Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 8 February 2018 at 10.00 am
Council Chamber, West Oxfordshire District Council, Woodgreen, Witney, Oxon OX28 1NB

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Monica Lovatt

Councillors:  Kevin Bulmer     Dr Simon Clarke     Laura Price
             Mark Cherry    Mike Fox-Davies    Alison Rooke

District Councillors:  Nigel Champken-Woods    Neil Owen
                      Andrew McHugh     Susanna Pressel

Co-optees:  Dr Alan Cohen     Dr Keith Ruddle     Mrs A. Wilkinson

Notes:  Date of next meeting: 19 April 2018

What does this Committee review or scrutinise?
• Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
• Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

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

For more information about this Committee please contact:
Chairman  -  Councillor Arash Fatemian
            Email: arash.fatemian@oxfordshire.gov.uk
Policy & Performance Officer  -  Samantha Shepherd Tel: 07789 088173
                                       Email: Samantha.shepherd@oxfordshire.gov.uk
Committee Officer  -  Julie Dean Tel: 07393 001089
                           Email: julie.dean@oxfordshire.gov.uk

Peter G. Clark
Chief Executive
January 2018
About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.
AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 22)

   To approve the minutes of the meeting held on 16 November 2017 (JHO3) and to receive information arising from them.

   NB. For ease of reference a copy of the actions from the last meeting are attached for information (JHO3a)

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 23 - 26)

   10:15

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

6. Healthwatch Oxfordshire (Pages 27 - 38)

   10:30

   George Smith, Chairman and Rosalind Pearce, Chief Executive Officer, will be present to report on the views and latest activities from Healthwatch Oxfordshire (JHO6).
7. **Response to IRP Recommendations (including West Oxfordshire Locality Plan; Outcomes of Independent Review; and Outcomes of Ways of Working Workshop) (Pages 39 - 174)**

10:45

The item (JHO7) gives feedback on progress made on recommendations made by the Independent Reconfiguration Panel (IRP) to this Committee and the Oxfordshire Clinical Commissioning Group (OCCG). The recommendations emerged following a referral made by this Committee to the Secretary of State relating to the decision by OCCG not to re-procure services at the Deer Park Medical Centre.

The item will cover progress on:

(a) development of a comprehensive plan for primary care and related services for Witney and its surrounds. OCCG representatives will share the West Oxfordshire Locality Plan with the Committee;

(b) feedback from the independent review of the OCCG’s process for developing a comprehensive plan for primary care in Witney and its surrounds. This review was commissioned by NHS England and representatives will attend to introduce this item; and

(c) a review of the relationship between this Committee and Health to ensure it commands public confidence. The Committee will receive feedback from the review and the next steps following a joint HOSC/Health ‘ways of working workshop.

8. **Cancer Services at the Churchill Hospital** (Pages 175 - 180)

12:00

In light of the recent focus in the press on cancer services at the Churchill Hospital, a report was requested from Health representatives (JHO8) on the provision of services at the Hospital and any actions taken to ensure the resilience of these services.

The role of HOSC in monitoring the provision of Cancer Care at the Churchill going forwards will be discussed.
9. **Chairman’s Report** (Pages 181 - 206)

12:45

The Chairman’s report is attached at JHO9. It includes answers to Committee members’ questions regarding Musculoskeletal Services (MSK) and an update on Banbury Health Centre.

LUNCH 13:30
Declarations of Interest

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

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, or
- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.
(in each case where the member or co-opted member is aware that the other person has the interest).

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

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

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

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

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

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

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

MINUTES of the meeting held on Thursday, 16 November 2017 commencing at 10.00 am and finishing at 3.45 pm

Present:

Voting Members: Councillor Arash Fatemian – in the Chair
District Councillor Monica Lovatt (Deputy Chairman)
Councillor Kevin Bulmer
Councillor Mark Cherry
Councillor Dr Simon Clarke
Councillor Mike Fox-Davies
City Councillor Mark Ladbrooke (in place of City Councillor Susanna Pressel)
Councillor Laura Price
Councillor Alison Rooke
District Councillor Nigel Champken-Woods
District Councillor Andrew McHugh

Co-opted Members: Dr Alan Cohen and Dr Keith Ruddle

Officers:
Whole of meeting Strategic Director for People; Julie Dean and Sam Shepherd (Resources)

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

51/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

City Councillor Mark Ladbrooke attended in place of City Councillor Susanna Pressel.

