Health and Wellbeing Board in December. There were a large number of proposals being considered.

The pilots at Wantage were going well – notably Ophthalmic and Audiology Services and a wide range of mental health services. Most people using those services were from the south west of the county. Oxford University Hospitals, the provider of the Birthing Unit at the Hospital, had indicated that they hoped to reopen this service within a few weeks. 219 responses have been received on the new out-patient services and they will have been evaluated by the time HOSC Members visit the hospital in May.

The Chair reported that she had already arranged to meet with Helen Shute to discuss the lessons to be learned from the previous experience of the OX12 Task and Finish Group.

District Councillor Paul Barrow stated that one of the difficulties for the OX12 group had been understanding the rationale and evidence base for decisions being made. He hoped that this aspect could be addressed in updates on the programme.

Dr Alan Cohen expressed concern that Community Services might mean different things to different people and there needed to be a discussion around that – possibly a joint meeting with this Committee and the Health & Wellbeing Board as had been previously suggested.

Helen Shute responded that they would be clearer on that and have discussion on it when the Committee visits Wantage on 4 May.

Barbara Shaw noted the reference in the report to 40 possible projects and asked if they could see that list to help them visualise what was intended. Helen Shute responded that some of the 40 were not really projects but were enablers or continuous improvements. She will come back to the Committee with a clearer list of projects.

The Chair emphasised that the in-patient beds issue was also of great concern to people and that work had still to be done to estimate the number of in-patient beds needed across the county given the experience of the pandemic. She asked for a further update on progress on the Strategy for the June meeting.

9/22 COVID UPDATE
(Agenda No. 9)

The Committee received a presentation on the cumulative impact of Covid-19 through 2020 and 2021 and an update on the vaccination programme.

Ansaf Azhar, Director of Public Health, summarised the current position which was that we were now moving into the recovery phase in which we needed to learn to live with Covid. There was still a need to move cautiously and consider how to protect the vulnerable against current and future threats.

The presentation looked at the direct impact and, at future meetings, the Committee would be welcome to consider the indirect impacts on health and care services and then the wider impacts on employment, education and mental wellbeing, once further

work had been completed to more fully understand these. David Munday, Consultant on Public Health, gave the presentation.

The Chair asked officers to address the concerns raised in emails from members of the public who were vulnerable and not feeling safe since the main Covid restrictions had been lifted.

Ansaf Azhar emphasised that the priority was still to protect the vulnerable and he had reiterated this in statements. Since the vaccine roll-out there has been no evidence that Covid is any worse than other respiratory illnesses. In January there had been no excess deaths despite the surge in Covid infections.

However, he urged everyone to continue the good practices developed during the pandemic – wearing face masks in crowded settings, keeping distance etc. A lot had been learnt about dealing with infectious disease that needed to be embedded in the culture in order to protect the vulnerable. New national policies were coming to address this.

Ansaf Azhar assured the committee that acute services and care services were still observing all the Covid precautions such as face masks.

Councillor Imade Edosomwan asked if vaccine certificates were required for health staff as he had heard reports of staff being asked to produce them.

Ansaf Azhar responded that it was not mandatory for health and care staff to be vaccinated. The position was that they were all strongly encouraged to get vaccinated.

Karen Fuller, Interim Corporate Director for Adult Services, confirmed that vaccination had been a condition of employment for social care staff and they had worked with staff to achieve near 100% compliance. The government had changed policy on that so it was no longer mandatory.

Councillor Damian Haywood asked about staff who had been removed from post due to this requirement and if they had been re-employed since the requirement had been dropped.

Karen Fuller responded that this was down to the individual employer. At the County Council the small number of staff involved had been re-deployed to other posts that did not require vaccination.

Barbara Shaw asked if there was information on the impact of long-Covid on health services. David Munday responded that research was still in progress on diagnosing long-Covid and the needs of patients as a result. The NHS was providing support and perhaps they could be asked to present at a future meeting on this.

Councillor Damian Haywood referred to reports that had concluded that the national response to the pandemic had been poor. He asked if we were well placed to handle any future pandemic.

Ansaf Azhar agreed that there were a lot of lessons to be learned from how the first wave was handled although the health service itself should certainly be thanked for how it responded and minimised deaths. He believed that the subsequent waves were dealt with well.

The surveillance group was still meeting once a week and while measures were being wound down there was a clear checklist available of what needed to be done to ramp up quickly again if needed.

Actions:
Karen Fuller to meet with the Chair, Councillor Barrow, Barbara Shaw and Dr Alan Cohen on infection control in care homes.

The Covid-Recovery Plan to be on the agenda for the May HOSC meeting.

10/22 CHAIR'S REPORT

(Agenda No. 10)

Members accepted the Chair's Report and agreed the actions within it.

11/22 HEALTHWATCH REPORT

(Agenda No. 11)

The Committee received a report from Healthwatch on views from the public on health and care issues. This included a report on a survey of GP practices. The Chair invited Glyn Alcock, Healthwatch Researcher, to summarise the report.

Glyn Alcock stated that the report was based on over 700 responses to the survey. They found that most people were contacting their GP practice by telephone. There was a lot of frustration at long waits. Some people found the call back facility useful but it was not suitable for people who were at work for example and unable to take a call back at an unspecified time.

Online facilities like eConsult and the NHS App were useful alternatives to phoning for some basic functions such as repeat prescriptions but could be cumbersome to use. The feedback indicated that people were very happy with the service received once they got through – the problem for many was long waits and in some cases people gave up.

The report was sent to GP practice managers after publication and much of the response from them was about the limits on their clinical capacity.

The Chair added that practices had also made the point to her that they had no choice in eConsult and there was a lesson there in the importance of codesign.

Councillor Damian Haywood asked if the Committee should invite NHS England to come to a meeting as they were responsible for issues such as eConsult, not the Clinical Commissioning Group.

Helen Mitchell, Scrutiny Officer, reported that she had been in touch with NHS E/I in relation to the vaccination programme and they had indicated that they would be happy to attend as long as there was clarity around what they were expected to address. They had a clear role in relation to Primary Care and it would be reasonable to invite them to the Committee on that issue.

Councillor Nick Leverton stressed the importance of discussing dentistry which was becoming more urgent. The Chair noted that it was among the items for consideration for the Committee's Work Programme for the next Council Year 2022/23.

Rosalind Pearce, Executive Director, Healthwatch, asked that the BOB-ICS report be rewritten to explain the acronyms as it would be mostly unintelligible to members of the public.

Action:
To support the discussion on 10 May, an appropriate officer from NHS E/I will be invited to attend to discuss primary care challenges and opportunities.

..... in the Chair

Date of signing .....

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Oxford University Hospitals
NHS Foundation Trust

Maternity Summary Slides

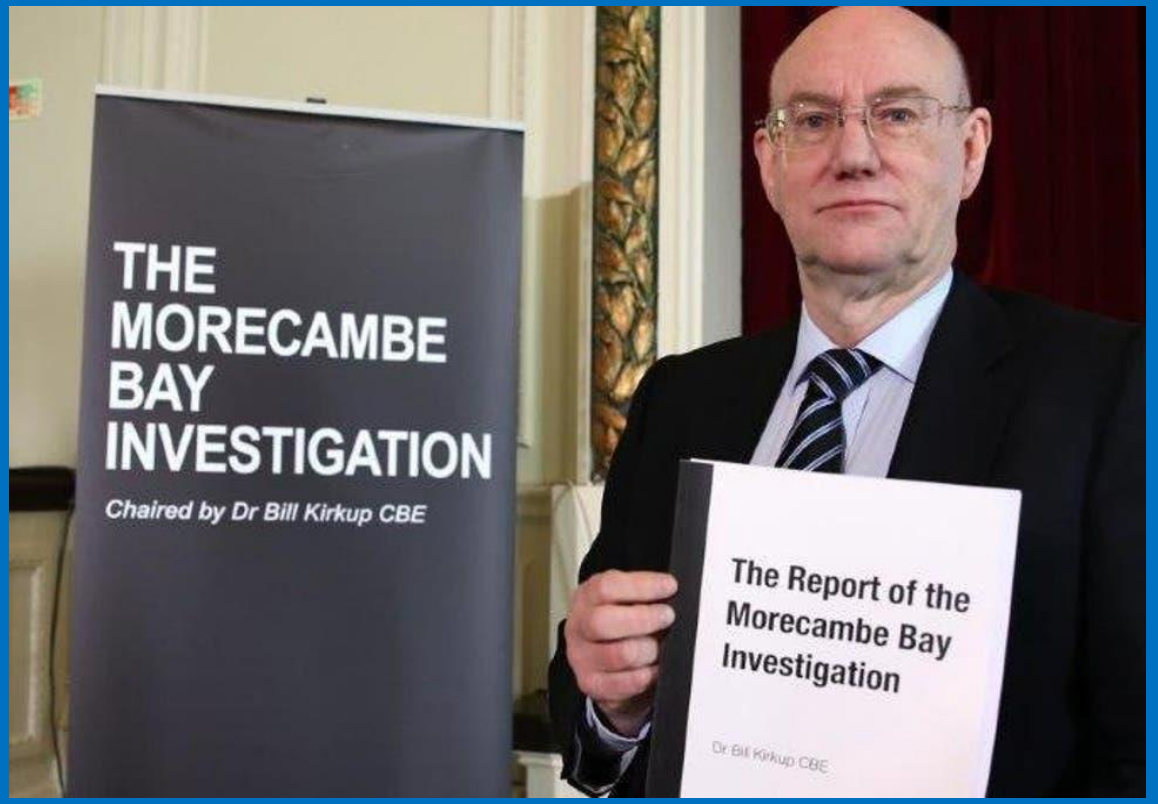
Sam Foster
Chief Nursing Officer
09/03/2022

Responsibility for safety…

“The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them...

The prime responsibility for ensuring that they provide safe services, and that the warning signs of departure from standards are picked up and acted upon, lies with the Trust, the body statutorily responsible for those services.”

Dr. Bill Kirkup



National maternity safety ambition

‘Halve it’ campaign

Our Collective aim is to make measurable improvements in safety outcomes for women, their babies and families in maternity in neonatal services, as set out in Better Births in 2016.

This includes halving the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025 (2010 baseline), with a 20% reduction by 2020. Also, reducing pre-term births by 25% (2015 baseline) by 2025 by reducing the pre-term birth rate from 8% to 6%.

Local Maternity Systems and Provider organisations have been undertaking a range of safety interventions and should continue to throughout the Long Term Plan (LTP) period, in order to meet the safety ambitions.

