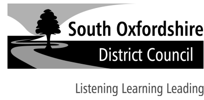
Notice of Meeting Public Document Pack



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 5 February 2015 at 10.00 am
County Hall

Membership

Chairman - Councillor Yvonne Constance
Deputy Chairman - Councillor Susanna Pressel

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Alison Thomson	Christopher Hood	
	Martin Barrett	Rose Stratford	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes:

- ***Date of next meeting: 23 April 2015***
- ***There will be a pre-meet for all members of the Committee starting at 9.15 am***

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	Councillor Yvonne Constance E.Mail: yvonne.constance@oxfordshire.gov.uk
Policy & Performance Officer	-	*Claire Phillips Tel: (01865) 323967* *Claire.phillips@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark

Peter G. Clark
County Solicitor

January 2015

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 - 12)

To approve the Minutes of the meeting held on 20 November 2014 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. **Toolkit - method for determining whether a proposed service variation or service development is 'substantial'.** (Pages 13 - 24)

10:15

Claire Phillips, Senior Policy & Performance Officer, Oxfordshire County Council will introduce the Toolkit for adoption and use by the Committee members **(JHO5)**.

6. **Healthwatch Oxfordshire** (Pages 25 - 32)

10:20

Rachel Coney, Director of Healthwatch Oxfordshire, and Dermot Roaf, Vice Chair, will present a report on recent projects **(JHO6),** to include an update on recommendations and information on the progress of commissioners and providers in delivering change.

7. **Primary Medical Services** (Pages 33 - 56)

10:45

Representatives from NHS England, (Thames Valley Team) Ginny Hope; and the Oxfordshire Clinical Commissioning Group, Dr Joe McManners and Rosie Rowe will present an overview of primary medical services within Oxfordshire.

Representative(s) of the Local Medical Committee (Paul Roblin), the City Federation and Primary Medical Limited will also attend to give a provider perspective.

The Committee will discuss challenges and service development. A briefing which has been prepared by NHS England (Thames Valley) team and the Oxfordshire Clinical Commissioning Group is attached at **JHO7**.

8. **Child & Adolescent Mental Health Services Review** (Pages 57 - 62)

11:45

Sarah Breton, Lead Commissioner, Children, Young People and Maternity Services, and Pauline Scully, Service Director, Oxford Health, will present to the Committee on the current service and its re-commissioning plans. A report is attached at **JHO8**.

9. **Outcomes Based Contracting** (Pages 63 - 66)

12:30

At its last meeting the Committee received a brief paper on the work being undertaken by Oxfordshire Clinical Commissioning Group to develop outcomes based contracting for mental health and older people’s services. The Committee asked for further clarity and detail in a number of areas. This paper addresses the issues raised and is the basis for further discussion **(JHO9)**.

Catherine Mountford and Barbara Battie of the Oxfordshire Clinical Commissioning Group will attend to present the item and respond to questions.

10. **Chairman's Report and Forward Plan** (Pages 67 - 68)

13:00

The Chairman will give an oral update on meetings she has attended since the last meeting. A draft Forward Plan is attached at **JHO10**.

11. Dates of Future Meetings - April 2015 - March 2016

Please note that the Joint Committee will meet on the following dates from April 2015 to March 2016:

23 April 2015
2 July 2015
17 September 2015
19 November 2015
4 February 2016

recycled paper

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 November 2014 commencing at 10.00 am and finishing at 2.15 pm

Present:

Voting Members:	Councillor Yvonne Constance – in the Chair Councillor Susanna Pressel (Deputy Chairman) Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Les Sibley District Councillor Alison Thomson District Councillor Martin Barrett District Councillor Dr Christopher Hood District Councillor Rose Stratford Councillor Jenny Hannaby (In place of Councillor Alison Rooke)
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Other Members in Attendance:	Councillor Mrs Judith Heathcoat for Agenda Item 4 and Cllr Nick Hards for Agenda Item 10

Officers:

Whole of meeting	Ben Threadgold (Social & Community Services) and Julie Dean (Chief Executive's Office)
Part of meeting	Director of Public Health

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

49/14 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Jenny Hannaby attended for Councillor Alison Rooke.

50/14 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillors Stratford and Hannaby declared a personal interest in Agenda Item10 – Community Hospitals – on account of their membership of the League of Friends in Bicester and Wantage Community Hospitals, respectively.

51/14 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 18 September 2014 were approved and signed as a correct record subject to the following amendments:

Minute 44/14 – Healthwatch Oxfordshire – paragraph 3, page 6, to correct 'She reported that HWO had established a reference group' to 'She reported that HWO ***were proposing to*** establish a reference group'.

Minute 45/14 – penultimate paragraph, page 8, to correct 'Dr McWilliam undertook to provide further information in the future on health inequalities' to 'Dr McWilliam undertook to provide further information on ***health inequality in relation to oral and dental services.'***

Matters Arising

The following issues were raised:

- Minute 40/14 – Toolkit – a draft toolkit had been sent to HOSC members and Health partners for comment and would be included on the 5 February 2015 agenda for adoption;
- Minute 40/14 – New Contract for Community Sexual Health Services – Cllr Pressel commented that the new opening hours would prohibit young people from attending, as they were within college/school opening hours and did not include Saturday opening. In her view the change in hours and the transition from one venue to another amounted to a substantial variation of service. She added also that it would also exacerbate health inequality. Dr McWilliam responded that there appeared to have been a misunderstanding explaining that all contracts required a period of bedding in, and the hours of opening were still in transition. He added that new contracts tended to raise issues which could not be predicted before embarking on the process. Dr McWilliam added that all procedures had been followed correctly and, in fact, the new service had been improved by the introduction in the contract of a new service for sexually transmitted infections. The Chairman agreed to include the matter on the agenda for the 5 February 2015 meeting;
- Minute 42, resolution (e), top of page 5, officers undertook to request the Trust to include information on their staff recruitment and retention when they report their progress on the implementation of the action plans to the 5 February 2015 meeting;
- Minute 43/14 – Emerging findings of the non-emergency patient transport services consultation - officers undertook to request copies of literature prepared by the Trust which had been used to advertise and signpost the changes for patients

using the non-emergency transport services and then to circulate them to members of the Committee;
- Minute 44/14 – Healthwatch Oxfordshire – paragraph 1, page 6 – Healthwatch Oxfordshire had informed officers that the film and transcript were still awaited but officers were following it up frequently;
- Minute 45/14 – Oral Health of Children in Oxfordshire – paragraph 1, page 8, Dr McWilliam undertook to bring a report to a future meeting on national data used for local surveys by Public Health;
- Minute 47/14 – an item on children's mental health issues has been brought forward to the 5 February 2015 meeting.

It was reported that all other actions listed in the Minutes had been carried out.

52/14 ORDER OF BUSINESS

It was **AGREED** to take Agenda item 9 after Agenda Item 10 to allow the attendance of Cllr Nick Hards.

53/14 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

The Chairman reported that she had agreed to three requests to make a public address/submit a petition. These were from:

- Councillor Judith Heathcoat, local member for Faringdon, in relation to Agenda Item 8 – Emergency Ambulance Services in Oxfordshire;
- Mr John Power, an Oxfordshire resident – submitted a petition in relation to the closure of a GP surgery in West Oxford; and
- Councillor Nick Hards, in relation to Agenda Item 10, Community Hospitals (address to be prior to the start of Item 10).

Councillor Judith Heathcoat addressed the Committee with regard to a serious road accident which had occurred in April 2014 within her division. There was concern about the inadequacy of the ambulance service attending the patient and the length of time it had taken for an ambulance to arrive. She read out a letter she had received from the Chief Executive of the South Central Ambulance Service (SCAS) offering his sincere apologies for the delay and explaining that demand had been very high that day, there were shortages of staff due to sickness and the satnav had directed the ambulance along a road which was too narrow.

Mr John Power addressed the Committee informing them that he had collected 700 signatures on a petition against the closure of the West Oxford GP Surgery which had occurred without consultation. His view was that the closure was a substantial variation of a service and therefore should have been consulted on. Mr Power directed members attention to a letter dated 13 January 2012 from the Practice Manager of The Jericho and West Oxford Practice (West Oxford Health Centre being a branch surgery of the Jericho Practice) advising of the move of both surgeries to the Old Radcliffe Infirmary site on Walton Street due to lack of space at the Jericho site and inviting patients to two drop in sessions to discuss the plans. The letter also explained that the new site would accommodate the whole patient list.

The Chairman requested the officers to look into the issue and then to write to Mr Power, at the same time circulating the response to all members of the Committee. She also informed Mr Power that included in the Committee's Forward Plan was an item on Transforming Primary Care to be scheduled for the forthcoming 5 February 2015 meeting.

54/14 REVISED CONSTITUTION

(Agenda No. 5)

Members considered a draft copy of the Joint Committee's Constitution which had been revised in light of the new Regulations 'Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) 2013 and associated guidance. They were advised that the document contained no changes to the functioning of the Committee, and that any change made was intended to align with the Regulations and Guidance.

Members felt that the decision made by the County Council to delegate to the Committee any referrals to the Secretary of State, as stated in the County Council's Constitution, should be made more explicit so that there was no confusion.

The officers were asked to look into HOSC representation for residents of Oxfordshire whose range of services were provided by CCG's based outside of Oxfordshire; and to report back to Committee.

It was **AGREED** that, subject to the above revision, to approve the draft Constitution to be then submitted to County Council as part of the general review of the Council's Constitution on 9 December 2014.

55/14 DELAYED TRANSFERS OF CARE

(Agenda No. 6)

The following representatives of the main Health partners attended the meeting in order to provide an update on performance and planned actions to address transfers of care (JHO6).

- John Jackson, Director of Adult Social Services (OCC) & Director of Strategy & Transformation (OCCG);
- Diane Hedges, Director of Commissioning (OCCG);
- Paul Brennan, Director of Clinical Services (OUHT);
- Yvonne Taylor, Chief Operating Officer, (OH)

In response to a question about delays in accessing available resources, John Jackson explained that Oxfordshire's Better Care Fund Plan had not yet been signed off by Oxfordshire's Health & Wellbeing Board due to specific financial challenges in the county, to the timetable for introducing Outcome Based Commissioning and in light of recent increases in the rate of emergency admissions. It was noted that a special meeting of the Health & Wellbeing Board would be held on 8 January at 1.30pm to consider the full Plan prior to its submission to NHS England on 9 January 2015.

The Panel were asked if the community hospitals were being used correctly for reablement and assessment purposes. Diane Hedges commented that a major cause of pressure was that expertise from individual organisations was not being pulled together sufficiently in order to drive action. Yvonne Taylor commented that delays were down, pointing out that three years ago 306 patients were waiting for a hospital bed, now the figure was 31. John Jackson also pointed out that the highest level of delay tended to be for those patients living in the rural areas of Oxfordshire, also adding that the longer people stayed in hospital, the more likely they were to require complex care packages. He also pointed out that new contracts had been introduced on 1 November this year and delays for home care were now at 30 per week. This was not the major problem. Anne Brierley pointed out that there had been a significant amount of investment in reablement services across the county recently, resources had been pooled, patient handover had become much slicker and any problems responded to in a quicker way. She added that the biggest challenge was how quickly patients were identified in the acute hospitals, particularly those requiring bed-based care outside of the acute hospital. There were no delays for those entering community hospitals.

John Jackson was asked if the major problems were caused around the need for nursing care. He responded that if they were self - funding then a choice delay for a particular community hospital or nursing could ensue, if full to capacity. He added that the trend for numbers of patients waiting for a nursing home had taken a downward turn, with currently under 10 delays across the system as a whole.

When asked how many readmissions there had been on a monthly basis, Paul Brennan responded that winter pressures monies had been allocated jointly amongst organisations leading to increased patient bed capacity and 7 day working. In addition, colleagues in the South Central Ambulance Service (SCAS) had extended their period of community working by operating a bus to assist students working weekends and evenings to get to and from work. Readmissions statistics were well within the national average, a 20 day standard. He congratulated Social Care for their work in reducing delays.

When asked whether the delays were due to the length of time it took to install adaptations required in a patient's house, John Jackson responded that this was very rare and was also the subject of target monitoring. Moreover, the problems tended to occur around those at risk of entering hospital and insufficient use by GPs of the 'alert' service whereby a call centre could arrange for a person to be attended at home, thereby avoiding hospital admission. Mr Jackson added that in reality, there were now more patients with a complex needs condition(s) resulting from a 50% rise in those aged 85+ in the past 5 years. This had led to a substantial increase in pressure on Health and Social Care, adding that there was an argument for doing even more to reduce delays. Moreover, the number of people supported at home had increased by 60% since April 2011. The issues surrounding the scale of rises in the ageing population was being addressed across all of the Health services including the Out of Hours Service, Accident & Emergency, Primary Care etc. He concluded by commenting that, in his view, the major issues associated with discharge arrangements in acute hospitals required more work, explaining that the people who entered hospital, and who were delayed, were generally frail older people with uncertainty around their condition from day to day, with no family carers living nearby.