Katie Read

The Chairman began the meeting by thanking Katie Read for all her good work as Policy Officer to this Committee and wished her well in her co-ordinating role for scrutiny in the County. He also welcomed her successor, Samantha Shepherd as Policy Officer to this Committee.
He also welcomed new member Dr Alan Cohen as co-optee and District Councillor Neil Owen representing West Oxfordshire District Council.

52/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

The following declarations of interest were received:

- Agenda Item 8 - Banbury Health Centre – Cllrs Arash Fatemian and Mark Cherry declared a personal interest on account of their being regular users of a GP practice in Banbury;
- Agenda Item 8 – District Cllr Andrew McHugh declared a personal interest on account of his appointment as a short-term locum at West Bar GP surgery, Banbury; together with his involvement in the running of social prescribing in Cherwell up to 2016;
- Agenda Item 9 – City Cllr Mark Ladbrooke declared a general interest on account of his wife’s employment in the library service at the Warneford Hospital.

53/17 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 14 September 2017 were approved and signed as a correct record subject to the inclusion within the Chairman’s Report (Minute 50/17) of the formal announcement of Dr Alan Cohen as a co-opted member of the Committee.

With regard to Minute 47/17 - Advice from the Independent Reconfiguration Panel (IRP) (final paragraph) – It was reported that the informal working group would begin its work in the near future despite the imminent change in chief executive of the OCCG.

54/17 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

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

- Agenda Item 9 – Sarah Lasenby, speaking as a member of the public
- Agenda Item 9 – Larry Sanders, speaking as a member of the public
- Agenda Item 10 – Written statement by Jane Southworth, on behalf of the Patient Participation Group (PPG), Deer Park Surgery, Witney
55/17 FORWARD PLAN  
(Agenda No. 5)

The Committee considered a proposed Forward Plan (JHO5). During the ensuing discussion the Committee added the following:

- Update on Mental Health services with a particular look at the provision of mental health services to former servicemen; and
- Musculoskeletal Service – following discussion at the last meeting the Committee requested that a more detailed briefing, including a progress report, be taken to the next meeting in February. Members were asked to submit any further questions for Health to respond to.

56/17 HEALTH INEQUALITIES COMMISSION - UPDATE ON THE RESPONSE BY HEALTH & WELLBEING BOARD  
(Agenda No. 6)

The Committee had before them a report which had been presented to the 9 November 2017 meeting of the Oxfordshire Health & Wellbeing Board (HWB) detailing progress made against the Health Inequality Commission (HIC) report’s sixty recommendations (JHO6). The County’s Strategic Director of People & Director of Public Health, Dr Jonathan McWilliam, together with Jackie Wilderspin (Public Health Consultant) and Ally Green, OCCG (representing Dr Joe McManners, Clinical Chair, OCCG) attended the meeting to respond to questions.

Dr McWilliam commented on the importance of keeping the topic alive amidst many other competing priorities. The Commission report had produced recommendations which were very specifically targeted at particular organisations and some which were outside of the normal statutory organisations. Furthermore, a key task of the HWB, in its capacity as an advisory partnership, had been to undertake an overview and co-ordinating role to the work of the Commission.

Jackie Wilderspin introduced the paper and responded to questions from members. The Committee welcomed the report recommendations and views, comments and questions from members were as follows:

- The usefulness of this work in breaking the silos apparent between organisations was very good. However, this type of work did not fit with planning timeframes and the measurement of performance. For example, BME women needed additional obstetric intervention in childbirth – was this taken into account with the proposals to close the obstetric services at the Horton General Hospital? Dr McWilliam responded that there was no need to wait for implementation of the proposals, organisations were welcome to act on them themselves;

- With regard to the need to carefully monitor food banks, in light of the Council’s removal of funding to support homeless shelters, a member asked if the need for food banks was increasing and wasn’t there a need to understand their use, rather than just mapping and monitoring? Jackie Wilderspin responded that
work was still ongoing in relation to their use and a report back on food bank activity had been requested;

- The decision to form an Innovation Fund was good but this might not meet the greatest need in some geographic areas. How robust was the strategy to conduct this? Dr McWilliam commented in response to this on the need to adopt three main approaches simultaneously. The greatest was the goal of adopting long term strategies for which funding was required both to spark and keep county-wide interest and to drive the Health Inequalities programme through. The short-term work was necessary to keep the programme rolling and action going via specialist interest and strategic drive. Health Inequalities were driven by population need, not where there were initiatives;