The journey to a national maternity safety ambition

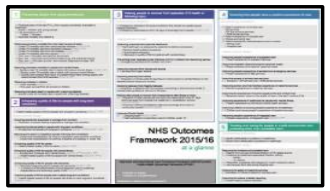
2014
Five Year Forward View

2015 – National Ambition

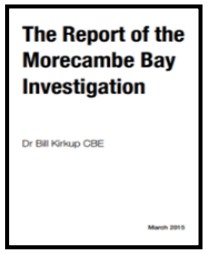
2016 – Safer Maternity Care Action Plan

2019 - Implementing the Neonatal Critical care review Recommendations

2010 - NHS Mandate & Outcomes Framework



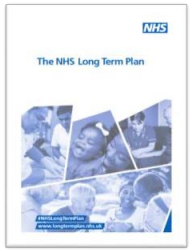
2015 – Kirkup Report



2016 – Better Births

2017 – Progress and next steps

2019 - Long term Plan



A key theme of the National reviews has been the voice of the parent, as a Board we must ask ourselves:

A parent's view: my challenge to board level safety champions

Nicky Lyon, Campaign for Safer Births and User Co-Chair of the National Maternity Safety Workstream, asks the following questions for Board level safety champions:

HOW DO YOU KNOW…

- If your unit is delivering the safest care possible?
- Do you read feedback and comments from parents? What changes have you made in response?
- Is your unit following all current guidelines? Are they documented, trained and audited?
- Have you checked that the staff in your unit have all the resources, training and support they need to do their job well?
- Is the MDT training developed in your trust with joint training briefings and handovers?
- Are you investigating all SI's and perinatal deaths robustly with external representation and invited parental input?
- Do you know how many stillbirths there have been in your unit? How many occurred in labour? How many SI's?
- Have you briefed the Board on maternity safety and the activity you would like to undertake to improve further?

Find out more: A parent's view: my challenge to board-level maternity safety champions

The National requirements that require board assurance in this timeframe include:

- **The Ockenden Report (2020) :** The report from the outset set out to give a **parent's a voice** so their concerns could be addressed- **Based on the serious failings** in maternity care initially raised by two bereaved families in 2016 at the Shrewsbury and Telford maternity hospital – subsequently over 250 case reviews have been undertaken and the themes of these led to National recommendations. The Board received initial an initial declaration endorsed by the Chief Executive Officer against 12 specific urgent clinical priorities which was submitted to NHSI in December 2021, following this, an assessment against seven immediate and essential actions (IEAs) were completed and reported to Trust Board in June 2020 - One year on Trust Boards are asked to review their position.

Maternity Incentive Scheme (**MIS**) The scheme supports **the delivery of safer maternity care** through an incentive element to trust contributions to the CNST. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care.

- **Continuity of Carer -** Evidence shows that continuity models improve safety and outcomes – “Better Births First and foremost continuity of carer means that there is consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: • Pregnancy • Labour • The postnatal period

- **CQC Action plan** following the visit in 2021 and the Results of the **CQC Patient Maternity Survey** published in February 2022

- **Safe staffing –** One of the MIS requirements is bi-annual assurance to the Trust Board on Midwifery staffing

- **Perinatal Mortality Review-** To be taken in private session as risk of identification of patients.

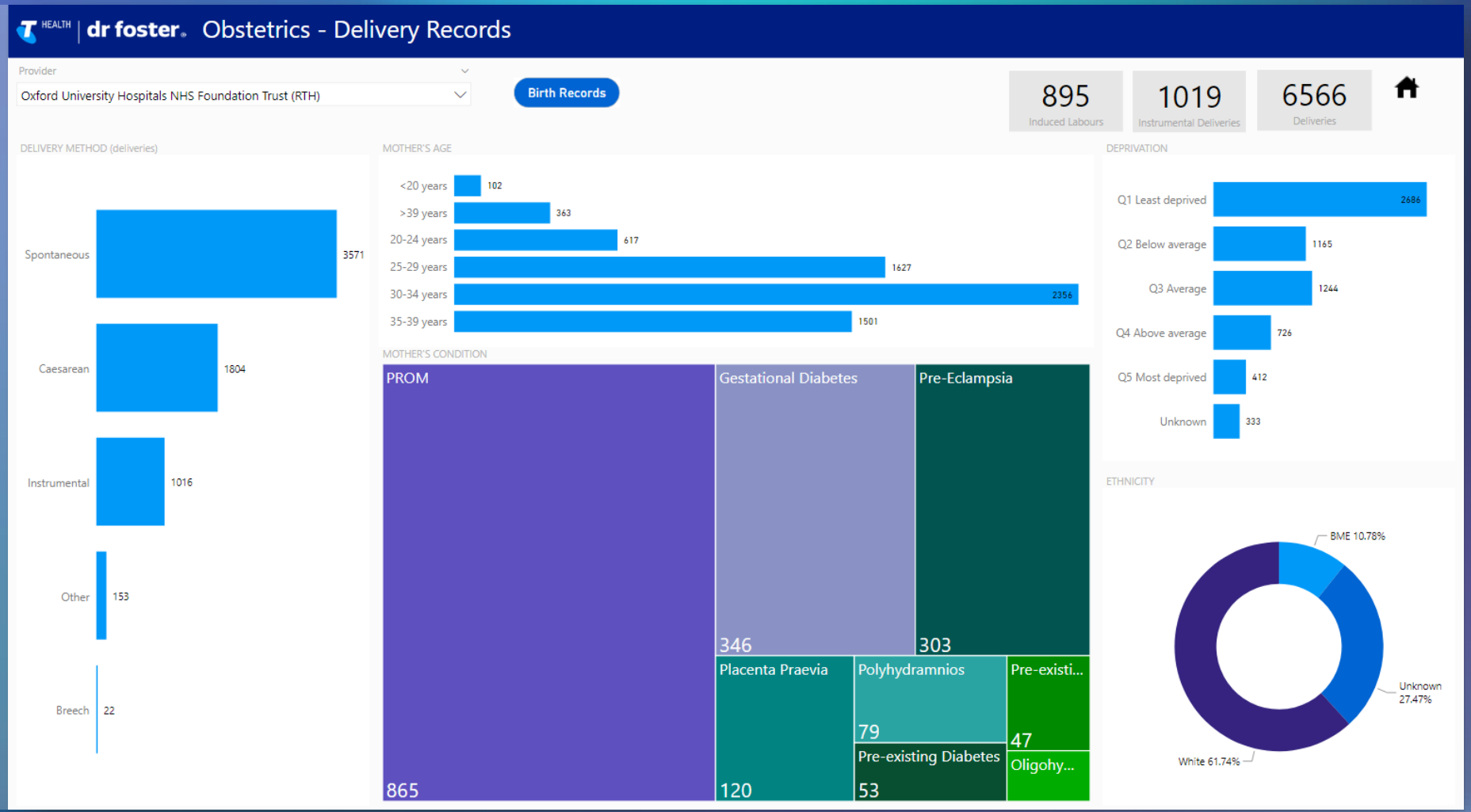
Activity Summary – delivery records

The Trust reports 6,566 deliveries in the 12 month period

3,571 = spontaneous vaginal
1,804 = caesarean section
1,016 = instrumental

- 36% (2,356) of mothers are aged 30-34yrs
- 41% of mothers fall into 'least deprived' (i.e. most affluent) deprivation quintile
- 61.7% of mothers identify as 'white' ethnicity

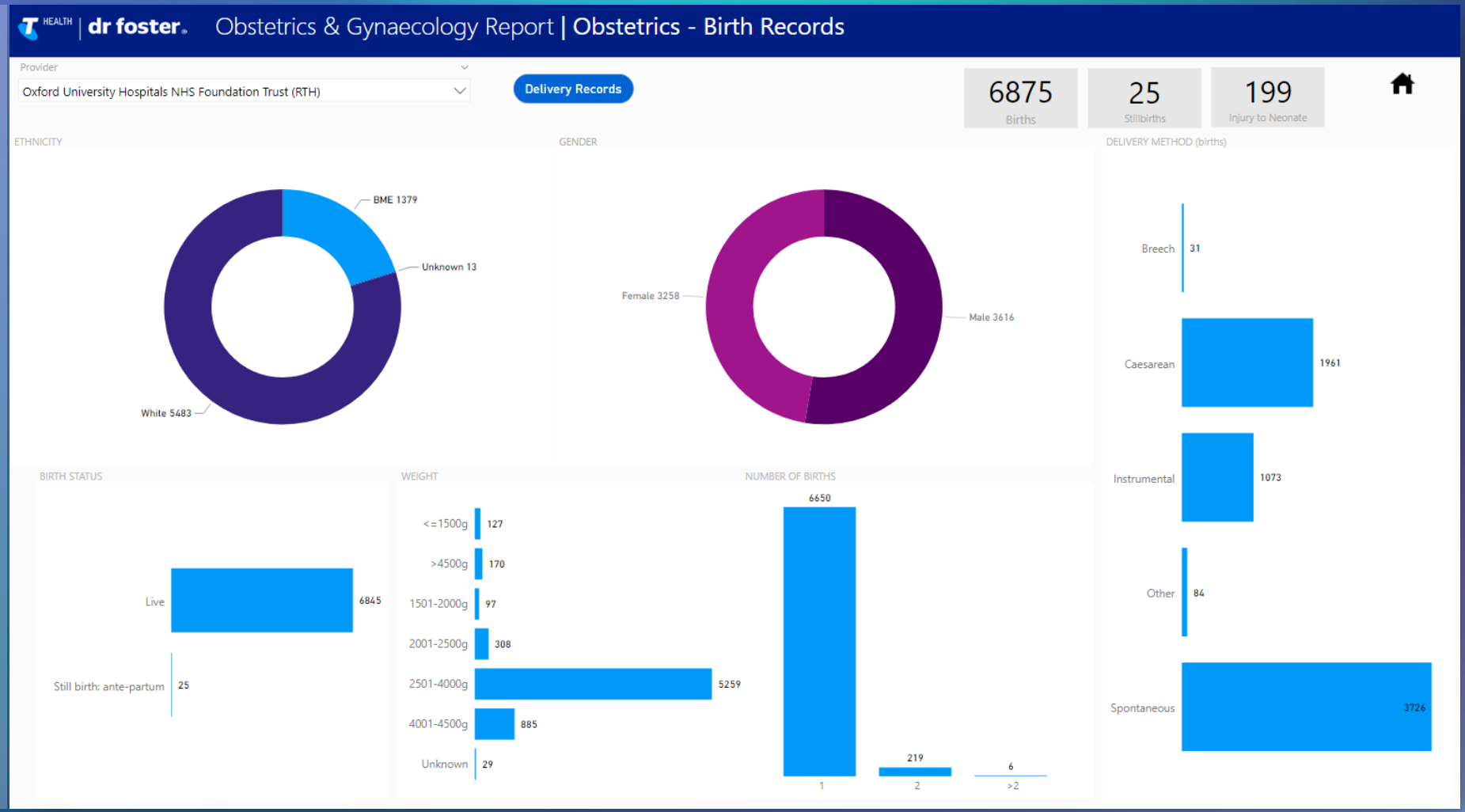
- 13.2% (865) mothers were diagnosed with PROM
- 5.3% with gestational diabetes
- 4.1% with pre-eclampsia