The Committee asked if patient experience had been reported and detailed family information had been done for these patients. Paul Brennan responded that the OUHT's Quality Committee had requested an audit of patients who had not been delayed, and of those that had. The Committee had also looked at patient conditions whilst in hospital, patient mobility etc. The audit outcomes had shown that there was no difference for those classified as delayed, than those who had not. However, it could potentially be a problem if a person's condition deteriorated following their discharge. Diane Hedges reported that two reports were to come back to the CCG Governing Body, the first on what needs to be done for intensive support, and the second looking at named individuals who had been the subject of a delay, highlighting the key reasons for that delay and considering the various actions that were taken at different levels. The aim was to work out what actions made the most difference.

In response to a question from the Committee about whether Outcome Based Commissioning (OBC) would make a difference to the situation and whether capacity or acuity and demand were the real issues, Paul Brennan commented that in his view there was no need to be incentivised to resolve this issue. The real issue was to ensure that patients were in the correct place on the care pathway with all agencies working together. The OBC opportunity would create an environment where different ways of working could be looked at and it would be the driver of new service configuration. Moreover, OBC would release the capacity to improve performance within the resources available. Patients in all the various parts of the system, who are not able to benefit at present due to capacity issues, would then benefit from being on the next step of the pathway.

The Committee asked about the cost of patient delay for those in acute care. Paul Brennan responded that there was an average of 120 patients classified as delayed in the Trust hospitals – not all of which were Oxfordshire residents. This would equate to approximately 5 wards, at a cost of £1.3m per annum for staffing and £6.5m per annum to run. John Jackson commented that the question was how to use the resources to the best effect as bed-based care was very expensive, it being much better for them to recover at home supported by care services.

Dermot Roaf, Vice Chairman of HWO, reported that a part of the current review into the quality of care in discharge was to look at the patient perception of it, rather than looking at it from an administrative view. He commented that HWO also awaited with interest to see what fruits OBC would bear. He reported that HWO were pleased at the degree that the Trusts were willing to participate in the review and their openness was appreciated.

The Chairman thanked all those who attended.

56/14 HEALTHWATCH OXFORDSHIRE
(Agenda No. 7)

Rachel Coney, Chief Executive and Dermot Roaf, Vice Chairman, attended to present their report on recent projects (JHO7). They responded to questions from members relating to what action had been taken on their report recommendations and action being done to raise their profile.

Members of the Committee suggested other sources where views could be gleaned for the Discharge Review, such as from Parish Councils and from lists held by the Oxfordshire Rural Community Council.

It was **AGREED** to thank HWO for their update.

57/14 EMERGENCY AMBULANCE SERVICES IN OXFORDSHIRE
(Agenda No. 8)

The Committee welcomed the following representatives from the South Central Ambulance Service (SCAS) and from the OCCG who had been asked to attend to report on service performance and commissioning of the service, respectively. A report was attached at JHO8.

- Linda Scot, Steve West and Sue Byre – SCAS
- Diane Hedges – OCCG

In response to a question regarding the reason for increased demand in the service, Sue Byre reported that the chief executives of ambulance services in the south east region had commissioned an academic survey of reasons for this, the findings of which were:

- Implementation of the 111 service - public use of the service had doubled over the last 2 years;
- Increases in the over 65 population and increases in complex conditions; and
- Changes in the climate and climate conditions affecting demand. For example, the dust cloud which had occurred earlier in the year, combined with pollution, had affected and exacerbated breathing conditions, which, in turn, had led to an unusually high demand in the service.

At a former meeting of this Committee, reference had been made to a pilot project operating in the Witney area which intended to make use of the base and ambulance resource of the St John's Ambulance Service, in order to expand the reach of SCAS. In response to a request for progress on this, Steve West explained that in reality St John's had struggled to provide the resource. It had not got up and running until August, but since then it had improved and SCAS were looking to provide a responder vehicle with a view to working within 6 minute drive zones. Performance was now getting to 85% within 8 miles of the Witney area but it did not operate in rural villages outside that zone. This service would be monitored over the winter period. However, SCAS were not looking to roll it out to other areas of Oxfordshire as it was too expensive to achieve.

In response to a question as to whether electronic patient records were compatible with GPS, Sue Byrne explained that efforts had been made to integrate it as far as possible and it now offered special notes in short form. The idea was to fully integrate access to a patient's summary care record in the future. The patient care record would give the paramedic an idea of care required but would also give access to a directory of services for that particular clinical area so that the most appropriate pathway of treatment could be selected.

Steve West referred to the quality aspect of the 8 minute call out statistics which had been published on the Department of Health website. He added that it gave a good indication of how the service compared with other services in relation to, for example, whether patients had been sent to the correct treatment centre. He added that SCAS had compared favourably with other services.

In response to a question about how services to rural areas were affecting patient clinical outcomes, Sue Byrne agreed that this was one of the major challenges for the service. She explained that there had been a huge increase in red incidents in some areas and a decrease in others. She added that currently there was no data on patient outcomes and the service was therefore working with the commissioners on opportunities to share data. She undertook to share the outcomes on this with the Committee, adding that performance rates would be given including an average on how far the outcome was outside performance targets. Diane Hedges confirmed that although there was no data on outcomes, the CCG would be able to drill down on some outcomes levels and this would be made available to SCAS.

With regard to a question on workforce recruitment, Sue Byrne informed the Committee that SCAS Oxfordshire had performed well on this issue, attracting more paramedics and new graduates to the service. It strived to be an employer of choice, making efforts to develop innovative methods of training people at a junior level and then later at degree level.

With regard to a question about how serious incidents had been reviewed and issues taken forward, Sue Byrne explained that over the last 16 months more scrutiny had been devoted to incidents that involved long waits. The Operations Team (Clinical Review Group) were now taking a detailed look at all of these incidents as part of the structure of clinical support with a view to learning from each incident and reducing problems. She added that there would always be spikes in demand when 3 ambulances might be required in a remote area – and this would always equate to a challenge – but there would be no complacency.

In answer to a question asking whether SCAS transported patients to hospitals outside of the region, Steve West responded that paramedics had full authority to take patients to the most appropriate treatment centre outside of the boundary, though this may depend on the patient's previous medical history and the availability of medical treatment at the time. Patient choice was also factored in.

With regard to a question about whether there were flaws in the technology used by the service to locate calls, Steve West explained that it was easier to locate calls coming in from a land line than from a mobile phone, which was not as fast or as

accurate. Work was ongoing on an app which would improve accuracy. Sue Byrne added that work was ongoing on a continuous basis to improve technology.

SCAS were asked about their arrangements for winter pressures outside Oxford City. Sue Byrne informed the Committee that there were a number of plans for winter work with the CCG for each area. There was some national funding available specifically for the Oxfordshire area for schemes such as the SOS Bus and other schemes. Steve West advised that they were working on it and three schemes were in train:

- New vehicles – 40% of patients did not require ambulances and transport could be provided in smaller cars. This would release what was a very limited ambulance resource;
- Introducing the aim of conveying patients to hospital earlier in the day so that they could be assessed and discharged the same day. This would require a very integrated service and the freeing up of resources; and
- Installing a liaison manager in hospital to manage the flow of patients. This had worked well last year and SCAS was doing it again this year.

In answer to a question about what SCAS learned from their collection of comparative information from other ambulance trusts (see Appendix for comparison), Sue Byrne commented that SCAS always aimed at sharing information and good practice at various levels, such as on - street triage (area linkage with police forces in order to give a better service).

The Committee **AGREED** to thank representatives for their attendance and requested the following in their next report to Committee in April 2015:

(a) more information on what SCAS had learned from elsewhere and how this had been actioned in Oxfordshire; and
(b) more detail on how they were integrating with the Fire Service.

The Committee also requested a formal response to the major incident which had been the subject of the address by Cllr Mrs Heathcoat, including what had happened, what had been learned and how the service had changed as a result.

58/14 COMMUNITY HOSPITALS
(Agenda No. 10)

Cllr Nick Hards was invited to address the meeting prior to discussion of the item. He raised a number of points relating to Didcot Hospital following a stint of voluntary work three years ago. These included:

- Staffing – he had noticed a problem with agency staff having to travel long distances from places such as Gloucestershire each day;
- An imbalance in facilities for the south of the county. Didcot was the largest growing area of Oxfordshire for housing. The hospital was very well situated near to the area where most of the additional housing was to be situated, adding that there was a substantial amount of land in which to expand. However, the site needed a strategic look at medical practice and mental health facilities. He asked that, for the above reasons, the Committee support a higher priority being given to the planning of health services.

The Committee welcomed Yvonne Taylor, Chief Operating Officer, Pete McGrane, Clinical Director for Older People's Services and Anne Brierley, Service Director for Older People's Services, Oxford Health, to the meeting to provide an update on community Hospitals, with specific reference to Townlands, Didcot and Bicester.

Two reports were attached at JHO10:

- A report on Didcot Hospital closures submitted to the South West Oxfordshire Locality Patient Participation Group; and
- A briefing paper from Oxford Health NHS Foundation Trust.

In relation to Cllr Hards' address, Yvonne Taylor responded that there was a need to look at the shape and range of bed based care across Oxfordshire to ensure that the NHS were able to deliver sub - acute care. Work was ongoing with OUHT on this.

The Panel were asked what measures were being taken to attract qualified candidates into the service so that there was less reliance on agency staff. Anne Brierley responded that a balance was required between experienced and student nursing staff. There was no easy solution to attracting staff in view of the high cost of living locally, but there were key strategies in train to address this. For example, OUHT were looking at a programme of rotations of staff and were working with Oxford Brookes University on their 'return to practice' courses. They were also looking to recruit key nurses in London as the cost of living was slightly lower in Oxfordshire. In addition a number of successful open days had taken place in the hospitals, which had gleaned a better intake of high calibre staff. In response to a question from the Committee about the uptake of key worker housing, it was reported that this was proving less attractive to people nowadays than when it had first started.

Councillor Les Sibley, local member, asked why there had been a delay to the opening of Bicester's new Community Hospital and why there was an insufficiency of beds for the ever increasing population of the Bicester area. He added that the Cherwell local Plan had indicated that an extension to the hospital was required to ensure that the Health infrastructure grew at the same rate as the community. Moreover, Bicester was set to become the second largest town in Oxfordshire, adding that now was the opportunity to bring forward an extension programme.

Yvonne Taylor explained that the completed building had to be made safe to house the patients and there were snagging issues normal for a new building. Also staff training had to take place prior to opening. She added that all of these issues were managed by NHS Property. Preparations to make the move during the first week of December were underway, but beyond this, the move would take place in the New Year because of the holiday period.

In response to a request about the possibility of keeping the older hospital open to help with winter pressures on beds, Yvonne Taylor said that although she recognised that this would be helpful, there would still only be staffing available for 12 beds and also that ownership of the old hospital would transfer out of the NHS once the move had taken place.

When asked about the sufficiency of care parking facilities, Yvonne Taylor responded that this was not set by the NHS but by the local planning authority. She added that a number of public meetings had taken place on the plans with the opportunity given to voice views at the time.

Cllr Sibley commented that the local plan had indicated that there would be 4 additional beds and asked if it would be possible to add bed space in the future. Yvonne Taylor informed him that the hospital had been built under design and the contract had been set some years ago. Oxford Health was the provider and it was not in their gift to increase bed numbers.

In response to a question about incentives for nursing staff, such as overtime opportunities and free car parking, Anne Brierley explained that they had not deviated from national Terms & Conditions. As far as the employment of agency nurses was concerned, she added that agency workers were a fact of life and that the Trust worked very hard with agency providers to ensure the quality of nursing staff. Pete McGrane informed the Committee of a number of issues that had been identified to attract nurses to consider community nursing:

- An upskill of clinical staff – the University of the West of England provided a day course to give staff more clinical skills; and
- A series of open days.

With regard to points raised about demographic increases across Oxfordshire, Anne Brierley explained that the issue was how to balance resources against need. New housing tended to attract young families and there would be a need to provide the kind of services all would need. Pete McGrane added that GPs recognised the changes in their responsibilities to patients in the current time – such as greater acuity which gave a diagnostic challenge to get patients out of hospital on a more sustained recovery. This would be a challenge to their competency to manage the process. There was much more of a need for strategic discussion about how to align the bed base, for example.

The panellists were asked how the relocation of Oxford Community Hospital was going. They responded that the move was going well and there was more opportunity for levels of clinical support. The Trust was pleased to see that HWO were doing a walk-through talking to patients about their experiences. They welcomed in particular their involvement with the mental health patients as well as the physical health patients.

When asked by the Committee what was going to improve in the community hospitals, Peter McGrane said that there was a significant drive to use technology within healthcare. For example, a piece of work was underway with a view to introducing simple technology with which to use video conferencing between the patient and the consultant. He commented, however, that there was a need to consider, generally, that of information governance and security. A further example given was to establish a nutritional standards policy with a trust-wide clinically led group doing regular dietary reviews. The Panel agreed that the hospitals were struggling to provide GP input.

The Committee **AGREED** to thank all for attending and responding to questions.

59/14 OUTCOME BASED COMMISSIONING

(Agenda No. 9)

Diane Hedges (OCCG) and Yvonne Taylor (OH) introduced the report (JHO9). They were asked how they defined outcomes with which to measure mental health. Yvonne Taylor gave some examples of the key measuring indicators for the outcome 'improving and functioning' which were 'reduced admission to hospital' and 'enjoying a leisure centre'. A further example of the key outcome 'engaging and communicating' might be 'getting a job'. They added that all these factors would be measured using a single tool so that impact could be measured also. Various disorders would be measured by clustering and the evidence base for these would be done on a national basis.