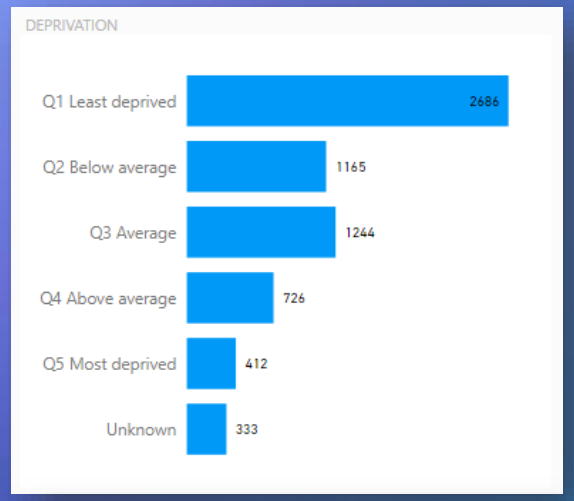
Activity Summary – births

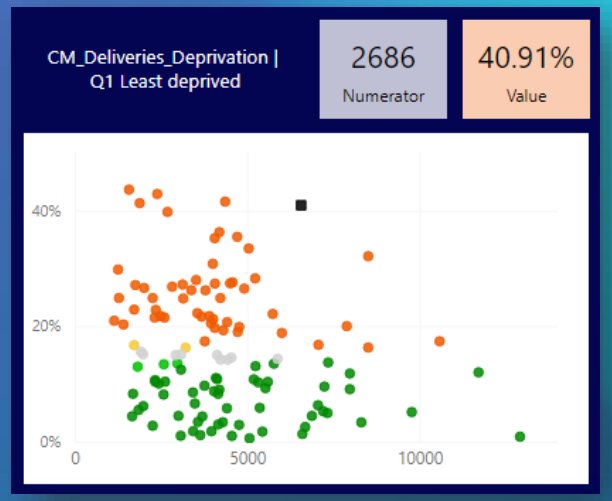
Of the 6,875 births in the year:

- 5,259 (76.5%) babies have a birthweight of 2501-4000g
- 127 (1.9%) babies have a birthweight of <1500g
- 225 (3.3%) babies are multiple births
- 25 stillbirths have been recorded in the data in the last 12 months

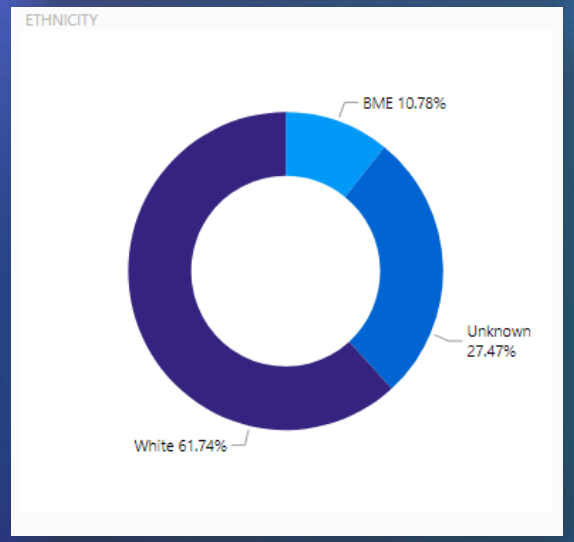


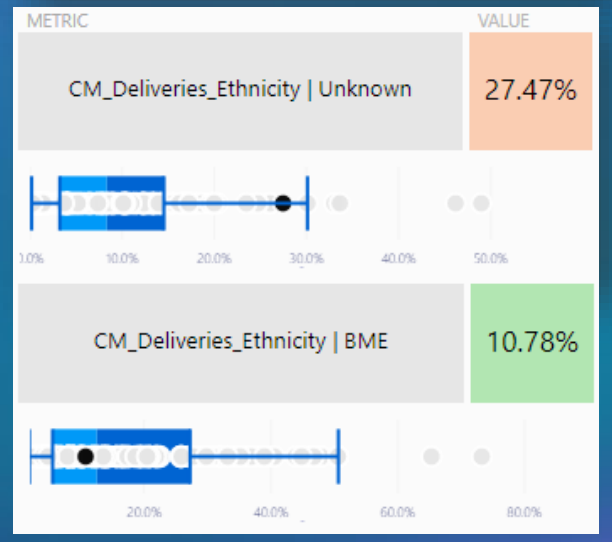
Case Mix – ethnicity & deprivation





- 41% of deliveries were by mothers in the lowest quintile of deprivation
- This is significantly higher than the national position
- The greater the quintile of deprivation the lower down the scatter plot OUH appears, suggesting that the mothers choosing to deliver at OUH are less deprived than in the peer





- The mother's ethnicity was unknown, or unrecorded in 27.5% of cases
- This compares poorly with the peer being well into the upper quartile
- If ethnicity is under-recorded comparison becomes less informative when reviewing health inequalities
- Black and minority ethnic (BME) mothers are slightly lower than the mean, but well inside the interquartile range

NATIONAL MATERNITY REVIEW

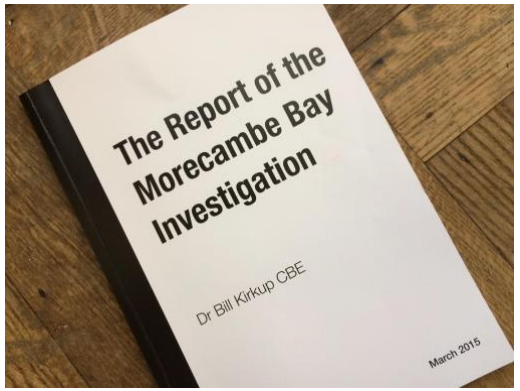
BETTER BIRTHS

Improving outcomes of maternity services in England

A Five Year Forward View for maternity care

CareQuality Commission

NHS
Oxford University Hospitals
NHS Foundation Trust



NHS Resolution

- Key focuses:
  Digital Roadmap agreement
  Estates options
  Bids for workforce development
  Develop training compliance assurance

Ockendon Assurance Tool 1 year on

Oxford University Hospitals NHS Foundation Trust

	Criteria	RAG	Review Comments
IEA 1	Enhanced Safety		There were two areas that evidence had not been provided for in June 2021. Evidence supplied since that date (please see Ockenden paper: One Year on)
IEA 2	Listening to Women and Families		Criteria compliant & evidence linked to assurance tracker.
IEA 3	Staff Training and Working Together		Action plans are in place to demonstrate how we will meet this IEA.
IEA 4	Managing Complex Pregnancy		Criteria compliant & evidence linked to assurance tracker.
IEA 5	Risk Assessment Throughout Pregnancy		Action plans are in place to demonstrate how we will meet this IEA.
IEA 6	Monitoring Fetal Wellbeing		Action plans are in place to demonstrate how we will meet this IEA.
IEA 7	Informed Consent		Action plans are in place to demonstrate how we will meet this IEA.
Section 2	Workforce Planning		Action plans are in place to demonstrate how we will meet this IEA.
	NICE Guidance related to maternity		Action plans are in place to demonstrate how we will meet this IEA.

Morecombe Bay Review

	Criteria	RAG	Review Comments
1	Is an apology given to those affected, for the avoidable damage caused and any previous failures to act.		Criteria compliant & evidence linked to assurance tracker.
2	Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.		Action plans are in place to demonstrate how we will meet this requirement.
3	Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.		Criteria compliant & evidence linked to assurance tracker.
4	Continuing professional development of staff and link this explicitly with professional requirements including revalidation.		Action plans are in place to demonstrate how we will meet this requirement.
5	Promote effective MDT working, joint training sessions.		Criteria compliant & evidence linked to assurance tracker.
6	Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care.		Action plans are in place to demonstrate how we will meet this requirement.
7	Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols.		Action plans are in place to demonstrate how we will meet this requirement.
8	Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience.		Criteria compliant & evidence linked to assurance tracker.
9	Joint working between its main hospital sites, including the development and operation of common policies, systems and standards.		Criteria compliant & evidence linked to assurance tracker.
10	Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing.		Criteria compliant & evidence linked to assurance tracker.
11	Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance.		Criteria compliant & evidence linked to assurance tracker.
12	Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.		Action plans are in place to demonstrate how we will meet this requirement.
13	Review the structures, processes and staff involved in responding to complaints, and learning are the public involved.		Criteria compliant & evidence linked to assurance tracker.
14	Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.		Action plans are in place to demonstrate how we will meet this requirement.
15	Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care.		Action plans are in place to demonstrate how we will meet this requirement.
16	Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality and provide appropriate guidance and training.		Action plans are in place to demonstrate how we will meet this requirement.
17	Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women		Action plans are in place to demonstrate how we will meet this requirement.
18	All of above should involve CCG, and where necessary, the CQC and Monitor.		Criteria compliant & evidence linked to assurance tracker.

Maternity Incentive Scheme

Oxford University Hospitals NHS Foundation Trust

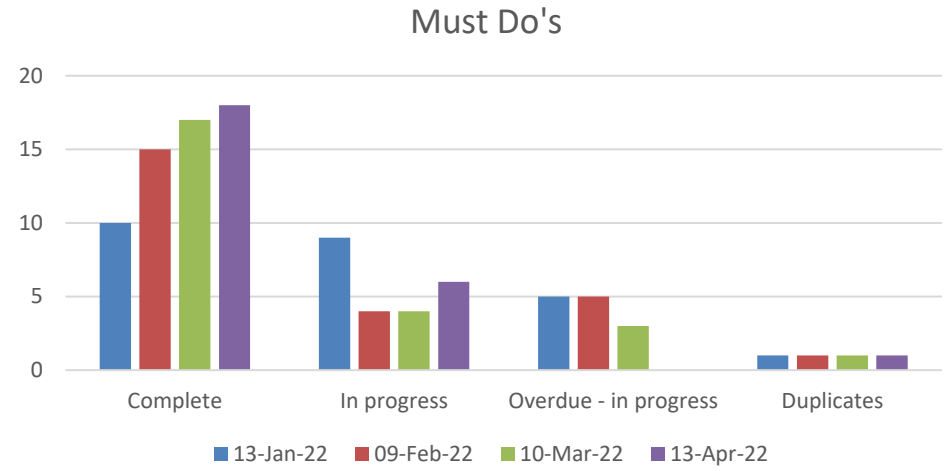
	Criteria	RAG	Review Comments
1	Are you using the PMRT to review perinatal deaths to the required standard?		Expecting to be compliant, evidence linked to assurance tracker
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Action plans are in place to demonstrate how we will meet this safety action (SA).
3	Can you demonstrate that you have transitional care services in place to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		Action plan developed to fully implement the pathway into transitional care.
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?		Action plans are in place to demonstrate how we will meet this safety action (SA).
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Expecting to be compliant, evidence linked to the tracker.
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (Version 2)?		Action plans are in place to demonstrate how we will meet this safety action (SA).
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?		Expecting to be compliant, evidence linked to assurance tracker.
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?		Action plans are in place to demonstrate how we will meet this safety action (SA).
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?		Action plans are in place to demonstrate how we will meet this safety action (SA).
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?		Expecting to be compliant. All qualifying cases have been reported to HSIB for 2021/22 to date.

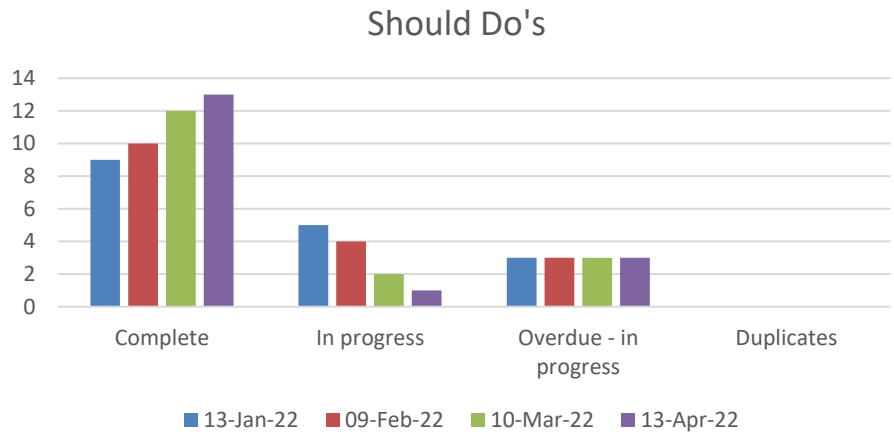
Continuity of Carer (CoC) as default model (Better Births requirement)

Oxford University Hospitals NHS Foundation Trust

Criteria	Review
National reports and assurance requires a plan to implement continuity of carer (CoC) as the "default model of care" by 21 March 2023 where staffing allows and building blocks are in place.	Guidance published 2021, now requires specific team structure and a midwifery working pattern that ensures the midwife follows the woman through every aspect of her care.
OUH current position	Lotus team is the only model of care that meets the criteria equates to 1% Mapping demonstrates the localities of greatest need to improve maternal and fetal outcome. Limited staff engagement as current establishment does not support expansion of the required model.
Proposal for implementation	Phased approach dependent on funding and resource available through the LMNS. Geographical based teams will be deployed dependent on monies and staff available to the areas that deliver best outcomes to the most vulnerable and deprived families.
Full business planning required	Paper to be submitted to TME on the confirmation of nationally available monies to support a significant increase in funded establishment to safeguard current provision of local and tertiary services and the implementation of full CoC.
Risks associated with achievement of CoC as a default model	Finance, staff engagement, recruitment to case loading teams

CQC Action Plan Update





- An unannounced inspection of maternity services across including onsite visits to the Women's Centre at the John Radcliffe Hospital, The Cotswold Birth Centre and the Horton Midwife Led Unit commenced 27 May 2021. The report was published on 02 September 2021. The outcome of this inspection resulted in a change of rating from good to requires improvement. A range of good practice was noted in the report alongside opportunities for improvement, with recommendations for nine 'must do' actions and eight 'should do' actions.
- An associated action plan was developed by the service and shared with CQC. The 17 overarching actions in the plan comprise 49 discrete actions (including one duplicate).
- Progress is reported through established governance processes. The action plan remains a standing agenda item on the Maternity Safety Champions meetings and has informed conversation with the executive team and our inspectors at the quarterly engagement meetings with the Chief Officers.
- The outcome of the inspection and action plan progress were, and continue to be the focus of targeted communications to a range of key stakeholders including service users, the Nursing and Midwifery Council, Partner Higher Education institutions, Maternity Voices Partnerships representatives and the Berkshire, Oxford and Buckinghamshire Local Maternity System.

2021 CQC Maternity Survey Results

Oxford University Hospitals NHS Foundation Trust

The results for the Maternity 2021 survey were published by the Care Quality Commission (CQC) on 10th February 2022.

- 533 patients were invited to take part, 264 completed the survey giving OUH Trust a 50% response rate, this was a 2% increase compared to the Trust's rate for the last survey in 2019. However, is 3% lower than the national average response rate of 53% for this year.
- CQC results show that: OUH Trust results were **better** than other trusts for 2 questions- (choice where to have their baby and feeding advice during evenings, weekends and nights)
- OUH Trust results were **worse** than other trusts for 1 question- (information and explanations given after the birth of their baby)
- OUH Trust results were **about the same** as other trusts for 47 questions.
- The Trust scored **better** than other Trusts for the first section of the survey "The start of care in your pregnancy".
- There were 15 questions in which the Trust shows a statistically significant decrease compared to the comparable results from the 2019 survey.

The report from the CQC summarises 5 areas where mothers' experience is **best** in OUH Trust and 5 areas where mothers' experience could **improve**:

The 5 areas identified as best were:

1. Mothers being offered a choice about where to have their baby during their antenatal care.
2. Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
3. Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
4. During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
5. During antenatal check-ups, mothers being asked about their mental health by midwives.

The 5 areas where the Trust could improve were identified as:

1. Mothers being involved in the decision to be induced.
2. Mothers being given enough information on induction before being induced.
3. Mothers being given the information or explanations they needed while in hospital after the birth.
4. Mothers having the opportunity to ask questions about their labour and the birth after the baby was born.
5. The midwife or midwifery team appearing to be aware of the medical history of the mother and baby during care after birth.

Safe Staffing Q1 and Q2

Oxford University Hospitals NHS Foundation Trust

Criteria	Review Comments
A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been calculated.	Data collection and submission for full BR+ reporting has been undertaken. Full report available by April.
Planned versus actual midwifery staffing levels – to include evidence of mitigation/escalation for managing a shortfall in staffing.	Mitigation contained within escalation policy followed to ensure safe care. Details within the maternity safe staffing paper.
Action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken.	Q1 and Q2 recruitment has netted 24.65 wte. In the same period there were 24.83wte leavers. Data collection and submission for full BR+ reporting has been undertaken. Full report available by April.
Midwife: birth ratio	The midwife to birth staffing ratio for Q1 averaged 1:25.80 and Quarter 2 averaged 1:29.59.
Percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus®	In Q1 and Q2 the number of management and specialist midwife roles in post accounted for 7.94% of the workforce in line with
100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour	In this data period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status.
Number of red flag incidents (associated with midwifery staffing)	The top three “Red Flag” incidents for the Q1 and Q2 are staff moving between areas, beds not opened to fully funded number (Wantage and Chipping Norton MLU’s closed) and staff working over their scheduled finish times.

- Summary and Next steps:

The Board are asked to receive and note the papers.
To discuss the progress one year post Ockendon review – also considering Morcombe Bay recommendations
To discuss the support required to deliver the national frameworks and recommendations
To support a future board seminar to review clinical outcomes

Dashboard

Champions' development and actions

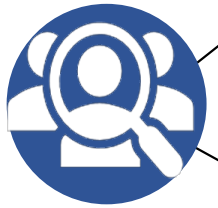
Oxford University Hospitals
NHS Foundation Trust

Thank you

Any questions…?

- Supplemental information

Key roles and responsibilities of the Board level Safety Champion



Your role is to provide proactive board level leadership to ensure that:

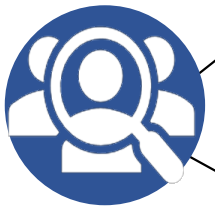
- ✔ High quality clinical care
- ✔ Maternity and neonatal service and facilities
- ✔ Workforce numbers
- ✔ Learning and training systems and
- ✔ Effective team working

are all in place

- ✓ **Oversee effective learning from incidents**
- ✓ Share learning as well as successes within and beyond your own trust
- ✓ Promote authentic engagement with service users who access maternity services
- ✓ **Act upon their feedback to help deliver services which are some of the best in the world**

The Board Safety Champion is ideally a non-executive director and the same individual providing executive sponsorship for the MatNeoSIP, acting as a conduit between the Trust board and frontline safety champions.

Key roles and responsibilities of the Board safety champion



- ➔Engage with staff and service users to determine views on safety and staff satisfaction through walkabouts, audit, investigation and user feedback
- ➔Review the quality of investigation reports and ensure they meet national standards;
- ➔Ensure Duty of Candour is upheld
- ➔Address recommendations from investigation findings; provide leadership and oversight for improvement
- ➔Ensure services are following national guidelines
- ➔ Oversee reviews and audit if the Trust is identified as an outlier
- ➔Ensure standards for effective data quality and coverage, as defined by NHS Digital in the new data quality standards are being met

Key contacts

- ➔ Maternity Voices Partnership User Chair
- ➔ Board level maternity safety champion
- ➔ Regional Chief Midwife
- ➔ Regional Lead obstetrician
- ➔ Local Improvement lead for MatNeo SIP
- ➔ Operational Delivery Network leads
- ➔ Lead commissioner for safety in LMS
- ➔ Maternity Transformation programme leads
- ➔ National Maternity Safety Champions

Further information and detail is set out in ‘Transforming Perinatal Safety’ resource pack

Safety champions – ask each other:

- How do you maintain oversight of safety incidents and monitor outcomes in relation to stillbirth, neonatal death, neonatal brain injury and maternal mortality?
- How are you balancing the response to COVID-19 with the continuing need to manage obstetric risk?
- How do you coordinate service changes via your Local Maternity System, Clinical Network and your Regional Chief Midwife?
- What are you doing to achieve a thorough understanding of the safety of your local maternity and neonatal services?
- How does your role integrate with internal governance and learning processes?
- How do you ensure your board is appraised of maternity safety?
- What are you doing to maximise your impact in your unit?
- Have you evaluated your role and its impact?
- What role are you playing as a catalyst for rapid learning?
- Do your maternity and neonatal teams have a good understanding of your role?

Maternity and Neonatal Safety Champions supporting co-production with Maternity Voices Partnerships

Board and frontline safety champions should work together with their Maternity Voices Partnership service user chair to co-develop plans, ensuring that options continue to be on the basis of a personalised risk assessment and package of care agreed with each woman based on options available at the time.

Together MVP's should aim to understand their population profile and offer services which truly reflect their needs with a focus on improving outcomes women with health inequalities and those from disadvantaged backgrounds.

Your MVP should be funded, the user chair should be represented on the LMSs and both board and frontline safety champions should work with the MVP user chair to ensure co-production is embedded in all safety improvement work.

More information on this can be found in 'Transforming Perinatal Safety' resource pack.

Achieving equity

To achieve the 'halve it' ambition, we need to improve care for populations most at risk of poor outcomes and Safety Champions can help to drive this. The NHS also has a legal duty to reduce inequalities through the NHS Constitution and Health & Social Care Act 2012.

Whilst **mortality rates are reducing for the population overall**, stark health inequalities persist (MBRRACE-UK 2019):

- **Maternal mortality** is 5 times higher for Black women, 3 times higher for mixed ethnicity & twice as high for Asian women than white women;
- **Stillbirth rates** are twice as high for Black & Asian babies and 1.5 times higher for babies born to mothers living in the most deprived areas
- **Neonatal death rates** are increasing for Black and Asian babies (x1.7) . The rate for babies born to mothers in the most deprived areas is x1.2.

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Temporary Suspension of Services in Maternity

NHS
Oxford University Hospitals
Trust

Closures

Chipping Norton and Wantage Midwifery led Units closed to intrapartum care since 26/08/2021

Services reviewed daily

The following closures happened in March:

Horton MLU was closed to intrapartum care twice

Wallingford MLU was closed to intrapartum care 16 times

Our Homebirth service was closed 24 times

Since August 2021, six women have been directly affected by these closures, with three of these in March 2022.