In answer to a question about how outcomes were agreed and how they were monitored, Diane Hedges explained that there would be an engagement process at every level. The starting point for agreement of outcomes would be to take 'I' statements as leads in order to make it meaningful. If it could not be measured it would not be put into the process. As the process became more sophisticated these might be put in over time. Yvonne Taylor explained that the process has to state what the clinical model would be. This would then become part of the contract.

Yvonne Taylor offered to provide a workshop for members of the Committee to take them through more of the detail relating to Outcome Based Commissioning. The Chairman, on behalf of the Committee, welcomed this.

The Committee thanked Diane Hedges and Yvonne Taylor for their attendance and **AGREED** to review it in 6 months or by the September 2015 meeting, after it had become operational. The review would include a look at the clinical models for the mental health and older people contracts.

60/14 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 11)

The Committee discussed the Forward Plan which had been circulated along with an Addendum. Members suggested that the following items be added into the Plan:

- cancellation of scheduled operations. The Chairman suggested that HWO be asked to input an understanding of patient experience into the report;
- Oral Health inequalities;
- A review of Ofcomm (Oxford Community Hospital);
- Health in prison in light of the increase in number of suicides and outcomes of the unannounced visits by the CQC and the area team.

.... in the Chair

Date of signing ....

IS FORMAL CONSULTATION WITH THE OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE REQUIRED?

A guide to assessing "substantial change" to services (updated February 2015)

Please read the following guidance before completing the attached questions.

A collective approach

The following process was originally designed collectively in 2005 by Primary Care Trusts, NHS Trusts, the Oxfordshire and Area Consortium for Patient and Public Involvement in Health, and the Oxfordshire Joint Health Overview and Scrutiny Committee. It was designed to establish an agreed method for determining whether a proposed *service variation or service development* is 'substantial' and therefore a matter upon which there should be formal consultation with Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC). It was updated in 2014 to reflect the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and changes in the NHS structures resulting from the Health and Social Care Act 2012.

Please note: this document should be read in conjunction with the Department of Health's "Local Authority Health Scrutiny Guidance to support Local Authorities and their partners to deliver effective health scrutiny"[1].

Formal consultation with Oxfordshire Joint Health Overview and Scrutiny Committee as opposed to informal consultation with the community

It should be noted that in accordance with Section 242 of the consolidated NHS Act 2006, all parts of the NHS and health service providers should seek to involve and engage the community on any planned service changes, *regardless* of whether substantial or otherwise. Ideally, there should be on-going engagement with service users in developing the case for change and in planning and developing proposals.

The process referred to in this paper relates to *formal* consultation with the Oxfordshire Joint Health Overview and Scrutiny Committee. Informal discussion and consultation between the NHS and OJHOSC is encouraged independent of this official process. This should support Oxfordshire County Council in fulfilling its responsibilities to review and scrutinise matters to the planning, provision and operation of the health service in the area. In particular, Oxfordshire Joint Health Overview and Scrutiny Committee will need to be assured that:

[1] Local Authority Health Scrutiny - Guidance to support Local Authorities and their partners to deliver effective health scrutiny. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

- A proposal is in the interests of the health service in Oxfordshire.
- Consultation on proposed changes has been adequate in relation to the content and the amount of time allowed.
- Appropriate explanation has been given where an NHS body has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.

If it is self-evident that a proposed service change is 'substantial', or that it is not, there is no need to follow the steps outlined below. These have been designed as a tool to assist in circumstances where there is doubt.

Consultation with health scrutiny is not required when:

- the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.
- there is a proposal to establish or dissolve or vary the constitution of a Clinical Commissioning Group or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.
- proposals are part of a trusts special administrator's report or draft report

How to apply the process

1. An informal meeting should be instigated at an early stage in the proceedings by the appropriate part of the NHS system, to enable the proposed service changes to be drawn to the attention of the Oxfordshire Joint Health Overview and Scrutiny Committee. The meeting would normally be called by the commissioner and service provider responsible for the service in question. The meeting will be open to the Chairman of the Oxfordshire Joint Health Overview and Scrutiny Committee and other appropriate people as required (e.g. Healthwatch, carer/user groups, voluntary organisations etc.).

In preparation for this meeting the Committee would expect to see detailed information regarding the proposals including information on the scale of the proposed change, effects on patients and financial considerations.

2. For the NHS/Health Service providers
The commissioner and provider should jointly undertake the assessment in Annex 1 to assess their position in relation to the series of statements posed, using paragraph **8** below as a guide.

Important note: *It is expected that any formal consultation would be undertaken by the commissioner of the service.*

3. Sending information
At the earliest opportunity the relevant NHS body should provide the Oxfordshire Joint Health Overview and Scrutiny Committee with details in writing of the

proposed service changes, an outline of the proposed timetable for implementation, and a copy of their own assessment (using the agreed method) as to whether or not the proposal is 'substantial'.

4. For the Scrutiny Committee
HOSC members and others as appropriate will then meet the commissioner and provider and go through the assessment process to enable the scrutiny group to come to a view as to whether the proposal represents substantial variation.

5. If everyone agrees
If both the NHS group and the scrutiny group are agreed that there **does not** need to be formal consultation, the presumption shall be that consultation with the relevant patient / service user / carer / community bodies will continue, in accordance with Section 242 requirements. The Committee encourages NHS bodies to engage with the Committee even if formal consultation is not required.

6. When and how
If both the NHS commissioner and the scrutiny committee are agreed that there **does** need to be formal consultation due to there being a substantial service variation or development, the scrutiny committee will be informed, as soon as is practicable:-

- of the date by which it requires the health scrutiny body to provide comments in response to the consultation and the date by which it intends to make a decision as to whether to proceed with the proposal. The scrutiny committee must be notified of any changes to dates.
- how the consultation will be conducted);

A copy of the consultation document will be made available to the scrutiny committee as soon as it is available.

7. If there is a difference of opinion
If the scrutiny group **does not** endorse the NHS body's view that formal consultation is not required, the best endeavours of all parties should be directed towards reaching a consensus position. Any views reached by either party should be on the basis of the best interests of the wider community and of a fair and reasonable assessment against the agreed criteria.

8. If an agreed position cannot be reached
If it continues to be impossible to reach agreement upon the need for a formal consultation, both sides may jointly or severally pursue the options open to them under their respective statutory instruments, such as escalation to the Secretary of State for HOSC or escalation to the providers Board.

9. Answering the questions
The questions to be considered fall under several different headings:- (1) the nature of the impact upon patients and public; (2) the rationale behind the proposed service change or development; and (3) clinical factors. *Please bear the following in mind:-*

- All statements are to be ‘scored’ on a simple ‘Yes/No’ or ‘Not applicable’ basis.
- At the foot of the table ‘Yes’ responses should be totalled in order to establish whether consultation is, or is not, required.
- Comments upon how each question has been “scored” may be included in the middle column.
- This is not an exact science; if the scores are similar, answers may be reconsidered to see whether some responses merit more ‘weight’ than others.
- It is important not to dwell too long on individual questions – the intention is that the *overall* picture will emerge if all questions are gone through fairly swiftly.
- Don’t forget that this is not about *how* to consult, but *whether* to do a formal consultation with Oxfordshire Health Overview and Scrutiny Committee.
- Some questions are highly likely to lead to a conclusion that formal consultation will be needed; these are marked with an asterisk.

This document is for guidance only and is not legally binding.

VERSION FOUR updated December 2014

Agreed by: Health Overview & Scrutiny Committee

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.

CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS NOT REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS REQUIRED**
NATURE OF IMPACT UPON PATIENTS AND PUBLIC				
Legal obligations set out under Section 242 of the consolidated NHS Act 2006 to 'involve and consult' have been fully complied with. *(Details of the methods of public involvement used must be provided)*				Legal obligations under Section 242 have not been implemented, either partially or fully.
Initial responses from service users (or their advocates), Healthwatch and/or other relevant organisations or individuals from the wider community indicate that the impact of the proposed change is not substantial or controversial.			*	Initial responses from service users (or their advocates), Healthwatch and/or other relevant organisations from the wider community indicate that the impact of the proposed service change is substantial or controversial.
Staff delivering the service have been fully involved and consulted during the preparation of the proposals.				Staff delivering the service have not been closely involved or consulted during the preparation of the proposals.

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.

CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION <u>IS NOT</u> REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION <u>IS</u> REQUIRED**
The service to be changed has had little or no financial or 'in kind' support from the local community.			*	The community has a sense of ownership of the service to be changed because of its charitable funding and/or support in kind.
The consultation so far undertaken has presented a range of options for service variation or development upon which comments have been sought.				The consultation so far undertaken (if any) has presented only one realistic option for comment, alongside the 'no change' option.
Option/s presented include proposals to improve patient access (to a site or via opening times) <u>and/or</u> specifically address any adverse impact upon patient travel needs.				Options presented represent a diminution of access to service/s, (to a site or via opening times) including by virtue of patient travel needs.
Proposed change of service has a differential impact that should reduce health inequalities (geographical, social, or otherwise).			*	Proposed change of service has a differential impact that could widen health inequalities (geographical, social, or otherwise).

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.				
CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS NOT REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS REQUIRED**
Proposed change in service has a positive impact (*Please score separately):-* • Upon other services elsewhere in the NHS system (including within the same organisation) • Upon services provided by the local authorities • Upon services provided by the voluntary sector.				Proposed change in service has a detrimental impact *(Please score separately)*:- • Upon services elsewhere in the NHS system (including within the same organisation) • Upon services provided by the local authorities • Upon services provided by the voluntary sector.
RATIONALE/POLICY BEHIND PROPOSED SERVICE CHANGE OR DEVELOPMENT				
The proposal is that of a *principle* driven by a national policy initiative upon which consultation is not normally required.				The proposal is the *implementation* of a national policy initiative of which consultation plans must form an explicit feature.

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.				
CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS NOT REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS REQUIRED**
The proposed service change or development is *primarily* driven by clinical factors but also has financial and/or staffing and/or other managerial benefits.				The proposed service change or development is *primarily* driven by financial, staffing or other managerial factors but also has clinical merit.
This service area has not had any small scale changes made to it recently that could cumulatively have a substantial impact upon patient services.				When viewed as part of the bigger picture, the proposal appears as one of a series of small incremental changes, the cumulative impact of which (upon patients/service users) can reasonably be regarded as substantial.
There is evidence that the proposal will ensure a sustainable service.				There is limited evidence to suggest the service would be sustainable as a result of the proposed changes.
The proposal forms part of a bigger plan upon which appropriate involvement and consultation has already been carried out.				The proposal forms part of a bigger plan, which has not been fully discussed with the wider community.

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.

CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS NOT REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS REQUIRED**
The proposal is consistent with the NHS body's and/or health service providers' strategic plan.				The proposal is an exception to, or diversion from the NHS body's and/or health service providers' strategic plan.
The proposal has the support of the Health and Wellbeing Board as it aligns with the strategic plan for health services in Oxfordshire.				The proposal doesn't have the support of the Health and Wellbeing Board as it doesn't align with the strategic plan for health services in Oxfordshire.
The proposal is designed to achieve National Service Framework standards.				The proposal has no bearing upon the achievement of National Service Framework standards.
CLINICAL FACTORS				
Initial responses from staff delivering the service indicate that they are in support of the proposed changes.				Initial responses from staff delivering the service indicate that they have serious reservations about the impact of the proposed changes on their patient group.

Please note your answer to the questions on the LEFT hand side in the left hand 'Yes/No' column; and your answers to the questions on the RIGHT hand side in the right hand 'Yes/No' column.

CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS NOT REQUIRED	**'Yes' or 'No'?**	**COMMENTS (including if 'Not applicable')**	**'Yes' or 'No'?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION IS REQUIRED**
The proposed service change improves clinical governance and reduces risk, and is based upon agreed best practice e.g. National Service Framework Standards, National Institute for Health and Care Excellence Guidance.				The proposed service change plays no part in improving clinical governance or reducing risk, and does not support or enable the implementation of e.g. National Service Framework Standards, National Institute for Health and Care Excellence Guidance.
The quality and quantity of service to all related patient/service users is to remain unchanged or to improve.				The opportunity cost of the proposed service change or development is that the quality and quantity of service provided to particular patient groups is to be reduced or compromised.
The proposal is designed to meet the expectations of patients.				The proposal is designed around the *critical mass* needed to provide the service effectively but may not meet patient expectations.

Please note your answer to the questions on the LEFT hand side in the left hand ‘Yes/No’ column; and your answers to the questions on the RIGHT hand side in the right hand ‘Yes/No’ column.

CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION <u>IS NOT</u> REQUIRED	**‘Yes’ or ‘No’?**	**COMMENTS (including if ‘Not applicable’)**	**‘Yes’ or ‘No’?**	**CHARACTERISTICS LIKELY TO LEAD TO A VIEW THAT FORMAL CONSULTATION <u>IS</u> REQUIRED**
OTHER				
The commissioning body is/are aware of and has/have been involved in the drafting of the proposal/s.				The commissioning body is not fully aware of and supportive of the proposal/s.
Detailed consideration given to the degree to which mitigations are in place to reduce any potential negative impacts of the proposed change.				Mitigations not are in place to reduce any potential negative impacts of the proposed change.
TOTAL NUMBER OF ‘YES’ TICKS FOR THE LEFT HAND COLUMN →				**← TOTAL NUMBER OF ‘YES’ TICKS FOR THE RIGHT HAND COLUMN**
Outcome / Decision? **Is this considered to be a significant change by provider?** **Is this considered to be a significant change by HOSC?**				

<u>PLEASE NOTE:-</u>

<u>If the response to any of the questions marked with a ‘*’ is ‘yes’, there is a very strong presumption that consultation IS required</u>

This page is intentionally left blank

healthwatch Oxfordshire

Healthwatch Oxfordshire

Update for the Health Overview and Scrutiny Committee – February 2015

1 Introduction

1.1 The main focus of this report is on providing a summary of the actions taken by commissioners and providers in Oxfordshire to recommendations made by Healthwatch Oxfordshire and its grant aided partners since April 2014. (Sections 2 and 3)

1.2 The report also provides an update on other internal and external HWO activity since the November meeting of this committee. (Sections 4 and 5.)

2 Tracking delivery of HWO recommendations

2.1 During the course of 2014/15 Healthwatch Oxfordshire has published a number of reports in which recommendations have been made to commissioners and providers about changes they should consider making to local services.

2.2 Some of these recommendations have been made directly by Healthwatch (for example those relating to the annual Hearsay event and those relating to GP Access). Others have been made by organisations to whom Healthwatch has given grant funding and project support. Healthwatch has then undertaken to bring the issues raised by these organisations to the attention of commissioners and providers. For example we have published reports produced by the Asian Women's Group, Oxford University Students and My Life My Choice.

2.3 HWO wrote to all commissioners and providers in Oxfordshire before Christmas, re-iterating the various recommendations we have made to each organisation this year, reminding them about the commitments they had made to address issues raised at the point of publication of the relevant reports, and asking for an update on delivery of those commitments.

2.4 We are delighted that all providers and commissioners responded and a report detailing their responses can be found on the Healthwatch Oxfordshire website, www.healthwatchoxfordshire.co.uk . Section 3 below summarises the key changes being delivered on behalf of local service users as a result of recommendations made by HWO and its partners this year.

3 Summary of action taken

3.1 **Oxfordshire County Council.** OCC have provided us with detailed evidence that demonstrates they are acting on the vast majority of the recommendations made to them this year by Healthwatch Oxfordshire. Highlights to draw the committee's attention to include:

a) Offering to review care packages for the 172 people identified as getting 15 minute visits for personal care, and amending the care package to remove this, if that is what the client wishes; ceasing commissioning of 15 minute visits for personal care for new clients.
b) Agreement to flex use of Direct Payments to enable more Asian families to pay family members for care.
c) Work that is underway to develop user informed customer standards for Personal Assistants and Supported Living service providers.
d) Developing systems through which performance of individual care agencies can be published by this summer.
e) Working with OCCG to ensure that Outcomes Based Contracting for older people's services results in a single health and social care assessment process.
f) Training and supporting people with Learning Disabilities to act as paid quality monitoring assistants and to be involved in service reviews such as the recent review of Supported Living Services.

3.2 **Oxfordshire Clinical Commissioning Group.** OCCG have provided us with detailed evidence that demonstrates they are also acting on the vast majority of the recommendations made to them this year by Healthwatch Oxfordshire. Highlights to draw the committee's attention to include:

a) Developing mental health first aid training for Asian Women; supporting community leaders to enable them to advertise mental health support services in the mosque; working with Restore to develop more culturally appropriate equality and diversity training material and developing bite size confidence to care courses that Asian Women will be able to access; disseminating information on halal medicines to all GP practices.
b) Submitting the Oxfordshire Mental Health Forum report as evidence to the project board charged with reviewing CAMHS services – although this review is not yet complete so the impact of this is as yet hard to guage.
c) Commissioning an SOS bus to support young people in Oxford City Centre on weekend evenings (see SCAS section).
d) Using the Sign Lingual report to inform the service specification and procurement process for the reprocurement of BSL interpreting services from June 2015, and targeting an intensification of staff training on deaf awareness in those NHS departments/services where this is particularly needed.

e) Ensuring the Oxfordshire bid to the Prime Ministers Challenge Fund for funding to improve access to primary care draws closely on the findings of the HWO report and that it includes bids for piloting schemes such as enhanced home visiting services, provision for extended appointments for patients with complex care needs and enhanced use of email for consultations.
f) Development of a "Use your NHS Wisely" campaign to help the public make best use of their GP service.
g) The invitation to HWO to sit on the Primary Care Programme Board, in order to ensure that recommendations made in the HWO report are addressed by the work of the Board.

3.3 **Oxford Health Foundation Trust.** OHFT have also taken HWO's recommendations seriously. Changes resulting from HWO recommendations in OHFT that are of particular note include:

a) Members of the IAPT service meeting Imams in Oxfordshire to promote access to talking therapies in the Muslim community.
b) Providing training to schools on mental health early intervention and prevention.
c) Running a MH in reach pilot programme in 3 schools, and as a result now assigning a PCAMHS link worker to all secondary schools and extending the piloted MH in reach service to further 5-10 schools each term.
d) Securing additional research monies to increase the clinical staff team in the Early Intervention Service, and increasing referrals into this service from 14-18 year olds.
e) Amending staff induction and training programmes to raise awareness of the needs of deaf people and how best to meet them.

3.4 **Oxford University Hospitals Trust.** OUHT has also taken steps to address issues brought to its attention by HWO. These include:

a) Participating in development of a whole system Mental Health Crisis Concordat, which includes actions to address student's fears around being dismissed when asking for help as well as a working group focusing on all elements of mental health across Oxfordshire.
b) Considering development of a Minor Injuries Unit for Oxford, but (with commissioners) agreeing this was not feasible, and developing an alternative 4 point plan to reduce minor A&E activity.
c) Improving information about interpreting services on the Trust intranet and in equality and diversity training, and reviewing use of plain English in letters.

3.5 **Southern Health Foundation Trust.** In response to HWO and its partners' recommendations, SHFT have:

a) Committed to developing and delivering improved training on the needs of deaf service users early in 2015.

b) Started a service redesign process that will lead to a reduction of inpatient beds and an enhancing of Intensive Support Team services to service users in the community.
c) Improved access to advocacy services.
d) Involved users and their families in peer reviews of community and inpatient services.
e) Rolled out Proactively Reducing Incidents for Safer Services (PRISS) training to staff in all Oxfordshire inpatient services and Going Viral training to all staff.
f) Put in place a transition policy between Community Learning Disability Teams and CAMHS to ensure that young people are referred and handed over to the adult services in a timely way using the Care Programme Approach (CPA).

3.6 **South Central Ambulance Service.** SCAS have only been asked to respond to one of HWO's reports , and in response they have:

a) Introduced an SOS "bus" to central Oxford for the busy nights in the town centre. The vehicle is crewed by a paramedic/ECP, an RAF nurse and St.Johns, to deal with minor illness/accidents/alcohol related incidents etc.

3.7 **NHS England.** NHSE has:

a) Raised the issue of access to interpreting services for a number of communities at The Thames Valley Quality Surveillance group, when it undertook to charge all CCGs in Thames Valley with reviewing the effectiveness of interpreting and translation services in their area and to remind the providers it commissions about how and when to access these services for patients.
b) Committed to ensuring that the HWO GP access report informs local plans to progress co-commissioning of primary care in Oxfordshire.

4 **Other external activity undertaken by HWO since the November HOSC meeting.** Since the last meeting of HOSC HWO has:

4.1 Undertaken all necessary planning and preparation to undertake upwards of 100 enter and view interviews to explore local people's experience of discharge from hospital, starting on 23rd February.

4.2 Agreed a project plan in partnership with Age UK Oxfordshire for undertaking a second large scale enter and view based project exploring issues of dignity in care in Oxfordshire , with enter and view interview work due to begin in April/May.

4.3 Undertaken the following project grant funded work:

a) Published the Oxfordshire Neurological Alliance Report on gaps and issues in services for this patient cohort.

b) Supported a Restore service user with her research into service user engagement best practice.
c) Awarded grants to:
   - Homestart to look into pre and post natal care for women they look after in Oxford and Bicester.
   - Guideposts Trust to explore whether the needs of young carers and carers of people with MH and LD being met.
   - Donnington Doorstep to look at the effectiveness of services made available to young people and families affected by child sexual exploitation.

4.4 Via a Board member, continued to lobby Oxford City Council on health and social care issues affecting the homeless community – which remain of concern.

4.5 Advised and supported BBC Oxford on the design and content of its NHS week.

4.6 Arranged to attend events and/or have a stall in public locations in Witney, Cowley, Banbury, Kidlington, Wheatley, Abingdon, Banbury, Woodstock, Bicester, Marston, Cowley, central Oxford and Wood Farm to talk to the public about local services.

4.7 Funded "talk to the public events" with partners in Chipping Norton and Kidlington.

4.8 Progressed work on best practice advice to care homes on establishing relatives groups.

4.9 Agreed an approach with OCC for Hearsay 2015, which will include events in the north, city and south of the county this year leading up to a Countywide event.

4.10 Undertaken a workshop to explore the unmet health and social care needs of working age adults to inform the JSNA.

4.11 Met with Directors of Quality and Patient Experience leads in all major commissioners and providers, and agreed with them the following joint priorities for quality improvement work in Oxfordshire in 2015/16:
a) Joining up people's care, when it is being delivered by a range of health and/or social care providers.
b) Communication between different organisations within the system about patients.
c) Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
d) Carer involvement in care planning and care delivery.
e) Better treatment of patients with physical and mental health needs, and recognising and addressing the psychological component of all healthcare.
f) Continuing to build a culture in which staff, carers and patients feel able to raise concerns or complaints without fear of retribution.

g) Supporting delivery of public education about how to use the NHS wisely and self-care programmes that might help reduce demand.

5 **HWO organisational development.** In the period since the last HOSC meeting, HWO has also :

5.1 Recruited 8 new Directors who will formally join its Board in March, including a new Chair who will take over at the March 23rd meeting.

5.2 Undertaken a staff restructure and advertised two posts which will significantly enhance its capacity to deliver its core business.

5.3 Moved to new, more accessible offices on the Oxford Business Park South.

5.4 Completed a 360 degree survey on our own effectiveness. 24 completed surveys were returned, and this represents a response rate of 36% from the individual email addresses we mailed the survey too. The key findings from these were that:

i. All respondents answered the question “do you know what we exist to do” and 95.8% of them said yes.

ii. 21 respondents told us about the areas of our work that they have had direct experience of. 100% of them had direct experience of our core work to gather the views of the public. 66% had direct experience of our media work and the work we have undertaken to make recommendations to improve services, and just under 50% had direct experience of the work we undertake to look into areas of concern. Perhaps unsurprisingly only 14% of those who responded were aware that we work with HW England on national issues.

iii. 21 respondents told us about how effectively they think we fulfil our core functions. The following percentages believe we are quite or very effective at:

Gathering the views of the public	60%
Awarding grants to groups to conduct research	79%
Commissioning projects to look into areas of concern	84%
Signposting people to services	33%
Reporting concerns in the press	53%
Making recommendations to improve services	55%
Working with CQC	35%
Working with HW England	29%

iv. 43% of 21 respondents believe our work has, or will, impact on their decisions, and 33% don’t know – which perhaps reflects the fact that our first impact report is only now being published.

v. Free text comments suggest the organisation is now recognised as beginning to deliver and as showing potential, but that particular focus is required on consolidating the changes made in the last six months, raising our profile with the public and holding others to account for the change we have recommended they deliver. Action is in hand to address all of these.

A fully detailed organisational response to this report can be found on the Healthwatch Oxfordshire website www.healthwatchoxfordshire.co.uk

The organisations are:

- Oxfordshire County Council
- Oxfordshire Clinical Commissioning Group
- Oxford Health NHS FT
- Oxford University Hospitals Trust
- Southern Health Foundation rust
- South central Ambulance Trust
- NHS England Thames Valley Area team

Healthwatch Oxfordshire is very grateful for their co-operation in producing this report.

This page is intentionally left blank

NHS England

NHS Oxfordshire Clinical Commissioning Group

Briefing on the Current State of General Practice in Oxfordshire and Transforming Primary Care for Health Overview and Scrutiny Committee Oxfordshire

NHS England Thames Valley Area Team
and
Oxfordshire Clinical Commissioning Group

19th January 2015

Executive Summary

The aim of this paper is to inform the Health Overview Scrutiny Committee (HOSC) on the current state of general practice in Oxfordshire. It has been brought to HOSC in order to brief members on the quality and access to services provided by general practice in Oxfordshire, and to inform them about the challenges facing the sustainability of GP services. Services locally face demographic changes, increasing public expectations regarding access, workforce pressures and economic and financial challenges. This paper outlines the national vision to address these challenges by transforming primary care and sets out the emerging local strategy to support and develop primary care in the next five years.

The national strategy described in Transforming Primary Care' issued by NHS England (March 2014[1]) identifies six key priorities:

1. Offering **holistic care**: addressing people's physical health needs, mental health needs and social care needs in the round. The paper describes how general practice is planning to co-ordinate more closely with integrated community health and social care teams.
2. Ensuring fast, **responsive access to care** and preventing avoidable emergency admissions and A&E attendances. The paper sets out a number of initiatives which will collectively have an effect of enhancing patient access to Primary Care (physically and digitally).
3. Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level. The paper describes how GP Practices undertake health prevention as part of the 'making every contact count' approach, encouraging patients to adopt healthy lifestyles that will promote health and wellbeing, as well as specific initiatives to address the needs of more deprived communities.
4. **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care. The paper sets out how practices are increasing their support for patients with complex care needs, and enabling patients to manage their own care better
5. General practice operating at **greater scale,** for instance through networking, federation or merger, whilst preserving strengths of **continuity of care** and **relationship with local communities.** The paper provides information on the primary care federations that have been set up in Oxfordshire in the last year to promote collaboration between practices.
6. General practice working as a more **integrated** part of a wider set of community-based services. Detail is provided on the local vision for increasing more services to be offered out of hospital, enabling people to access more care closer to home.

What this means for patients is reflected in Appendix E.

This is a joint paper produced by Oxfordshire Clinical Commissioning Group and NHS England Thames Valley Area Team, the two organizations responsible for commissioning general practice services. Oxfordshire County Council is responsible for commissioning public health interventions from primary care.

---

[1] Improving General Practice – A Call to Action Phase 1 Report March 2014: NHS England

Briefing on the Current State of General Practice in Oxfordshire and Transforming Primary Care for Health Overview and Scrutiny Committee Oxfordshire

Introduction

1. The aim of this paper is to inform the Health Overview Scrutiny Committee on the current state of general practice in Oxfordshire, which currently comprises 80 practices with 547 GPs, 138 Practice Nurses and 243 other health care professionals.

   It describes the challenges facing the sustainability of GP services, outlines the national vision for transforming primary care and articulates the emerging local strategy to support and develop primary care in the next five years.

   This is a joint paper produced by Oxfordshire Clinical Commissioning Group and NHS England Thames Valley Area Team.

   The Appendices provide additional information on how primary care services are commissioned and funded, their quality monitored and the plans for increasing joint commissioning of general medical services.

National vision and strategic direction for transforming primary care

2. The Department of Health with NHS England describes the vision of 'Transforming Primary Care' (March 2014[2]) as 'the next step towards safe, personalised, proactive out-of-hospital care for all, starting with the 800,000 patients with the most complex health and care needs who will be given a personal care and support plan, a named accountable GP, a professional to co-ordinate their care and same-day telephone consultation if needed.

3. In its vision NHS England identified six key national strategic priorities for improving general practice, namely:

   - Offering **holistic care**: addressing people's physical health needs, mental health needs and social care needs in the round.

   - Ensuring fast, **responsive access to care** and preventing avoidable emergency admissions and A&E attendances.

   - Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level

   - **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care

[2] Improving General Practice – A Call to Action Phase 1 Report March 2014: NHS England

- General practice operating at **greater scale,** for instance through networking, federation or merger, whilst preserving strengths of **continuity of care** and **relationship with local communities**

- General practice working as a more integrated part of **a wider set of community-based services**

4. The local commissioning strategy aims to achieve these objectives and to address local challenges to the sustainability of general practice

Local Challenges to the Sustainability of General Practice.

5. Health and Social Care services locally face a number of challenges including demographic changes, changes in public expectations regarding access, workforce pressures and economic and financial challenges.

6. Nationally there is an ageing population, with increasing numbers of citizens having multiple long-term conditions and complex health and care needs. The number of people with multiple long term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018 and this is resulting in a large increase in consultations, especially for older patients. Nationally the average patient had 3.9 consultations each year in 1995 rising to 5.5 consultations each year by 2008.[3]

7. In addition Oxfordshire is set to experience significant growth in the population in areas identified for new housing over the next 20 years, as outlined in the Strategic Development Plans for each of the respective District Council areas. NHS England, along with NHS Property Services, are working to actively engage with Local Authorities in order to understand their housing growth plans. We are currently undertaking a mapping exercise for each of the council areas, so that all the major house development sites are identified and the quantity of housing and expected population increase is understood. In addition, we also have the housing trajectories so that the phasing for each of the developments is known, so giving a better insight into when the expected growth is likely to have an impact (it is recognised that some of this growth is already underway and the impact is already being felt). The mapping exercise also identifies which practices are likely to be most impacted by each of the house developments.

   NHS England Thames Valley Area Team works closely with Oxfordshire Clinical Commissioning Group to ensure that any expansion of premises in response to population growth can be aligned with local strategic plans as well as working closely with other partner organisations such as NHS Property Services and Community Health Partnerships so that there is an broader understanding of the NHS estate and facilities available.

   The process that NHS England Thames Valley Area Team uses to assess future demand for GP services linked to population growth is described in

[3] http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf

Appendix B. The mapping exercise being undertaken by NHS England will feed into a wider review of the estate available across primary care, community health and social care which is underway to understand what property is available and the extent to which it is fully utilised.

8. As in other areas of health and social care public expectations relating to access to services are changing, with more people wanting to be able to see a GP in the evenings and at weekends.

   In 2014 HealthWatch Oxfordshire[4] undertook a public consultation on access to GP services and its results have identified specific issues relating to GP access for Oxfordshire. These include:

   - Although 71 % reported being able to access their GP within a week, 29% reported dissatisfaction with waiting times; waiting more than one week for a GP appointment is acceptable to some people.
   - 18% of respondents were dissatisfied with the length of time to answer their call; and there was significant interest in alternative methods of making appointments such as email, text and web-based.
   - Awareness of GP Practice opening hours could be improved: 27% were unaware of opening times.
   - Extended access: 77% of respondents would like access to weekend and evening appointments
   - Some respondents also expressed dissatisfaction with Out-Of-Hours services: long waiting times, unhelpful advice
   - Access to own GP: 34% did not see their own GP; 12% of these were over 76
   - Unnecessary A&E attendances: 176 respondents reported using A&E instead of GP

9. Public views on how practices could improve care for patients are also identified by practice Patient Participation Groups. Each practice in Oxfordshire has a Patient Participation Group whose role is to ensure that the public voice is heard throughout the commissioning process, including decisions made by practices. In addition there is a Patient Participation Forum for each of the six localities in the County. These include representation from patient participation groups, local third sector agencies and district councils. They enable greater patient, carer and public face to face involvement in the design, planning and provision of health services, the development and consideration of proposals for changes in the way these services are provided, and decisions to be made by the OCCG affecting the operation of services.

10. Primary care is also facing workforce problems in terms of retention and recruitment and overall morale. The GP workforce has grown at only half the rate as other medical specialties and practices are experiencing difficulties in recruiting GPs and practice nurses to vacancies.

4

http://healthwatchoxfordshire.co.uk/sites/default/files/oxfordshire_healthwatch_gp_survey_final_october_2014.pdf

The Horsefair Surgery in Banbury which had experienced significant problems in recruiting GPs undertook a survey in 2014 to identify whether other practices in the Thames Valley were experiencing similar problems. Their survey found that:

- Of the respondents 38% were unsure if their practice would be in existence in 5 year's time increasing to 48% unsure if their practice would exist in 10 year's time.
- In response to 'My practice finds it easy to recruit GP partners', 64% responded 'No', in response to 'My practice finds it easy to recruit salaried doctors', 51% responded 'No' and 65% when asked about is it easy to find locums responded 'No'.
- 79% recorded that 'one or more GPs in my practice is experiencing 'burn-out' due to increasing and unsustainable pressure of work'.
- Respondents were asked if they have an intention to retire or take a career break in the next 5 years to which 48% responding 'Yes', and in asking respondents of plans to leave general practice in the next five years, the highest age-band indicating 'Yes' is in the 45-54 age-group and the highest number indicating their intention to leave in the next year are in the 60-65 age band.

11. As in other parts of the local health and care system, general practice is experiencing financial pressures. Spending on services has been relatively static since 2008 despite the increase in demand, whilst spending on acute care has increased during this period. The proportion of the total healthcare budget directed to primary care services shrank from 27% in 2006/07 to 23% in 2012/13[5]. Some practices are experiencing particularly acute financial difficulties especially those losing those Minimum Practice Income Guarantee (see Appendix A for details), raising concerns regarding their long-term viability, and a number of practices have merged to increase their economies of scale.

12. *"Improving general practice – a call to action'* [6] reported a growing dissatisfaction with access to services. The Extended Hours Directed Enhanced Services (DES) supports practices in providing GP and Nurse appointments outside of the core contracted hours of 08:00 to 18:30.

---

[5] An inquiry into Patient Centred Care In The 21st Century – Royal College of General Practitioners 2014
http://www.rcgp.org.uk/policy

[6] The NHS Belongs to the People – A Call to Action
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

Improving General Practice – a call to action Slide pack
http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf

Improving General Practice – a call to action Evidence pack
http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf

Currently 86% of practices in Oxfordshire are providing Extended Hours to their patients.

Directed Enhanced Services (DES) are offered out to all Practices and NHS England and Oxfordshire CCG work collaboratively to encourage all practices to provide these nationally commissioned services in order to improve access and improve patient satisfaction with access to services; however it is the Practices choice as to whether they provide the service. Practices made decisions on signing up to the Extended Hours Directed Enhanced Services (DES) by reviewing the National Patient Experience Survey data, Practice satisfaction surveys and in consultation with their Patient Participation Groups.

13. .

14. From the 31st March 2015 it will be a contractual requirement for all practices to offer online booking for their patients. 75% of practices in Oxfordshire are already offering this service along with access to records and repeat prescription requests.

15. **The GP Patient Survey**
The GP Patient Survey is sent out every six months, commissioned by NHS England and implemented by Ipsos MORI. It is designed to give patients the opportunity to comment on their experience of their GP practice. Every six months, over one million questionnaires are sent out to adult patients, randomly selected from all patients registered with a GP in England.

The survey asks patients about a range of issues related to their local GP surgery and other local NHS services, including: how easy or difficult it is for patients to make an appointment at their surgery; satisfaction with opening hours; and the quality of care received from their GP and practice nurses.

The GP Patient survey results published in January 2015 show that satisfaction with access to services has again declined, as reported in the *'Improving general practice – a call to action'.*

Satisfaction in Oxfordshire remains above the national average and that of the rest of the NHS England Thames Valley Area. Table 2 in Appendix D shows an analysis of the keys access and quality questions in the National Patient Survey. But Oxfordshire is performing below the national average in terms of how long it takes to see or speak to a GP or nurse.

In summary, satisfaction with telephone access has decreased in Oxfordshire by 1% from 82% in 2013/14 t0 81% in 2014/15 (nationally, there has been a decrease of 1% from 73% in 2013/14 to 72% in 2014/15). There has also been a 1% decline in the satisfaction in opening hours from 78% to 77% (nationally, a 1% decline from 77% to 76%).

Patient satisfaction in the overall experience they have at their practice, their confidence in their GP and their nurse and whether they would recommend their practice to a family or friend has remained the same in Oxfordshire from

2013/14 to 2014/15 and as shown in Table 2 remains higher than that of the NHS England Thames Valley Area and national averages.

Local Views on how to improve GP services

16. Following publication of NHS England's priorities identified in 'Improving General Practice – A Call To Action' (2014)[7] Oxfordshire Clinical Commissioning Group undertook a public consultation in the summer of 2014 to establish public views on what aspects of GP services they wished to retain and what aspects they would like to see improved. A wide range of voluntary organisations, community groups, practice patient participation groups were consulted as to how best to develop GP services. The following key themes emerged:

17. **Respondents are happy with/would like to keep…**

- 90% (439) of respondents agreed that they received good quality of care from their GP practices, compared to 7% who felt that they did not.
- 31% (149) of respondents said they received good care in managing their long term condition
- 67% of respondents (324 people) felt that making an appointment is easy or acceptable compared to 32% (156) who felt it was not easy or difficult

18. **Respondents would like to change…**

- 57% would be willing to attend a different surgery for an urgent appointment, compared to 33% who declined while 10 % remained neutral. These results were similar for urgent nurse appointments.
- 65% (172) of people said they would be willing to see a specialist nurse at another surgery to manage their long term condition compared to 35% (110) who strongly disagreed with this approach.
- 50% (160) of those with a long term condition said they would be interested in using more technology to help them manage their condition, 19% (61 people) said they would not be interested and 31% (97) remained neutral.
- When asked about what technology people would like GP practices to adopt, 274 people (57%) said they would like text message appointment reminders, 80% would like to book an appointment online (there are further results that indicate that while online appointment booking is in place in some surgeries, people feel it needs improving), 62% said they would like test results by text and 71% would like to be able to email their GP for advice.
- 109 people called for greater communication around the role of the pharmacist in supporting patients while 86 people said further work needed to be done to increase

[7] Improving General Practice – a call to action Slide pack
http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf

patient's confidence in consulting a pharmacist and raising awareness of the level of training and the qualifications that pharmacists have attained. A further 69 respondents suggested greater privacy was needed to encourage patients to consult pharmacists about their ailments.

How National Priorities, Challenges to the Sustainability of General Practice and local priorities are being addressed

19. In order to address these pressures and to support the development of a strong and sustainable general practice capable of managing demand and increasing care out of hospital, the Oxfordshire Clinical Commissioning Group (OCCG) has identified the transformation of primary care as one of its five strategic priorities. A joint development board has been established with membership including NHS England Thames Valley Area Team, Oxfordshire Clinical Commissioning Group, Local Medical Council and HealthWatch Oxfordshire to progress this work.