Recruitment Plan

Oxford University Hospitals NHS Trust

- April 2022 – 11wte midwifery vacancies plus 2 predicted vacancies in June and July
- 35 midwifery students interviewed from May 2022
- 16 external applicants' interviews arranged for May 2022
- April 2022 – 12 wte Midwifery Support Workers (MSW) vacancies
- MSW interviews have taken place with a programme of ongoing recruitment
- 5 midwifery training places for conversion from RN to RM to commence September 2022
- Overseas recruitment of midwives to become UK registrants
- Nurse recruitment in place as part of midwifery workforce ongoing

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Extra information in response to queries at HOSC meeting 10 March 2022

1. HOSC members asked for more detail behind the current **temporary suspension of services at 2 of OUH's 6 midwifery-led units (MLUs)** and the reasons for this.

At the time of the HOSC meeting, OUH was hoping to resume these services by the end of March 2022 but this has not been possible.

The statement below was sent to the HOSC Policy Officer on 21 March to be shared with the HOSC Chair and members:

Alison Cuthbertson, Director of Midwifery at OUH, and Catherine Greenwood, Clinical Director for Maternity at OUH, said: "We are very sorry for the ongoing inconvenience we know the temporary closure of the Wantage and Chipping Norton midwifery-led units (MLUs) has caused women and their families.

"Unfortunately, due to continuing staffing constraints, we are unable to re-open these sites at this time. We are disappointed that this remains the case and are sorry that the situation has stayed the same for some time.

"We aim to re-open these units as soon as we can do so safely. Although we hoped that a date could be set by now, absences, mostly due to COVID-19, remain very high.

"Thank you to our hardworking staff for continuing to provide safe care to women and for their ongoing support of families who are being cared for at our other sites."

Additional information for further context:

- In response to pressures, OUH has redeployed midwifery staff from non-clinical roles wherever possible to maximise the number of staff available. This has meant that the Trust has had to consolidate services to ensure safe patient care. Other maternity units in the NHS are experiencing similar pressures.
- Other low risk birth services across Oxfordshire remain unchanged. There is the Horton General Hospital MLU in Banbury, north Oxfordshire, and Wallingford Maternity and Birthing Centre (MLU) in the south.
- These run alongside the Oxford Spires MLU at the John Radcliffe Hospital.
- The Home Birth service is running as usual.
- Women should call their community midwife if they have any queries or concerns.
- An announcement will be made when a date for reopening is finalised.

2. HOSC members asked for more information about **staff sickness absence rates** and **nursing vacancy rates**.

- Staff absence data and vacancy data are both published in our Trust Board papers – within the Integrated Performance Report (IPR). The latest IPR for the last Trust Board meeting on 9 March is published on the OUH website here. The data are from Month 10 of the 2021/22 financial year (January 2022) – key information relating to staff sickness absence and vacancies as follows:

- OUH staff sickness absence was 4% in January, slightly higher than the Trust's target of 3.1%, due to COVID-19 and the Omicron variant

- Our overall OUH staff vacancy rate was 5.6% in January, better than the Trust's target of 7.7%
- The current vacancy rate for Band 5 Staff Nurses across the Trust is 13.5% and for nursing overall is 8.2%
- Centralised recruitment for all general Band 5 adult nurses and theatre nurses continues, as well as initiatives to engage with and recruit newly qualified nurses from Oxford Brookes University
- Over the last financial year the Trust has welcomed 350 internationally educated nurses which will continue to reduce the vacancy rate as they secure their full Nursing & Midwifery Council (NMC) registration
- The Trust continues to recruit overseas and is planning to recruit a further 200 nurses to join the Trust between April and December this year

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

BOB ICB Strategy for working with people and communities

Draft - 12/04/22



Contents

Developing the engagement strategy

We understand that we can only succeed if we truly represent the communities we serve and that to do so we will need to seek the views of and engage with all those affected by the work of BOB ICB.

This working document is an initial draft proposal for BOB ICB's strategy for engaging with people and communities.

This proposed approach will be further developed and presented to the ICS Programme Development Board on 25 May, as well as to NHS England on 27 May and then finally sent to the ICB board for consideration once formally constituted - expected 1 July 2022.

We would greatly appreciate any comment, feedback or suggestions that partners, stakeholders and members of the public may have on this strategy to help us better shape it into the framework for partnership working to which we aspire.

Once ratified by the board, the strategy will remain a dynamic document which can be added to, modified and improved, as appropriate and necessary, to help the ICB to better achieve its goals, and to better reflect the needs and experiences of those we serve.

Please send us your thoughts and ideas via the engagement strategy page on our engagement microsite or by emailing us at engagement.bobics@nhs.net by Wednesday 18 May.

Timetable for development

Below is a timetable for how we hope to develop the strategy before presenting it to the ICB once legally constituted (expected July 01 2022).

March 2022	Development of first draft strategy
31/03	Submission to NHSE as part of ongoing reporting
15/04	Completion of 2nd working draft
April-May	Partner and stakeholder engagement on strategy
25/05	3rd working draft presented at ICS Programme Development Board
27/05	Advanced draft submitted to NHSE
01/07	Final draft ready for submission to ICB for consideration / approval

1. Context and introduction

Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (BOB ICS) serves the healthcare needs of almost 1.8 million people. Our system comprises a variety of partner organisations and stakeholders, including NHS Trusts, Primary Care Networks, Local Authorities, District Councils, the Voluntary, Community and Social Enterprise (VCSE) sector and Healthwatch, all of which are crucial for health care delivery, strategy, and improvement.

Situated in the heart of Thames Valley, BOB ICS is broadly coterminous with the local authority boundaries of Buckinghamshire, Oxfordshire, and the three unitary authorities of Reading, West Berkshire, and Wokingham. Our three places, shown opposite, are based on current Clinical Commissioning Group (CCG) boundaries and acute hospital flows.

The three geographical 'places' within BOB ICS

On 1 July 2022, Integrated Care Boards (ICBs) were established as the new statutory NHS organisations which assume the commissioning role of CCGs, as well as some NHS England functions. These include:

- the commissioning of primary medical care services
- pharmacy, optometry and dental (POD) services
- certain other specialist services.

The ICB is also accountable for NHS spending and performance within the system.

Generally, the population within the BOB ICS area enjoys good health and a relatively strong socio-economic condition. Our highly research-active trusts - RBFT is one of the most research-active district general hospitals in the country - and our partners in the Academic Health Science Network (AHSN) continuously drive innovation to improve the lives of our citizens. Despite this, there are pockets of severe deprivation. The demand for our services often exceeds our capacity to provide them; people are living longer and sometimes with multiple long-term conditions. More people are using health services and have high expectations of what health services can provide. Given the finite amount of money available, BOB ICB must decide how it can best support those most in need.

COVID-19 has had a huge impact on the delivery of healthcare. The scale of the pandemic and the pressures under which the NHS has had to operate over the past two years have been unparalleled. The pressures continue as we continue work to recover elective care and non-COVID services, to manage the ongoing vaccination programme and to ensure we are prepared for future waves of COVID-19.

In light of this context, all ICSs aim to:

- **Improve outcomes** in population health
- **Tackle inequalities** in health outcomes, experience, and patient access
- Enhance **productivity and value for money**
- Help the NHS support broader **social and economic development**

Placeholder - BOB ICS's strategic vision and key objectives are in development. We aim to create an ICS built on effective engagement and partnerships to successfully serve our citizens.

We know that effective communication and engagement is key to achieving these goals. The COVID-19 pandemic resulted in increased collaboration across the system. The vaccination programme strengthened partnerships with primary care, the VCSE sector and local authorities, resulting in improved vaccination rates for vulnerable communities. Statutory partners, such as Healthwatch, gave an insight into the experiences of our citizens and made recommendations which enabled corrective action where needed. Developing the links between acute settings, including private providers, aided capacity management throughout the pandemic response. The strength of these partnerships was critical to the way that the NHS, and the communities we serve, were able to adapt to rapidly changing circumstances.

We are committed to progressing and sustaining these relationships by empowering community representatives and providing a range of public-facing engagement facilities and delivering virtual/in-person forums. In this way, we will continue to develop an effective system with engaged partners and involved stakeholders.

To help us achieve our goals we will seek opportunities to engage at the most effective geographical level, whether this be system - in other words, across the whole ICS population – or at place (local authority level), or indeed at local neighbourhood level. For example, while national public health messages may be best approached at system-level, we understand that one of the best ways to respond to health inequalities is by utilising local knowledge and engaging with seldom-heard communities at a very local level. Continually assessing the appropriateness of where and how we engage is therefore a key principle of engagement for BOB ICS.

Effective engagement requires us first to define and understand our audience. To do so we consider four broad categories:

- Patients – people who are using our services
- The public – everyone who may need our services at some point
- Staff – the people who work for and provide the ICB's NHS services to the population
- Stakeholders – organisations that are impacted by, have an interest in or share a responsibility with the ICB over the provision of its services as well as those who fund, regulate and hold the ICB to account

The memberships of these groups can and do overlap. Much of the ICB's population health agenda and long-term strategy is aimed at ensuring that as few members of the public as possible become patients. Effectively communicating with them through appropriate engagement mechanisms is a key contributor to this outcome. To develop or grow relationships with different groups, we need a much deeper understanding of their connections to us, their values, and their ambitions and priorities.

This strategy document sets out how we will work with people and communities. It has been produced in collaboration with our partners and stakeholders and will continue to develop as the ICS progresses. While this strategy outlines the approach to engagement across the system, it is owned by the ICB, as outlined in the Health and Care Bill.

2. Aims and principles of engagement

BOB ICS is committed to working with patients, the public and other stakeholders to maintain, develop and design services that deliver the outcomes that matter for patients. This includes developing services which are high quality, affordable and sustainable, whilst also promoting self-care and helping people stay healthy.

This document outlines how BOB ICS will engage meaningfully, so that we strengthen the quality of our relationships by learning from the feedback and showing how it affects our plans.

We will develop a way of working that ensures that public and stakeholder engagement is embedded into everything we do. It is only by listening to each other, sharing knowledge and experience and working together that we can best understand the needs of the communities we serve, and develop our services to meet those needs.

Furthermore, we will ensure that engagement takes place at the appropriate level, with the right people and in the most appropriate geography, whether that is at general practice level with patient participation groups (PPGs), or neighbourhood level, where PPGs and primary care networks (PCNs) work with wider community groups, at local authority level (place), or at an ICS-wide level.

The NHS England ICS implementation guidance on "working with people and communities" published in September 2021 included ten principles for engagement and we have used these as a basis for developing the principles that underpin our approach.

BOB ICS sees effective engagement as a two-way process that will be guided by the following principles:

- Listening
- Understanding
- Engaging
- Informing
- Enabling & co producing
- Embracing diversity, equality, and inclusion

We set out below how we understand these principles and how they will guide BOB ICS's engagement activity going forwards.

Listening
Active listening to learn from the knowledge and experience of others is core to any engagement. It is only by hearing a range of views and opinions that we can develop solutions which reflect the needs of the populations we serve.

Patients, people and communities must be at the heart of everything we do. Listening to the voices of all concerned is how we will establish clear linkages between our work and the benefits experienced by patients.

Understanding
We understand that circumstances change and relationships develop, which is why engagement should be sustained as part of ongoing business. We will continually build our understanding by reaching out to communities, inviting input and showing how that input has contributed to our work and decision making through a 'you said, we did' model of engagement.

BOB ICS covers a large geography and it is not always appropriate for engagement to take place system-wide. Our engagement with the public will therefore often be focused on place, and we will ensure that we maintain the importance of our more local place-based partnerships when engaging with partners and communities. In doing so we will seek to build on existing place-based understanding and relationships.

Engaging
We will ensure that our engagement activity is always meaningful and tailored to the people and organisations with whom we are engaging. This includes considering the right time, the right people and the right geography, i.e. neighbourhood, place or system level.

Effective engagement is an ongoing process through which we all learn, develop and adapt. BOB ICS will establish an "always on" engagement facility which encourages involvement. This can include both qualitative and immersive activities such as citizens' juries, focus groups, deliberative events, as well as online surveys which engage large numbers of local people. The approaches used will be driven by the nature of the work being undertaken.

We will always remain mindful of the need to be clear of what we are asking of those with whom we engage, be open on the parameters and scope of the engagement and always to ensure that we give feedback on how their input has affected our plans.

Informing
Meaningful engagement can only take place when people are adequately informed. We will ensure that our website and digital repository are always kept up-to-date with news, documentation and information on our work.

Keeping our public informed, however, requires more than simply making documentation available, but also ensuring that it is accessible. We will always use plain language and avoid narrowly understood terms and inaccessible acronyms wherever possible.

In addition to ‘on-demand’ information which is made available via our website, we will also put in place proactive mechanisms for keeping our populations and stakeholders informed via email newsletters and targeted social media activity,

And in addition to digital information sharing we will also ensure that, where appropriate, we will engage, inform and exchange in person.

Effective engagement also involves being careful not to obscure what is relevant and interesting by providing too much information. We will make sure that it is easy to access the appropriate type and format of information to enable engagement in the way that is right for all - be that detailed set of proposals, an executive summary, an easy read document or a video overview.

Enabling & co producing

Public sector engagement is not always seen as an enabler of positive change. When engagement happens simply to meet minimum standards of involvement, consultation and accountability, the quality of relationships can become austere and transactional.

Building effective relationships with the people and communities we serve will be critical to delivering on BOB ICS’s ambitions for co-production and partnership working. True partnership working means creating an environment where decisions are not taken by reference to organisational hierarchy but rather where the voices of stakeholders can be heard so that decision making takes place at the most appropriate level (neighbourhood, place or system) - not simply at the most senior level.

BOB ICS will build relationships by enabling meaningful engagement and allowing for genuine co-production wherever possible. Co-production is at the core of the type of partnership working underpinning the creation of integrated care systems. By coproduction we mean the building of relationships between the ICB, the partners of the ICS and the individual members of the public we serve, that allow us to share power and to plan the delivery of services together in a way that recognises that all parties have vital contributions to make.

We do this by building and reinforcing relationships and by empowering partnerships. We will leverage existing community connections at all levels and network with community leaders and influencers to ensure that seldom heard and excluded groups have their voices heard. We will go beyond the obligation of public sector engagement, and instead strive for lasting involvement through mechanisms which provide transparency, build trust and hold decision makers to account.

Embracing diversity, equality and inclusion
BOB ICS will champion diversity, equality, and inclusion. We will challenge all partners to demonstrate progress in reducing inequalities and improving outcomes.

We will support neighbourhood and place-level engagement, ensuring the system is connected to the needs of every community it serves.

Whilst this strategy seeks to outline the engagement activity of BOB ICS, we will also continuously seek ways to coordinate partners across the patch and leverage knowledge of local communities and neighbourhoods.

We will reflect on and learn from engagement practices developed to date and ensure that system level engagement compliments the ongoing work happening at place and neighbourhood level.

In addition to ensuring effective engagement takes place across different geographies we will also build relationships and partnerships with diverse demographic representation. Maintaining and developing local relationships to ensure that seldom-heard groups, faith groups, public, patient and community groups are able to play their role as partners and contribute to a wider understanding of their needs and experiences will be a priority for the board. This will mean tailoring our approach to engagement depending on the particular needs of the audience rather than trying to create a one size fits all approach.

3. Mechanisms for engagement between BOB ICB and our people and communities

We recognise that successfully involving our partners, stakeholders and the public will require a range of engagement mechanisms. This will involve, meeting, listening, sharing, acknowledging and respecting the views and experiences of different groups and enabling information-sharing across the system. Our experiences during COVID-19 demonstrated the importance of having established, quality relationships in the communities we serve. Through sustained involvement, in a variety of forms, we can build on existing relationships, establish new ones, and ensure engagement becomes a habit which underpins everything we do.

Below we outline some of the mechanisms by which BOB ICB will ensure engagement at different levels across the system:

Lay members / patient representatives on committee or partnership boards

As the governance structure of the ICS and ICB is developed, so too will the structure for involving people as lay members or patient representatives on committees or partnership boards.

Engagement Reference Group

BOB ICB will establish an Engagement Reference Group (ERG), bringing together representatives from across the ICS and supporting the ICB to develop its approaches to engagement. Membership of this group will be flexible, rather than dictated by BOB.
The ICB will demonstrate consideration of the ERG's advice through a "you said, we did" approach.

Engagement Forum

To ensure we engage as widely as possible, we will develop an engagement forum. Convening twice per year and open to the public, service users, providers and system partners, the forum will provide an arena for sharing experiences, open discussion and the opportunity to build networks across the system.

Specific projects / programmes of work

BOB ICS has many stakeholders who will need to be involved and communicated with in different ways. We will ensure communications and engagement activities are tailored around the nature of the work, adapting the engagement activity as appropriate. This would be done in partnership with our stakeholders.

Website and online engagement portal

The ICB has developed a dedicated microsite with regularly updated news and information on BOB ICS. The site provides background on the ICS as well as its people and partners and offers visitors the opportunity to sign up to newsletter updates.

It also serves as our primary online engagement tool. We are aware that meaningful engagement takes place between informed stakeholders. For this reason we regularly update the resources available in the document repository to include:

- Relevant board papers
- ICS updates
- Presentations from stakeholder workshops and town hall events

Over time the site will also offer more immersive opportunities to engage via online surveys designed to seek the views of a much wider stakeholder base.

The site can be visited here: https://bobics.uk.engagementhq.com

Proactive media and social media

We will design and deliver a proactive media and social media campaign to publicise how the public can be involved in the work of the ICS and enable our residents to be more engaged in managing their own health and wellbeing. This will be supported by the development of an active digital / online presence to foster new engagement opportunities with a diverse audience through Twitter, Facebook and other online platforms where appropriate.

Closing the loop - ‘You said, we did’

To ensure transparency and accountability, engagement feedback will be collated into a report, shared with relevant stakeholders and participants and published on the website. We will also develop a continuous feedback loop by publishing explanations for how the ICS has used feedback received. The timeframes for this may vary, depending on the engagement project occurring.

4. Roles, responsibilities and resources

Part of ensuring we engage meaningfully is continually working closely with our system partners and the populations we serve. We understand that how, when and who we engage with will vary and so we will tailor our approach to meet specific needs. For example, engagement regarding service changes should initially focus on those who are affected most, such as patients, carers and staff. This focused approach will ensure efficient use of capacity and resources, to the benefit of all stakeholders.

We recognise that experts by experience can provide invaluable input to change projects. We will use existing links to patient groups, carers and voluntary sector networks, and also develop new relationships as part of our system-working agenda. Our BOB VCSE Alliance boasts extensive place and system-level knowledge and connections, which will aid distribution of communication messages and engagement efforts. We will also work with a range of faith groups, community leaders and groups representing the range of ethnicity in our population to ensure we can successfully cater to our diverse citizens. We will work closely with our local authority partners to support engagement with seldom-heard and vulnerable groups in an inclusive, meaningful way.

BOB ICB also has a strong relationship with its 5 local Healthwatch organisations. Historically, Healthwatch has supported place-based projects, provided essential access to patient voices, and given detailed analysis and recommendations. As we move towards system-working, we have completed several engagement workshops during the development of this strategy. We recognise the value of Healthwatch's contributions for our engagement and involvement ambitions and ensuring we can meet the needs of our population. We will therefore continue to work closely with Healthwatch representatives at both place and system level. Place Executive Directors will be the main link to the local Healthwatches. We are developing partnership agreements to deepen engagement and support how both Healthwatch and the VCSE Alliance work with us.

Local Authority partnerships also present opportunities for targeted engagement efforts at place-level. The creation of joint commissioning teams has shown the importance of joined-up working and provides the foundations for building strong relationships with council colleagues and local communities. As we develop the ICB, we will nurture these connections and strive for sustained, place-level engagement.

The functional structure of BOB ICB is still in development and so the role of the ICB's non-executive directors and the communications function itself is yet to be determined. The need to improve cross-system communication was highlighted at our recent engagement workshops. Through using existing communication channels and discussions with our partners, we will streamline how information is shared throughout the system.

5. Monitoring and evaluating the strategy

We remain conscious of the need to go beyond simply putting engagement mechanisms in place and to ensure that effective and meaningful engagement takes place. It is only by doing so that we can move forward with the confidence that our decision-making benefits from the insights and experiences of stakeholders and with the support of our partners.

In terms of effective engagement, our first point of evaluation is to engage on this strategy itself - to know whether partners and stakeholders feel that their voices can be heard and appropriately taken into account through the engagement mechanisms we are developing.

This strategy is not intended as a static document, however, and so, from time-to-time, we shall seek the views of partners as to how and whether our approach to engagement needs to be refined. This could be a standing agenda point at the proposed reference group meetings for example.