20. Oxfordshire Clinical Commissioning Group clinical chairman has articulated a vision for general practice which aims to see it both sustained and improved in the next five years. This vision is to have high quality, safe, equitable and sustainable general practice across Oxfordshire. It aims to preserve the parts of general practice that work well- the small team approach, personalised service close to patients, continuity of care, and the autonomy of individual practices. At the same time practices will collaborate more to gain the advantages of working together in business planning, management, Information Technology, organisational development, capital etc.

21. The vision proposes that Primary Care would provide the 'broad foundation' of care, but for patients with greater needs access could be via community 'hubs'/intermediate care, for example Community Multispecialty Providers. These could be run by groups of practices, potentially working together with community services. For more specialist or 'hyper acute' care specialist acute hospitals would be used. Crucially the access to the different 'tiers' would be managed by primary care working with the other providers. These new models of care are consistent with national proposals outlined by NHS England in its *Five Year Forward View*. GP practices in Oxfordshire have been consulted on this vision and broadly support it. Oxfordshire Clinical Commissioning Group are now developing a strategy to deliver this vision and the six key national priorities. Proposed action includes the following:

22. **Providing holistic care**
As the complexity of patients' care needs increase it is important to address people's physical health needs, mental health needs and social care needs in the round and to offer more proactive care. This requires primary care to coordinate more closely with neighbourhood integrated community health and social care teams. To support this integration, practices working together collaboratively as federations plan to use care navigators to help co-ordinate the care of patients with complex needs. Funding to support these roles is being sought from the Prime Ministers Challenge Fund.

23. In addition new workforce roles such as physicians assistants, generalist community nurses, and emergency care practitioners will be tested to support a multi-disciplinary approach and to expand the range of workforce roles in primary care.

24. **Ensuring fast responsive access to services**

Currently 86% of practices offer Extended Hours, providing GP and Nurse appointments outside of the core contracted hours of 08:00 to 18:30. Practices decided whether to provide Extended Hours by reviewing National Patient Experience Survey data, Practice satisfaction surveys and in consultation with their Patient Participation Groups. Outside these hours patients are able to seek GP advice from the Out-of-Hours service.

In addition from the 31st March 2015 it will be a contractual requirement for all practices to offer online booking for their patients. 75% of practices in Oxfordshire are already offering this service along with access to records and repeat prescription requests.

Oxfordshire's Out-Of-Hours Service has seen a rise in numbers of over 5% in the period April to October 2014 with a number of individual months reaching between 9 - 10% higher than in previous years. This, together with other indicators and public feedback, suggests that access to GP care at weekends and in the evenings needs to be expanded.

A proposal requesting funding for a range of schemes that will improve access to GP services across the county is currently being sought from the Prime Ministers Challenge Fund. The interventions will collectively have the effect of enhancing patient access to Primary Care (physically and digitally), increasing focus on patients with complex care needs, and supporting patients in managing their own care better. Key initiatives include: Neighbourhood Hubs providing same day urgent care delivered by GPs, Emergency Care Practitioner Early visiting teams, Care Navigators and the introduction of Video and E-Consultations. Collectively they will produce 70,000 new consultations or appointments per year.

Prime Minister's Challenge Funding is only available for 2015/16 but it is anticipated that, if the increased access to GP services reduces demand on A&E and unplanned acute admissions, funding for these services will be continued by Oxfordshire Clinical Commissioning Group. The schemes to improve access have been designed and will be delivered by Oxfordshire's GP Federations (see 26.)

25. Reducing Health Inequalities and Preventing Ill-Health

Compared nationally, overall, Oxfordshire has relatively low levels of deprivation. However, there are particular areas in Oxford City, Cherwell, and Vale of White Horse districts which are among the 20% most deprived areas in the country.

Oxfordshire Clinical Commissioning Group, examples include:

For patients of the Leys Health Centre, a project is running to increase the uptake of childhood immunisations by additional telephone and letter contact to patients to encourage uptake and book patients into appointments. Another project has aimed to increase uptake of cervical screening appointments by South Asian and new migrant women, through telephone contact and booking women into appointments.

Banbury

In Banbury, 5 of the 13 Practices are located in, or will take patients from areas of inequality. Banbury Health Centre is situated in Grimsbury & Castle ward, serving patients in that deprived community. It is open from 8.00am until 8.00pm, every day, all year round.

.

The Banbury regeneration programme (Brighter Futures in Banbury), focuses on three key wards: Grimsbury and Castle; Neithrop and Ruscote. The Oxfordshire Clinical Commissioning Group North Locality Clinical Lead is engaged with the Brighter Futures programme. A project was conducted at West Bar surgery, targeting all women who hadn't taken up a cervical screening invitation, many of whom were from the South Asian community. The Cooking Skills project is another project which takes place in key areas of inequality in Banbury, with group sessions for people who want to learn how to cook and to cook healthy meals on a budget. It works through groups such as the children's centres; food bank; homeless hostels; Black and Minority Ethnic (BME) groups; older people's groups; Learning Disability Trust and many others. The cooking tutor is employed by a local GP Practice and the project steering group comprises the Practice Manager and Practice Nurse, as well as the cooking tutor and the Equality & Access Manager.

Promoting Good Health and Preventing Ill-Health

Much of the work of general practice is geared to preventing disease from becoming worse through early detection and prompt treatment. For example, prescribing of anti-cholesterol drugs and treatments for raised blood pressure have done much to decrease mortality from heart disease and stroke over recent decades.

Primary care also plays an active role in pre-natal healthcare, carrying out immunisations and some screening programmes eg cervical screening. Primary care is also a major provider of contraception services and is plays a part in the detection and management of outbreaks of infectious disease.

Preventing Ill-Health

Practices also undertake health promotion as part of the 'making every contact count' approach, encouraging patients to adopt healthy lifestyles that will promote health and wellbeing. In addition specific initiatives include:

- A pilot is currently underway of a carers information pack being given to carers when consulting their GP to support their health and wellbeing;
- All Practices have trained Smoking Cessation Advisers. They receive regular update training and information.
- One Practice in Banbury employs a Health Trainer to support patients with healthy lifestyle issues;
- The County Council commissions practices to undertake the NHS Health check programme.

26. Personalising Care

Personal care planning is being used to ensure that patients have personalized care plans that address the full range of their needs. All practices in Oxfordshire are offering a national directed enhanced service to develop care plans for the 2% of patients who have the highest complex care needs in the practice and who are more at risk of an unplanned hospital admission and who would be likely to benefit from more tailored, active support from their GP surgery. Under this programme, the patient has a named GP who has overall responsibility for the care and support that the practice provides and for ensuring that they have an up-to-date personal care plan.

.

Many patients with the highest health needs reside in care homes. National evidence suggests that enhanced primary care medical services to care/nursing homes has had success in driving up the quality of care and reducing admissions and attendances to hospital and length of stay for patients where admittance to hospital is unavoidable. In nursing homes where there is no arrangement for a GP practice to provide weekly, routine visits and reviews, care is often reactive.

There are 108 care homes in Oxfordshire (40 care homes and 68 care homes with nursing) giving a total of 4,887 bed spaces. In 2013-14 there were 2,482 attendances to A&E, 2,196 non-elective admissions, and South Central Ambulance Services received 2,530 emergency 999 calls for residents of care / nursing homes. Oxfordshire Clinical Commissioning Group is in the process of commissioning a service from practices whereby they would offer to provide additional medical support to care homes including initial assessment of new care/ nursing home residents; medication reviews; anticipatory care planning, and a weekly schedule visit by the usual GP for all patients needing a review. This new service will be available from April 2015.

27. Primary Care operating at greater scale

In order to access the benefits that can be gained by practices collaborating with one another, practices across Oxfordshire have been involved in discussions as to whether to form primary care federations, legally separate organisations that can offer benefits to member practices and that can offer a wider range of services. In 2014 seven federations have formed:

- Oxfed – comprising 22 of the 27 City practices
- Abingdon federation – comprising 3 practices, 2 in Abingdon and 1 in Berinsfield
- NOxfed – comprising 12 practices in the north
- Westfed – comprising 8 practices in the west
- ONE fed – comprising 10 practices in the north east
- Valefed – comprising 11 practices in the south west

Noxfed, Westfed, ONE fed and Valefed have formed as not-for-profit federations with the support of Principal Medical Ltd, a GP owned not-for-profit company that currently provides Out-of-Hours and Hospital at Home services in Oxfordshire. Practices in the South East locality are currently reviewing whether they wish to federate with their support.

The legal arrangements for the federations were completed by the end of 2014 and the federations are now in a position to respond to requests to tender as provider organisations. They have actively led the development of proposals for the Prime Ministers Challenge fund.

28. **General Practice offering a wider range of community services**

Currently individual practices provide a range of services over and above primary care national core services, offering patients an alternative to attending secondary care. GP practices can elect to provide these services providing the service criteria are met.

Amongst the services provided in primary care in Oxfordshire are:

- Arrhythmia Primary Care Services
- Dermatology (Skin Cancer) Primary Care Services
- DVT Primary Care Services
- Examination of the Newborn Primary Care Service
- Minor Injury Primary Care Scheme
- Near Patient Testing Primary Care Scheme
- Oxfordshire CCG Leg Ulcer Primary Care Services
- Secondary Care requested procedures Primary Care Services
- Warfarin Monitoring Primary Care Services

In the *Five Year Forward View,* NHS England's strategic vision[8], there is a clear commitment to increase the range of services being offered out of hospital to enable people to access more care closer to home. A number of care pathways for long term conditions such as diabetes and dementia care are currently being redesigned to identify opportunities to increase care out of hospital, potentially in neighbourhood or locality hubs. An example of how this is being taken forward is being demonstrated by the Primary Care Memory Assessment Service (PCMAS). This primary care based service aims to achieve access to more timely diagnosis and support services and primary care is well placed to play a bigger role in the treatment and care of patients with dementia and improve the rate of diagnosis.

The initiative sets out a three-stage assessment process so that diagnosis and management of mild cognitive impairments and dementia can be made in primary care in most cases safely and appropriately. This is an alternative to the usual referral to a specialist memory clinic. This service has been tested in six general practices in Oxfordshire Clinical Commissioning Group South west Locality and is now in the process of being offered to all Oxfordshire general practices.

29. **Quality Monitoring and Improvement of Primary Care**

Appendix C describes how NHS England Thames Valley Area Team monitors quality amongst Oxfordshire Clinical Commissioning Group practices. In addition it has worked with Oxfordshire Clinical Commissioning Group on a joint scheme in 2013/14 to improve quality and reduce unwarranted variation. The quality initiatives include review of out-patient referrals to secondary care with the aims of improving quality of patient referrals by using the most appropriate pathway. There are a number of ways in which the quality of general practice is measured; including patient experience.

[8] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004.

The Quality and Outcomes Framework rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. All Oxfordshire practices participate in the Quality and Outcomes Framework.

All Practices Quality and Outcomes Framework data is published nationally via the Health and Social Care Information Centre in the October following the financial year end. i.e. 2013/14 Quality and Outcomes Framework Achievement data was published in October 2014.[9]

Achievement for 2013/14 shows that;

The national average achievement score for practices was 831.4 points out of 900. This is 92.4% of the total available.

The Oxfordshire average achievement score for practices was 862.2 points out of 900. This is 95.8% of the total available.

162 practices in England achieved the maximum of 900 points, 2 of which were in Oxfordshire; Wallingford Medical Practice and Islip Medical Practice.

NHS Friends and Family Test in Primary Care

The NHS Friends and Family test (FFT) is an important opportunity for patients to provide feedback on the services that provide care and treatment. Patient's feedback will help NHS England to support Practices in improving services for everyone.

The NHS Friends and Family Test question is set out as follows;

"We would like you to think about your recent experience of our service.

How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment?"

The responses are: "Extremely Likely"; "Likely"; "Neither likely nor unlikely"; "unlikely"; "Extremely unlikely" or "Don't Know"

GP practices are required to implement the NHS Friends and Family Test from 1st December 2014. However, December will be a bedding-in period, and practices are not required to submit the data relating to feedback received in December 2014 to NHS England. The first submission of data will, therefore, take place in February 2015 relating to the NHS Friends and Family Test feedback received in the month of January 2015.

[9] http://www.qof.hscic.gov.uk/index.asp

The monthly data will be published on NHS England's website and on NHS Choices. In common with the introduction of the NHS Friends and Family Test in other service areas, this is currently expected to start after the first three month's data has been submitted, to give the process time to bed in before monthly publication starts,[10] therefore publication will start from May 2015.

Next Steps

This paper has identified the challenges facing general practice in Oxfordshire and has outlined the emerging vision and strategy to address these challenges and to sustain and improve the quality of primary care. The authors would welcome comments from Health Overview Scrutiny Committee on this emerging strategy and its advice on the public consultation which will be undertaken to seek wider views on these proposals.

Authors

Ginny Hope
Head of Primary Care

NHS England Thames Valley

Rosie Rowe
Head of Provider Development (Out of Hospital Care)
Oxfordshire Clinical Commissioning Group

Helen Clanchy
Director of Commissioning
NHS England Thames Valley

Dr Joe McManners
Clinical Chairman
Oxfordshire Clinical Commissioning Group

[10] http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Friends%20and%20Family%20Test%20in%20General%20Practice%20guidance.pdf

Appendix A: How Primary Medical Services are commissioned NHS England Thames Valley Area Team

NHS England Thames Valley Area Team monitors the contracts to deliver primary medical services held between NHS England (The Commissioning Board) and the 240 GP practices across the NHS England Thames Valley Area, 80 of which are in Oxfordshire. In order to do this with limited Area Team resources we use various sources of information to check that practices are meeting their contractual requirements such as the Quality and Outcomes Framework data, GP Patient Survey results, Care Quality Commission (CQC) reports, complaints, Friends and Family test and comparable benchmarking data with similar practices via a tool called the Primary Care web tool. All of this includes working closely with all the Clinical Commissioning Groups (CCGs) across the Thames Valley to share data and information about the practice's commissioning data and share local intelligence. Clinical Commissioning Groups have a statutory duty to support NHS England Area Teams to improve the quality of primary care delivered by their constituent practices.

NHS England Thames Valley Area Team works closely with the Local Medical Committees (LMCs) if an issue of underperformance is identified to ensure that the practice is treated fairly and the LMC can provide support and guidance to the Practice. It is important that information is triangulated rather than looking at data in isolation to ensure that an accurate and up to date picture of how practices are performing is gathered.

Joint Plans for Primary Care Co-Commissioning in Oxfordshire

Primary Care Co-Commissioning is about joining up the commissioning arrangements between NHS England and the Clinical Commissioning Group in order to:

- Co-ordinate focused support for primary care
- Deliver local priorities better
- Reduce system barriers and inefficiencies
- Put clinicians at the heart of commissioning primary care
- Increase the quality of primary care commissioning
- Improve patient experience

Oxfordshire Clinical Commissioning Group is proposing that it undertakes joint commissioning with NHS England Thames Valley. The benefits of this will be greater scope to develop local schemes to deliver primary care strategy and to amend national Directed Enhanced Services. It is an opportunity to have locally sensitive and place based commissioning to improve the quality of primary care commissioning. Both Oxfordshire Clinical Commissioning Group and the NHS England Thames Valley Area Team are responsible for quality of primary care – joint commissioning will avoid duplication and allow alignment of approach to quality.

GP Funding

The General Medical Services (GMS) contract rewards practices for essential services, as well as additional services that practices can choose to offer.

Practices' receive income through a number of different funding streams for different services including essential services, additional services, the Quality and Outcomes Framework (QOF) and enhanced services. Some practices may also receive seniority factor payments and payments for dispensing services.

The GMS global sum formula (the Carr-Hill formula) distributes the core funding - called the global sum - to general practices for essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age and deprivation. Global sum formula - NHS Employers

From 2004, when the new General Medical Services (nGMS) contract was introduced, the Minimum Practice Income Guarantee (MPIG) has been used to top up the global sum payments for some practices, to match their basic income levels before the new contract. Payments made under Minimum Practice Income Guarantee (MPIG) are called correction factor payments.

However, as part of the GP contract settlement in 2013, the Department of Health decided to phase out Minimum Practice Income Guarantee (MPIG) top-up payments over a seven year period, starting in the financial year 2014/15.

Seniority factor payments were also introduced as part of new General Medical Services (nGMS) contract in 2004, to reward GPs' experience. Payments are calculated based on a GP's years' of reckonable service in the NHS and 'qualifying income fraction'. The qualifying fraction determines the proportion of the seniority payment a GP receives, depending on whether they earn between 1/3rd and 2/3rds, or more than 2/3rds, of the national superannuable income, but excluding seniority payments.

It has been agreed that seniority payments will cease on 31 March 2020. In the meantime, those in receipt of payments on 31 March 2014 will continue to receive payments and progress as currently set out in the Statement of Financial Entitlements (SFE). There will be no new entrants to the scheme from 1 April 2014. The current qualifying arrangements will continue for those currently in receipt of payments.

As well as providing essential General Medical Services, some practices, usually in rural areas, provide dispensing services to patients who find it more difficult to access a pharmacy. Dispensing doctors receive a fee for each item that they dispense. The dispensing doctors' fee scale is calculated by dividing dispensing doctors' remuneration, by the number of items expected to be dispensed in the relevant year.

In addition to the payments for essential services, practices can also choose to offer enhanced services. Practices get additional payments for any of the services that they choose to provide. Directed Enhanced Services (DESs) are commissioned nationally by NHS England. Local Authorities (LA) and Clinical Commissioning Groups (CCGs)

commission local services, e.g. Local Enhanced Services (LESs) and Local Investment Schemes (LISs).

Practices may also receive payments through the Quality and Outcomes Framework (QOF) which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. Quality and Outcomes Framework includes incentives for some additional services.

In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[11]

[11] NHS Primary Care Transformation | 12 September 2013

Appendix B: Planning for Growth in Oxfordshire
Local challenges to the Sustainability of General Practice

Mapping information is used to assess whether the existing premises and facilities have the capacity to absorb proposed the population increase in housing developments. If it is established that there is capacity, then the additional patients will be absorbed by the local practices as and when the housing growth takes place. If it is identified there is not capacity to absorb additional patients, NHS England will work with practices to find solutions to this and this can take the form of either making modifications to the existing premises e.g. extensions and remodelling to create additional space or where this is not possible the relocation of a practice to new larger premises. In certain scenarios for example in areas of major housing development, the projected housing growth may be deemed too large to be absorbed by any one or even a combination of the existing practices, and in these instances NHS England will commission, via a tender process, an additional GP practice to provide these services to the new patients of specific house developments.

Ascertaining the capacity within the existing local infrastructure also informs discussions with the local council and house developers in order to gain Section 106 / Community Infrastructure Levy (CIL) monies to help make the premises modifications required to absorb this population increase.

The process for practices to gain approval for premises developments is currently under review and the new guidance is expected shortly. However, broadly this involves a practice submitting an Outline Business Case to NHS England, giving the general outline and rationale for why larger premises are required. The information gained from the mapping exercise, along with other considerations such as the general condition of the existing premises, will help to inform the decision making process for these cases. If approval is given, then the full Business Case is developed and submitted to NHS England for final approval.

NHS England will work closely with the local Clinical Commissioning Groups (CCG's), to understand their future primary care strategies so that any expansion of premises can be aligned with these plans as well as working closely with other partner organisations such as NHS Property Services and Community Health Partnerships so that there is an broader understanding of the NHS estate and facilities available.

Appendix C: NHS England Thames Valley Area Team
Measuring Quality and Performance Management

The publication of the Francis Report and the Winterbourne Report Governments response makes improving quality ever more pertinent and timely. There are many recommendations within the final report, fundamentally, it points to delivering a health service in which the patients must be the first priority in all that the NHS does. Also the vision for the NHS described in 'Equity and Excellence: Liberating the NHS' states "*to achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all*". To be successful in delivering the scale of change required by the health service in England, the approach to putting patient's first, improving primary care and specifically general practice provision needs to intensify.

The Primary Care Web Tool enables NHS England access to data which provides an approach to Improve Quality, Access and Patient Experience in General Practice. The tool contains outcome standards which were developed by a wide range of clinicians and other health care professionals. The outcome standards represent the basic patients should expect to receive form general practice. Taken as a whole, they provide the public, patients, General Practice, Clinical Commissioning Groups and NHS England's Area Teams and regional hubs with a set of standards, at a minimum, a practice should be delivering against the contract and are a first step at putting in place foundations for GP practices, Clinical Commissioning Groups and Area Teams to support peer review. The focus is on taking a holistic view of practices outcomes and trends overtime and not individual targets.

They are based on areas of general practice where there is evidence these will be effective in delivering priority health improvement outcomes in the NHS Outcomes Framework.

The tool allows Commissioners to analyse indicators and identify outlying Practices. Practices could be outliers in terms of over and under performance compared against their peers. The data therefore should be used to start a conversation between Commissioners and Practices.

Where contractual non-compliance is identified NHS England Thames Valley Area Team follows a single operating model which ensures remedial action is taken so that practices meet contractual compliance. In cases of significant failure contract breaches and notices to terminate contracts can be issued. NHS England works closely with the regulatory body, the Care Quality Commission (CQC) when contractual sanctions are required. The Care Quality Commission has the statutory powers to inspect GP practices, issue enforcement notices and place practices "in special measures" and in very extreme cases close practices. Again, NHS England Thames Valley Area Team works closely with the Clinical Commissioning Groups to ensure that they are aware of any such issues that may impact on the ability of practices in their area to deliver services to patients.

The Care Quality Commission (CQC) uses intelligent monitoring as part of the operating model for the way they regulate services, including:

- Registering those that apply to Care Quality Commission (CQC) to provide services
- Intelligent use of data, evidence and information to monitor services
- Using feedback from patients and the public to inform our judgments about services
- Inspections carried out by experts
- Information for the public on our judgments about care quality, including a rating to help people choose services
- The action taken to require improvements and, where necessary, the action taken to make sure those responsible for poor care are held accountable for it.

Each NHS GP practice has been categorised into one of six bands, with Band 1 representing the highest and Band 6 the lowest priority for inspection. The bands have been assigned based on the proportion of indicators that have been identified as a 'risk' or an 'elevated risk'.

The bandings give the Care Quality Commission, NHS England, Clinical Commissioning Groups and NHS GP practices, a guide to areas where they may need to look into in more depth. The bandings and indicators support the wider inspection approach and sources of information available to the Care Quality Commission teams. They should prompt NHS GP practices to ask questions, reflect and (if appropriate) take action in respect of their own performance in relation to others.

NHS
England

NHS
Clinical Commissioning Group ***Oxfordshire***

Appendix D: Table 2 NHS England Thames Valley Area Team Results GP Patient Survey, Oxfordshire Clinical Commissioning Group, published January 2015

CCG	Satisfaction with Telephone Access				Satisfaction with Opening Hours				Overall Experience of GP Surgery			
	2012/13	2013/14	2014/15	Total Difference	2012/13	2013/14	2014/15	Total Difference	2012/13	2013/14	2014/15	Total Difference
Oxfordshire	84%	82%	81%	-3%	80%	78%	77%	-3%	90%	89%	89%	-1%
England Total	75%	73%	72%	-3%	80%	77%	76%	-4%	87%	86%	85%	-2%
TVAT Total	78%	72%	74%	-4%	78%	74%	74%	-4%	88%	84%	85%	-3%

CCG	Confidence in GP				Confidence in Nurse				Recommend Practice			
	2012/13	2013/14	2014/15	Total Difference	2012/13	2013/14	2014/15	Total Difference	2012/13	2013/14	2014/15	Total Difference
Oxfordshire	95%	94%	94%	-1%	89%	86%	86%	-3%	84%	83%	83%	-1%
England Total	93%	93%	92%	-1%	87%	86%	86%	-1%	80%	79%	78%	-2%
TVAT Total	94%	92%	86%	-8%	88%	85%	80%	-8%	81%	78%	79%	-4%

Key	
(green)	Equal or Greater than England
(amber)	Less than England

NHS England

NHS Oxfordshire Clinical Commissioning Group

Appendix E: Oxfordshire Clinical Commissioning Group

Patient feedback on Access to GPs and Managing Long Term Conditions

	Patient Comments	**Oxfordshire Clinical Commissioning Group**
Access to GPs	• I wish to book an appointment on-line.	• In Oxfordshire 75% of practices already offer on-line booking. From the 1st April 2015 all practices will be required to offer on-line appointments.
	• I wish to have choice of appointments at weekends and evenings.	• In Oxfordshire 86% GP Practices offer extended hours appointments outside of the core hours 08:00 – 18:30. Outside these hours patients are able to seek GP advice from the Out-Of-Hours service.
	• I wish to wait less than a week for a GP appointment. • I would be willing to attend a different surgery for an urgent appointment.	• A proposal has been submitted for the Prime Ministers Challenge Fund that Neighbourhood Hubs provide same day urgent care delivered by GP. This proposal also includes a number of initiatives to help patients who have the highest complex care needs and who are more at risk of unplanned admissions, would lead to producing 56,000 new consultation slots or appointments per year.
Managing Long Term Conditions	• I would be willing to see a specialist nurse at another surgery to manage their long term condition. • I would be interested in using more technology to help manage their condition.	• Proposals for Prime Minister's Challenge Funding aim to expand the number of 20 minute appointments available for patients requiring complex care. It also includes plans to trial use of Video and E-consultations.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

5 February 2015

Child and Adolescent Mental Health Services Review

Introduction

This paper provides an update to members of the Joint Health Overview & Scrutiny Committee on the current review of the Child & Adolescent Mental Health Service (CAMHS) in Oxfordshire. The review is being conducted jointly between Oxfordshire Clinical Commissioning Group and Oxfordshire County Council.

1 Background

The Oxfordshire CAMHS service is part of an existing contract that the Clinical Commissioning Group has with Oxford Health NHS Foundation Trust. The service is jointly commissioned between the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council via the Section 75 Mental Health Pooled Budget. The investment in CAMHS is currently £6.1m. The services provided cover:

- Primary Community Mental Health Service (PCAMHS or early support)
- Tier 3 CAMHS Teams (specialist multi-disciplinary teams)
- Family Assessment & Safeguarding Service (FASS)
- Child and Adolescent Harmful Behaviors Service (CAHBS)
- Neuropsychiatry Service
- Learning Disability and Mental Health specialist service
- Infant Parent Perinatal Service (mothers and babies)
- Integrated Social Work Service
- The Outreach Service (OSCA) which also covers crisis and out of hours.