- Continuous feedback and annual reporting, closing the feedback loop with ‘you said, we did’
- Annual evaluation of BOB ICS, to include public and stakeholder engagement - ensuring statistically significant and meaningful participation in evaluation survey
- Establish social media engagement metrics
- Develop a newsletter subscription list and ensure X number of newsletter updates per year

6. Appendices (Work in Progress)

To include:

•How the strategy was developed with people and communities
•Information about how people can get involved
•Links to other strategies (e.g. communications, carers, health inequalities)
•Details on approaches for Integrated Care Partnership/places/ provider collaboratives *
•Action plan for ICB **

Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

Item	Action	Lead	Progress update
Minutes of 23 September	Health partners to be invited to the next OCC scrutiny training	Helen Mitchell OCC	To be actioned in the new municipal year. In progress
28 November Meeting			
COVID	Jo Cogswell to report to the next meeting on the allocation of Winter Access Funds.	Jo Cogswell, Oxfordshire CCG	A comprehensive item will be considered at the Committee's meeting on 10 May 2022. Completed
COVID	Recommended that HOSC planning (at their virtual meeting) will develop a template for reporting to HOSC, which will include a section on what contribution is being made to COVID recovery.	Helen Mitchell, OCC	Remains delayed due to service pressures. Officers continue to provide advice to officers on the writing style of reports to aid all the Committee and the public's understanding of often complex health related information. In progress
BOB ICS	Training on BOB ICS to be organised for January.	Helen Mitchell, OCC	Training to be scheduled early in the new municipal year In progress.
Admission to care homes	Stephen Chandler (OCC Director of Adult Social Care) agreed to provide an update on engagement with Care Homes at the next meeting	Karen Fuller, OCC	Completed Meeting occurred on 25 April and note is appended to Chair's report
Admission to care homes	Stephen Chandler offered to meet with HOSC co-opted members Barbara Shaw and Alan Cohen, and the Chair, to discuss discharges to care in response to detail asked for and to steer OCC on other data HOSC might receive in future	Karen Fuller, OCC	Completed Meeting occurred on 25 April and note is appended to Chair's report

Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

Item	Action	Lead	Progress update
Admission to care homes	That Senior officers provide further information on the reporting of people who are medically optimised for discharge from acute hospitals, and how some of the successes in reducing that number can be maintained into the future.	Ansaf Azhar and Karen Fuller, OCC	Completed Meeting occurred on 25 April and note is appended to Chair's report.
Admission to care homes	That Senior Officers provide further information as to the consequences of implementing national guidance associated with the discharge of patients to care homes in the early stages of the pandemic.	Karen Fuller, OCC	We robustly followed all guidance at each stage of the pandemic in relation to admission to care homes from acute hospital. Completed
Admission to care homes	That Senior Officers provide further information on the emerging pattern of community and home-based care, and how this can be linked to current developments in the County.	Karen Fuller, OCC	To be addressed as part of the forthcoming Community Services Strategy. Members will receive information on the strategy at appropriate intervals during 22/23 municipal year. Completed
Cllr Barrow's Infection Control Report	Oxfordshire County Council (OCC), through its adult services, should hold regular discussions with OACP, OCHA on how locally we can maximise the advice from online sources beginning with the Bushproof and Department of Health documents.	Karen Fuller, OCC	OCC are in regular conservations with both OACP and OCHA to ensure that we maximise all sources of advice and guidance which is cascaded to providers via multiple channels/networks accordingly. This includes any changes in guidance and regulations. Guidance is taken from the Department of Health and Social and the UK Health security agency (UKHSA) In progress
Cllr Barrow's infection control report	OCC carries out a regular review of current infection control procedures in care homes and the support provided.	Karen Fuller, OCC	This is built into our routine procedures in relation to infection control and monitoring outbreaks. OCC works in partnership with Oxford Health care home support service, CQC and UKHSA. In progress

Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

Item	Action	Lead	Progress update
Cllr Barrow's Infection control report	OCC should ensure that its winter plan contains the recommended training and infection control support as identified by recommendations also made in the report	Karen Fuller, OCC	The Winter Plan contains and is managed in conjunction with the local outbreak management plan and standard operating procedures. In progress
10 March Meeting			
Access and Waiting Times	Information is supplied on the number of patients on the ENT waiting list and the total waiting time from referral	Sara Randall, OUH	Information supplied by OUH is appended to this action plan. Completed

Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

Item	Action	Lead	Progress update
Access and Waiting Times	Information is supplied on the number of patients who have removed themselves from elective treatment waiting lists	Sara Randall, OUH / Matt Akid OUH / Lisa Glynn OUH	We (OUH) have no way of knowing if a patient has chosen to leave an NHS waiting list in order to use private healthcare as this is not captured within our coding reasons for patients coming off waiting lists. We are therefore unable to provide this information to Members. Sourcing precise data that shows us how many people have left waiting lists in total is a significant task for the Trust at any time. We would like to assure Members that at the present time we do not have any concerns relating to the financial or overall sustainability of services as a result of people leaving our waiting lists. We are doing our upmost to ensure the backlog of procedures is dealt with in a timely fashion so that no patient feels the need to leave our waiting list Completed
Access and Waiting Times	Information is supplied on the new elective care access offer across the BOB footprint (the provider collaborative)	Sara Randall, OUH	BOB ICS Elective Recovery plan & provider collaborative would need to be presented by BOB ICS colleagues - James Kent/David Williams In progress

Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

Item	Action	Lead	Progress update
Access and Waiting times	Information is supplied on vacancy and sickness rates across midwifery	Sara Randall, OUH	Staff absence data and vacancy data are both published in our Trust Board papers – within the Integrated Performance Report (IPR). The latest IPR for the last Trust Board meeting on 9 March is published on the OUH website here. The data are from Month 10 of the 2021/22 financial year (January 2022) – key information relating to staff sickness absence and vacancies as follows: • OUH staff sickness absence was 4% in January, slightly higher than the Trust's target of 3.1%, due to COVID-19 and the Omicron variant • Our overall OUH staff vacancy rate was 5.6% in January, better than the Trust's target of 7.7% • The current vacancy rate for Band 5 Staff Nurses across the Trust is 13.5% and for nursing overall is 8.2% Completed
Access and Waiting Times	That Members meet separately with James Scott to explore workforce challenges across Oxfordshire/the NHS	James Scott, BOB ICS	Initial meeting between Helen Mitchell and James Scott in the diary for 5 May to ensure effective future engagement with Members. In progress
ICS/ICB Item	That Members engage with Catherine Mountford and OCC about the evolution of the ICS/ICB from a governance perspective and how/where democratic references can influence how the ICB/ICS operates in practice.	Helen Mitchell, OCC / Catherine Mountford, Stephen Chandler	In progress.

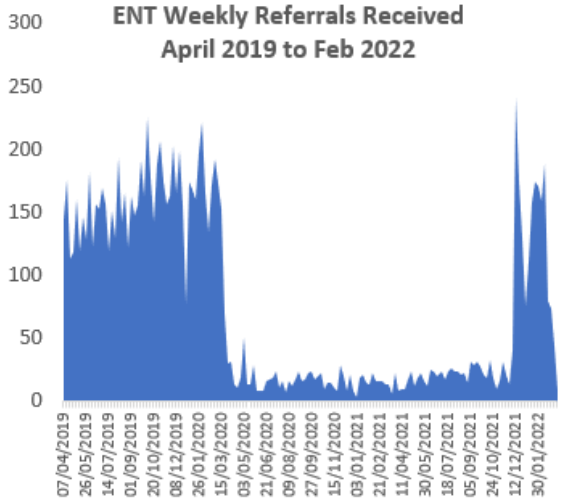
Consolidated Action Plan – Health Overview and Scrutiny Committee 27042022

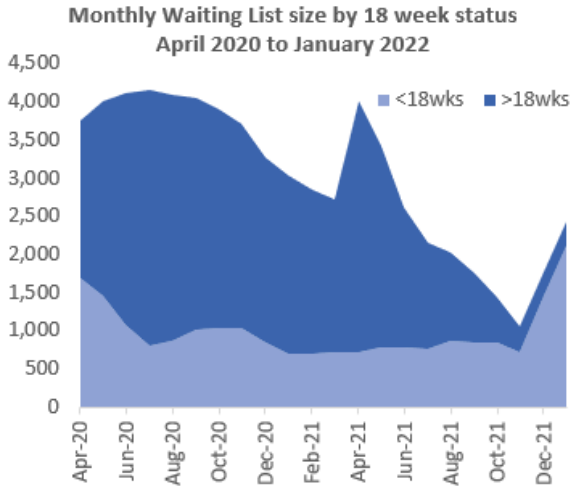
Item	Action	Lead	Progress update
ICS/ICB	That the convergence of service offer across BOB is placed on the Committee's work programme. **The context to this was Cllr Van Mierlo's point about IVF treatment cycles differing across CCGs **	Sarah Adair, OCCG Helen Mitchell, OCC	Thames Valley Priorities Committee has responsibility for this Priority Setting (oxfordshireccg.nhs.uk) This Committee agrees which drugs and treatment should be low priority and which should be funded across BOB so they are the same. For agreement at Committee, 10 May, that this answer satisfies the need to revisit / not revisit as part of the Committee's work programme in 22/23.
Covid Recovery	That the covid recovery plan is placed on the agenda for 10 May meeting	Ansaf Azhar, OCC	This will be on the agenda at the 9 June meeting. Completed
Healthwatch Update	That to support the discussion on 10 May, an appropriate officer from NHS E/I attends to discuss primary care challenges and opportunities	Helen Mitchell, OCC	In consultation with the Chair, any questions that fall within the remit of NHSE will be shared with for response via email. Completed
Chairs Update	That Members of the Committee come forward in which to develop a glossary of NHS acronyms.	Helen Mitchell / HOSC Members	Cllr Champken – Woods came forward at the last meeting to start an early draft. In progress

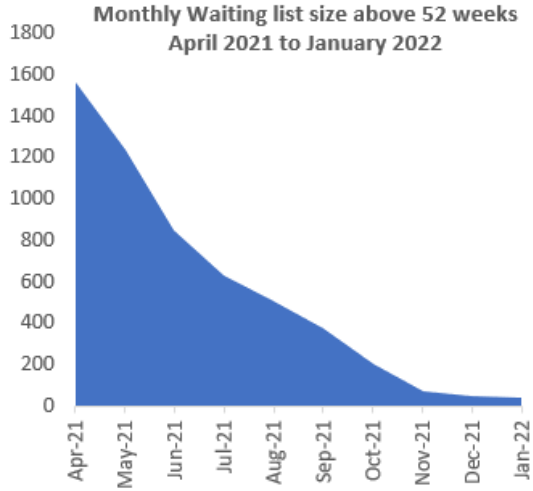
Information Supplied from OUH on ENT Waiting Times

NHS
Oxford University Hospitals
NHS Foundation Trust

Ear, Nose and Throat (ENT) Waiting List







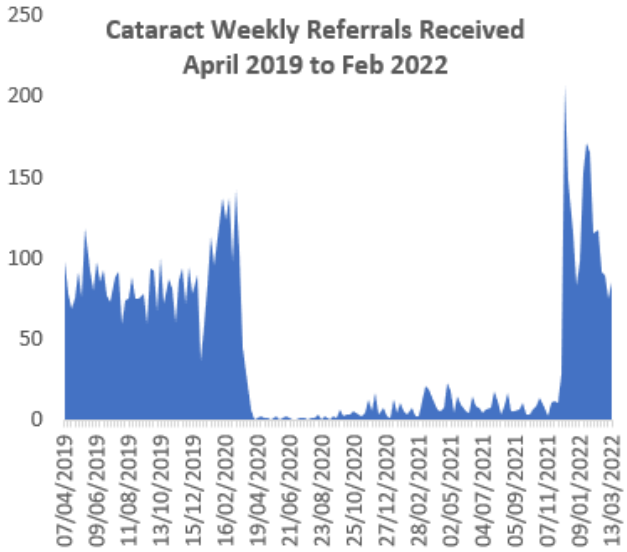
Waiting List as at 31st January 2022

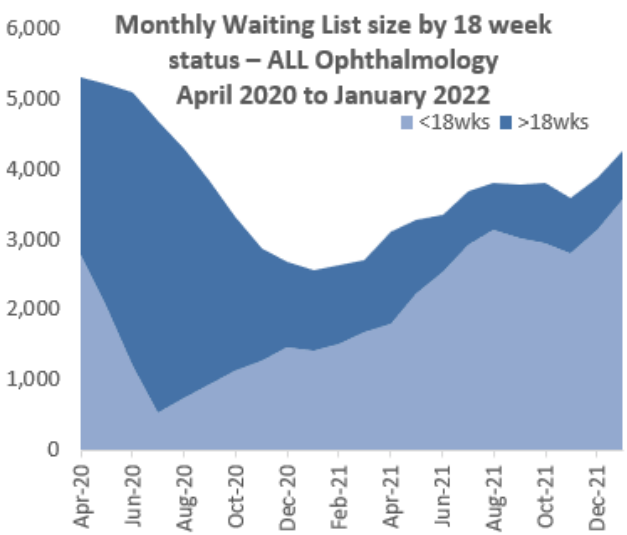
% within 18 weeks	Total Waiting	Waiting <18wks	Waiting >18wks	Waiting 52wk+
88.60%	2,395	2,121	313	39