The Clinical Commissioning Group does not commission inpatient beds for CAMHS. Since 2012 the beds provided at the new Highfield Unit on the Warneford Hospital site have been commissioned by NHS England and are accessed by a wide range of young people from across central and southern England. Most Oxfordshire young people who need an inpatient bed can be admitted to the Highfield Unit. The exception is young people with a learning disability where inpatient beds sit in hospitals outside of Oxfordshire. NHS England acknowledges that there is a

shortage of inpatient beds for young people with a learning disability nationally which exacerbates the difficulty of finding the appropriate placement for these children in a timely way.

The Oxfordshire CAMHS service works closely with schools and schools are one of the main sources of referrals to CAMHS. School based counselling services are usually purchased by schools individually or are provided by the school's own pastoral team and have not been included as part of the review although schools have been part of the review team and widely consulted.

3. Drivers for change

It is good commissioning practice to review services to ensure that they are delivering what was originally intended and to plan any proposed changes for the future. There is recent evidence that the Oxfordshire CAMHS service is of good quality and this was reflected in the recent Oxfordshire Ofsted Report and also the Thames Valley Strategic Review of CAMHS services. It is, however clear that there are a number of new and emerging demands on the service that means it is unlikely to be fit for future demand and new strategic developments, and this is agreed by both the commissioners and the current provider.

The local changes that will impact on CAMHS include:

- ✓ Increasing demand for CAMHS services and increasing complexity in cases once assessed. There has been a 12% increase in the number of referrals year on year and this has been one of the reasons why waiting times for appointments have increased.

- ✓ Delivering the Council's Placement strategy for Looked After Children and those on the edge of care so that the riskiest young people stay in Oxfordshire rather than go to placements outside of Oxfordshire. This will mean that more young people will be moving through the system and requiring mental health interventions and staff will need supervision and support around managing young people with more risky behaviour.

- ✓ Changes to the Council's Children's Services including further Academy conversion and realigning Early Help and Childrens' Social Care services within a reduced funding envelope.

- ✓ Increasing pressure on mental health budgets where the financial envelope has stayed the same but the demand has increased.

4. Picture of children and young people's mental health in Oxfordshire

1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder – that is around three in every class at school. About half of these (5.8%) have a conduct disorder, whilst others have an emotional disorder (anxiety, depression) or an Attention Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16-24 age groups. Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.

Vulnerable groups are more likely to develop mental health difficulties and the prevalence is as follows:

- 45 - 60% of Looked After Children aged 5 to 17 will have mental health difficulties: over four times higher than for all children.
- 70% of people with Autistic Spectrum Disorder also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder that is further impairing their psychosocial functioning.
- 40% of children and young people with a learning disability are likely to develop a mental health disorder.

In Oxfordshire:

- CAMHS work with approximately 3500 children and young people at any given point in time (just 3% of the population of 5-18).
- More than a third of the inpatient beds at the Highfield Unit are used by young people with an Eating Disorder.
- The most common diagnosis in CAMHS is anxiety and depressive illness, closely followed by hyperkinectic disorder (pattern of severe, developmentally inappropriate inattention, hyperactivity and impulsivity).
- The age of young people on referral to CAMHS follows a predictable pattern with a gradual rise from 5 years to 11 years old and then a steep increase as young people move into adolescence.
- GPs are the main referrers to CAMHS but schools also make up a significant proportion of referrals. Work has been undertaken to inform schools that they can refer direct and that referrals can come from any member of the children's workforce.
- 75% of young people are seen within 12 weeks of their referral. Those referred as an emergency are seen within 24 hours. Those referred as urgent are seen in 7 days.
- Young people and families can re-refer themselves directly to CAMHS within a year of their case being closed without going through another referral.

Review process

This review of CAMHS commenced in September 2014 and will be completed on 31st January 2015. The review has been led by the CCG as lead commissioners but has been driven by a multi-agency project team that has met monthly. Children and young people have been consulted as have parents of young people using the CAMHS services. A Parents Reference Group and a Young People's Reference Group have been established to be part of implementing the recommendations of the review. There has been substantial consultation with schools, including an online survey and an excellent response was received with more than eighty responses. Similarly there has been a survey of GPs, discussions with Children's Social Care Teams and more recently face to face meeting with countywide CAMHS Teams to establish what is working well and what could be improved.

Findings from the review so far

The CAMHS Review is just being completed and will be published in March. What is already clear is that there is an **increasing demand** for CAMHS services and these services have to be delivered within the **same financial envelope** in a time of continuing financial restraint.

We know that the referral rate locally has increased by 12% (equates to 388 extra children and young people) from 12/13 to 13/14 and we expect an even greater rise in 14/15. The service is currently meeting the targets to see young people who are referred as an emergency (within 24 hours) and they also see young people who are referred for an urgent referral within 7 days which again is within target. However, we have seen an **increase in waiting times** for the assessment of routine referrals into services. This is by far the single biggest issue that the review has found and this has been echoed by all the stakeholder groups who have contributed to the review.

CAMHS teams are also reporting that the children and young people who are referred present with **increasingly complex needs**. These needs cut across health, education and social care and increasingly with housing need and so there is a need for **a more integrated approach** across partners (including commissioners) to deliver better and more efficient services.

Communication (primarily with schools, primary care and social care) has been raised both in terms of information to the family and referrer but also in respect of the quality of information on referrals received. The review proposes that there should be a **different approach to early mental health support** which clearly describes what the service offer is and how that differs from services such as school nurses and school counselling services. This should also ensure that **information about services** and pathways is clearly available to young people, families and professionals through a variety of media such as online services.

The review has also highlighted the need for **more joint working between adult mental health services** and CAMHS, especially for young people with disabilities and special educational needs.

Conclusion

It has become very clear during the review that CAMHS cannot deliver the entire mental health strategy alone. It is reliant upon other partners delivering universal service to have in place effective and evidenced based interventions that prevent the need for more specialist and expensive service such as CAMHS. It is therefore essential that in developing a coherent pathway we do collaborative commissioning across the Clinical Commissioning Group and County Council and across adult and children's services. We are also keen to foster and develop a stronger relationship with the voluntary sector to explore opportunities and innovation, especially in the areas where local organisations have established expertise and experience.

The balance of resources between early mental health support and more specialist mental health interventions will need to be prioritised. There is a clear and compelling evidence base for investing in early intervention with a return of £12 for every £1 invested. However there is also an increased need to improve services to vulnerable groups such as children looked after and those on the edge of care, young people with Autism and those young people who have been sexually abused.

Next Steps

- The review will be completed at the end of January. The report on the review will then be published following the March meeting of the Project Group.
- Work will commence on developing the new model of CAMHS provision and this will be informed by the review.
- The model will then go out for wider consultation and the Children's Trust (sub-group of Oxfordshire Health and Wellbeing Board) will sign off the model by September 2015.

It is expected that the new model will be implemented by April 2016.

Sarah Breton

Strategic Commissioner, Children, Young People and Maternity Services

This page is intentionally left blank

Oxfordshire
Clinical Commissioning Group

Update on Outcome Based Contracting

1. Introduction

At its last meeting the Joint Health Overview and Scrutiny Committee received a brief paper on the work being undertaken by Oxfordshire Clinical Commissioning Group to develop outcomes based contracting for mental health and older people's services. The Committee asked for further clarity and detail in a number of areas. This paper addresses the issues raised and is the basis for further discussion.

2 Defining and monitoring the outcomes

2.1 Outcomes and indicators

The high level outcomes that we are focusing on have been developed from previous work undertaken with the County Council in terms of developing joint commissioning strategies and, importantly, by listening to what users and carers told us were important to them. Each outcome has associated with one or more indicators which are we will use to measure whether there is improvement. Each indicator has a clear definition and the contract will specify the baseline (or the timeframe in which the baseline will be agreed) and the improvement trajectory over the lifetime of the contract.

For each service area the high level outcomes and some indicators (these are only some of the proposed indicators not the full set, these are still subject to contract negotiation) are given below:

<u>Mental Health</u>

- People with severe mental illness will live longer
- People will improve their level of functioning
- People will receive timely access to assessment and support
- Carers will feel supported in their caring role
- People will maintain a meaningful role
    - Indicator: Proportion of people in employment, education or structured volunteering
- People will continue to live in stable accommodation
- People will have better physical health –
        - Indicators: Reduced use of urgent care pathway; Proportion of people with "normal" BMI and Reduction in the number of people smoking

Older People

- As an older person or carer, I want to be helped to be healthy and active
    - Indicators include: Percentage of people discharged to community rehabilitation from acute care; Percentage of people who complete the reablement service that receive no on-going care; Flu and pneumococcal immunisation rates
- As an older person or carer, I want to be helped to be as independent as possible in the best place for me
    - Indicators include reduction in delayed transfers of care
- As an older person or carer, when I am in need or care, it is safe and effective
- As an older person or carer, I want to have a good experience and be treated with respect and dignity

2.2 Contract management

The outcomes and indicators are in addition to standard quality schedules that are within the overall contract. A single contract will be let for each service area. The contract would be the NHS Standard Contract which includes clauses to cover foreseeable risks such as poor performance, provider failure, termination conditions etc. There is a clearly outlined escalation framework for addressing poor performance which includes the ability to withhold payment. The main change is that the payment currency will be outcomes not activity.

The contract would be let for a longer period (probably 5+2 years) to enable provides to have security to make the service and pathway changes required. This will be supported by a clear performance framework. The overall performance framework within the contract will clearly identify all measures that need to be delivered; this includes both the indicators being used to measure delivery of the outcomes and those that are core quality measures (for example infection control, waiting times, national clinical standards and safeguarding standards). The contract will be clear as to the actions to be taken if the provider fails to provide the data or deliver the required performance. At all times the priority will be to ensure the delivery of safe services.

3 Provider Assessment and current position

3.1 Approach to Provider Assessment

Oxfordshire Clinical Commissioning Group agreed that for these service areas it would be in the best interests of the patients and public to work with the current providers. This involved an assessment process ("Most Capable Provider Assessment") The Clinical Commissioning Group ran this process in line with our responsibilities under the NHS Procurement, Patient Choice and Competition Regulations. It is for the CCG to decide what services to procure and how best to secure them in the interests of patients, within the framework of the Procurement, Patient Choice and Competition Regulations.

It is important to recognise that the most capable provider assessment is undertaken to ensure that OCCG is assured that the providers are willing and capable of delivering services that will achieve the identified outcomes. A positive outcome from the most capable provider assessment would lead to a recommendation to proceed to contract negotiation.

The most capable provider assessment assesses Provider proposals against the following criteria:

a. Provider engagement and demonstration of appetite to jointly develop a new service model
b. Acceptance of key principles
c. Demonstration of capabilities

3.2 Update on Mental health

Contract negotiations with the Oxford Mental Health Partnership (comprising of Connections, Elmore Community, Oxford Health NHS Foundation Trust, Oxfordshire Mind, Response Organisation and Restore) are underway.

3.3 Update on older people

The proposal submitted by Oxfords Health NHS Foundation Trust and Oxford University Hospitals NHS Trust has been evaluated. The Evaluation Panel determined that in light of the moderated scores, the proposal met the threshold set out in the most capable provider assessment in five of the six domains The proposal from the Providers was based on a different population and service scope from that which was set out by the commissioners in their invitation to participate in the process and productive discussions are ongoing to reach a joint understanding of scope and reach agreement on the methodology for determining the financial envelope. We expect to conclude these discussions in the next month.

This is a complex service area so it is not surprising that it has been necessary to have on-going discussions regarding scope and financial envelope. The positive approach taken by the Providers must be recognised alongside their commitment to making this work for patients.

4 Scrutiny of potential changes in services

Following contract award, if Providers wish to propose changes to services to enable them to deliver the improvement in outcomes these would be subject to normal arrangements for engagement and consultation (depending the nature of the proposed changes). This is covered by legislation and NHS England guidance to commissioners.

Dr Barbara Batty, Clinical Lead for Older People, Oxfordshire Clinical Commissioning Group
Catherine Mountford, Director of Governance and Lead for Outcomes Based Contracting, Oxfordshire Clinical Commissioning Group

This page is intentionally left blank

Draft HOSC Forward Plan – Proposed Items

Below is a list of forward plan items that have been suggested by HOSC members during previous meetings and discussions held to identify priorities for the year ahead.

23rd April

- NHS England Commissioning (specialist services)
- Healthwatch
- SCAS (rural and major incident response)
- Oral Health and Dental Services
- Sexual Health Contract

2nd July

- Oxford Health Foundation Trust Strategy
- Urgent Care Pathway
- Horton Hospital Update
- Healthwatch
- Health & Wellbeing Board Strategy & Annual Report

Future Meetings

17th September
19th November

Items to be scheduled:

- Complex Health Needs
- Immunisations
- Adult Mental Health
- Care Quality Commission Inspections
- Southern Health
- Health of Ethnic minorities
- Single Health & Social Care Strategy
- Health in Prisons
- Community Hospitals Review
- Health Planning
- Oxford University Hospitals (action plans update)

This page is intentionally left blank