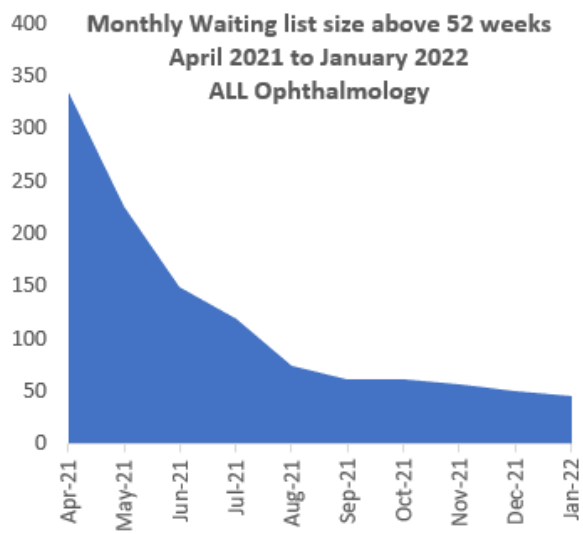
Growing volume of outpatient pathways for ENT since reopening in Q3. This matches the sudden spike in referrals received, which seems to have normalised to pre-pandemic levels. An increasing volume of undated referrals highlights an outpatient capacity issue in ENT, which may consequently require more surgical capacity also – plans are in development stage for 2022/23. Long waits have been successfully addressed during 2021/22, with zero patients waiting over 104 weeks at the end of March 2022. However increased capacity is required to prevent a further build up of waiting times.

NHS
Oxford University Hospitals
NHS Foundation Trust

Ophthalmology Waiting Times Trend







Waiting List as at 31st January 2022

% within 18 weeks	Total Waiting	Waiting <18wks	Waiting >18wks	Waiting 52wk+
84.80%	4,212	3,571	687	46

A growth in outpatient pathways in all Ophthalmology since April 2021 and a further increase since January 2022, which relates to Cataract services reopening. Referrals have returned to pre-pandemic levels and with the combination of a growing outpatient waiting list, more outpatient capacity is required. No patients waited more than 104 weeks for treatment at the end of March 2022.

healthwatch Oxfordshire
Your voice on health and care services

Accessing GP services – overview of what Healthwatch Oxfordshire has heard from patients April 2021 – March 2022

Heard from over 1500 people in the past 12 months about their experiences of accessing GP service. Many different sources – email, telephone, research, surveys, Healthwatch Oxfordshire Feedback Centre (website based).

Not all negative comments / experiences, people are feeding back about positive experiences.
Common issues:

- Getting through on the telephone
- Face to face appointment
- Using online tools
- Change in way GPs operate, expectation this will revert back to 'how it was' not happening
- Communication with patients re how to access GP and what is the process / what they can expect

Summary of five reports that were completed in 2021-22.

HWO reports found on our website here **https://healthwatchoxfordshire.co.uk/our-work/research-reports/**
Main report on Access to GP services where we heard from over 700 people is presented separately.

1 Getting treatment for earwax and hearing problems in Oxfordshire - September 2021

173 responses

Most people were surprised and disappointed to find out that GP practices no longer provide earwax removal services.

We recommended to Oxfordshire CCG that they:

1. Produce clearer guidance on earwax management and treatment options, eligibility for NHS care, and the reasons why most GP practices do not offer these services.
2. Reduce health inequalities by providing greater support to people who may have difficulty accessing earwax treatment.
3. Provide all patients with suspected earwax build-up a preliminary ear check with a practice nurse or other trained member of staff.
4. Produce and disseminate information to help patients identify safe and cost-effective services. Producing a website with answers to frequently asked questions.
5. Provide clear and comprehensive communication for patients and GPs about the new over-55 earwax removal service.

Response to the recommendations from OCCG can be found here
https://healthwatchoxfordshire.co.uk/wp-content/uploads/2022/01/20211221_Earwax-removal_final_published.pdf

Healthwatch Oxfordshire is currently conducting our 6-month review of progress against the actions described above.

2 'Keeping an eye on things': people's experiences of home blood pressure monitoring in Oxfordshire and Buckinghamshire – February 2022

159 responses, six in-depth interviews

Results

We found that:

- people monitored their blood pressure for a range of reasons and had different experiences
- most people were positive about checking their blood pressure at home. They found it convenient and relatively easy
- some people needed support to use a monitor. Others preferred to have their blood pressure taken at their GP.

Most people kept a record of their blood pressure readings. However, many wrote the results on paper to give to their GP.

More than 70% of people agreed that they would consider monitoring other aspects of their health and wellbeing.

From the feedback we identified several factors that could encourage people to take part or remain engaged in home monitoring. These include:

- having access to clear information about blood pressure and how to check it
- flexibility in how to submit readings
- good communication and regular feedback from their GP.

Recommendations

We made the following recommendations:

- The CCGs in Oxfordshire and Buckinghamshire to work with primary care providers to increase support to people who monitor their blood pressure at home.
- NHSX to develop or promote use of a mobile 'remote monitoring' app that people can use to record blood pressure and other lifestyle monitoring data.
- Oxfordshire and Buckinghamshire CCGs to commission research on access to and use of home blood pressure monitoring by people in black, Asian, and minority ethnic groups.

Response from CCGS / BOB ICS:

https://healthwatchoxfordshire.co.uk/wp-content/uploads/2022/02/20220202_Combined-Response-to-Healthwatch-Report-on-BP-Home-Monitoring.pdf

3 "What is it like living in and around Didcot in 2020?" - April 2021

146 people shared their opinions of living in the Didcot area and experiences of accessing health, social care and community services between September and December 2020.

Key findings

- Overall people are positive about living in the area and being able to find information on how to access services.

Issues about living in Didcot and surrounding areas included:

- Almost a quarter of respondents complained about access to GP practices and health service appointments
- GP access due to COVID-19 showed that almost a third of people said that the impact had been positive reporting how much better it was to be able to use telephone/video/e-consult as an option
- 54.2% of people were registered with an NHS dentist – many travelling out of area due to lack of NHS provision in Didcot
    - 35% (n17) people using NHS dentistry said that since the COVID-19 outbreak there had been "No appointments available since March" and highlighted the issue of "dentists not allowing any checks ups and will only see you in an emergency"

- 42% of people reported that traffic and poor road conditions were a negative factor regarding traffic jams and air quality
- 15% of people cited lack of provision and facilities for young people and families as a problem in the town
- Anti-social behaviour was raised by over 15% of respondents
- Crime was an issue raised by over 15% of respondents.

Concerns expressed included:

- The impact of online/remote access on access to healthcare on those who do not/cannot use these services (internet/mobile phones)
- Inequity of access to dentistry services between those who can afford to pay for private care and those who cannot and are reliant on NHS dentistry services
- Impact of housing growth on infrastructure and health services.

4 Using interpreters to access health and social care support in Oxfordshire – March 2022

We heard from 97 people – 34 health professionals and 63 service users and analysed a further 30 additional comments from people through our ongoing conversations with communities.

Views of people who use interpreters:

"I was not able to request interpretation services due to my language difficulty"

Mixed awareness about availability of interpreter services

When asked how they knew they could have an interpreter, of 62 responses:

- 70% respondents told us they had found out about interpreting services via family members, or their local community group.
- 33% also told us they had learnt about the service via a GP (19%), health professional (8%) or receptionist (6%).

Not everyone is offered an interpreter when booking an appointment

When asked if they were offered an interpreter, responses varied:

- 40% of survey respondents said they had been offered this support.

However, 52% told us they either had not been offered, or were "not sure" if they had been offered an interpreter.

When asked when they were offered an interpreter in their interactions with health and care services, of 60 responses:

- 33% told us "I was not offered an interpreter"
- 28% "during my appointment".
- 23% told us they were offered an interpreter when booking online or on the phone
- 6% at reception

Satisfaction with access to interpreter

Of 60 survey respondents who had accessed an interpreter (some more than once and via different routes):

- 56% had received interpreting support via phone
- 41% told us they had used a friend or family member
- 30% used face to face interpreter (Use of phone was predominant during the survey time due to COVID-19).

When asked if this was their preferred choice of receiving interpreting support, 50% of responses told us it was their preferred choice, 22% said "no", and 26% were "not sure" (of 53 respondents).

Overall people told us they were happy with the quality of interpreting support they received. Of 47 survey responses to this question:

74% said support was either "excellent, very good or good".
24% said the support was "okay" or "poor".

Recommendations

1. Better promotion of interpreting support and patients' rights, and access to interpreter across all services and communities:
   a. Clear and accessible information on all service websites regarding rights to have an interpreter and the websites are easily translated.
   b. Ensure that interpreting providers can offer all community languages
2. Ongoing training and awareness within services regarding:
   a. the use of interpreters to be offered at booking at appointments
   b. why an independent interpreter is preferred from family and friends (confidentiality, safeguarding) and offer choice
   c. d/Deaf awareness
3. Investigate existing use and effectiveness of headphones during clinical procedures and appointments.
4. Further research about the access to and use of interpreters by the South Central Ambulance Service NHS Foundation Trust, 111 and other frontline emergency services, as well as Community Pharmacies.
5. Engage with the voluntary sector to understand access needs for affordable interpreting services.

Roundtable discussion was held on 22nd March.

5 GP website revisited

Follow up report on progress against recommendations made in April 2021 report 'GP website check-up – December 2021

Healthwatch Oxfordshire acknowledge that the preceding months have been a challenging time for GP surgeries and their staff and thank them for their continuing commitment to delivering quality health care.

Our review of the 67 GP websites looked for changes made against the recommendations in our April 2021 report. We found that not all websites had addressed our recommendations, however there are improvements in:

1. accessibility of information about registering at practices
2. availability of information about Patient Participation Groups

The importance of accessible GP websites has grown over the past 18months and Healthwatch Oxfordshire believe that a consistent website across all GP surgeries would provide greater access to patients. Earlier this year, because of our first report, we had discussions with the OCCG about how this might be achieved. We would welcome a discussion with OCCG and GP practices about the practicalities of achieving this, recognising it will take time and resourcing.

Of concern is that websites did not give information to patients who to contact if they cannot find a GP to register with. This must be addressed by clear signage to the OCCG website and giving the contact telephone number for the OCCG.

Reviewing websites regarding translation and interpreting services there is a mixed bag on offer. All GP websites should:

- Make it more obvious on the front page how to translate the website and check this is working
- There needs to be, on the front page, clear and easily accessible information about all patients' right to interpreter (spoken language and sign language) at all appointments and how to ask for this.

A consistent website across all GP surgeries would address these requirements.

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