- The Joint Strategic Needs Assessment (JSNA) and all other policies were in danger of allocation to those who shouted the loudest? Jackie Wilderspin stated that the Commission had formed its report on representations from communities at meetings and objective data from the independent Director of Public Health’s independent report and the JSNA. Dr McWilliam encouraged a request from the Committee to see the assessment criteria to see which projects qualified for funding. As an additional piece of scrutiny, and as a good companion to the Commission’s report, he suggested that members read ‘Oxfordshire Uncovered’ by the Community Foundation which highlighted where inequalities lay across the county;

- In light of the recommendations contained in the report highlighting the future work needed to monitor the impact on school readiness in terms of previous family link work done with nurseries prior to the closure of children’s centres, Dr McWilliam reminded the Committee that he had flagged up the need to take an overview of this trend in his independent report. He added that school readiness was monitored via Child Health. The Committee requested an update on criteria determined and agreed upon;

- A member asked about ongoing work on gaps in the provision of mental health services for older people in relation to access to the service on the basis of age, not need. NHS England had stipulated that it should be on need. Jackie Wilderspin responded that a review of mental health services was currently in progress and work was also ongoing on getting a mental health need assessment to support the review. The Health Inequalities Commission would be tapping into this review;

- In response to an enquiry about whether social prescribing was likely to arrive in north Oxfordshire, Jackie Wilderspin stated that explorations were ongoing into this issue as service use data was very poor. Patient records with regard to ethnicity were incomplete, the belief being that a proportion of patients chose not to have it recorded, thus making analysis impossible. However, whatever data was available could be used to encourage all organisations to make use of it equitably. She added that there were no detailed plans regarding social prescribing at present. A Team was currently working on it. The Committee requested the timetable for rolling out details, when available, for social prescribing;
A member asked if there was more that could be done by the HWB to encourage take-up on services to assist with poverty, i.e., the living wage and affordable housing. In addition, was there anything Public Health could do to increase the provision of affordable housing within the county. Dr. McWilliam stated that it was a joint effort by both the county and district councils, both being public health organisations. It was the key business of the Health Improvement Board, a partnership group reporting to the HWB who engaged with all the wider determinants of Health affecting all key organisations;

In response to a question about whether the recommendations of the Commission were reflected in the STP plans for major development in Health to respond to need, Dr. McWilliam stated that this Committee in its role as scrutineer, had an important role to play in prompting each organisation to think about health inequalities, adding that it would be very helpful if HOSC was to keep it on its future Agendas in order to keep the subject alive. Ally Green agreed to request Dr. McManners, Chair of the Commission, to give a response to the Committee’s questions and these to be circulated to all members of the Committee;

A member asked about issues relating to housing need for older people in social housing. Jackie Wilderspin responded that this had not been addressed as yet, but once it had she would circulate a response to the Committee;

A member expressed concern in relation to the abundance of references to the support of older people digitally and about the complex nature of the forms, such as that for the Attendance Allowance applications. Dr. McWilliam agreed with this observation.

On the conclusion of the question and answer session, the Committee thanked Dr. McWilliam and Jackie Wilderspin for their attendance and AGREED that the Health Inequalities Commission recommendations be re-visited every 6 months for the foreseeable future.

57/17 HEALTHWATCH OXFORDSHIRE - UPDATE
(Agenda No. 7)

The Committee welcomed Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) to present the regular update of issues/activities since the last meeting (JHO5). She offered her Chairman, Professor Smith’s apologies as he had been delayed. Rosalind Pearce highlighted the following:

- There would be a stall on Stroke Awareness at Thame Market on 28 November. She reported that despite the usual practice of working with HWO Buckinghamshire, unfortunately they would be unable to join in on this occasion. Cllr Champken - Woods thanked her for arranging this as it was at the request of the Committee. She added that a stall was also planned in a town in the Vale of White Horse area in April next year;
A key recommendation coming out of the recent Forum meeting was that the Oxfordshire Health & Wellbeing Board (HWB) needed to have better ways of engaging with the voluntary sector. Dr McWilliam responded that this had been taken on board and a review of HWB Board governance was taking place. This matter would be on the HWB Agenda for the next Board meeting on 22 March 2018;

HW0 would be facilitating a meeting to establish a project fund in January 2018 to enable research on Health Inequalities.

Questions and responses received from the Committee were as follows:

- In response to a question about whether issues had been raised with HW0 about the restricting of day services, Rosalind Pearce stated that people had contacted HW0 post change. Many were unhappy that they were unable to access services that they would have to travel further to. Age UK had been doing a significant amount of work in the community with the people affected, as had HW0 following their concern about social isolation amongst older people. She added that HW0 was planning to try to understand the longer-term impact of this and then to embark on a piece of work starting in September 2018, for report in February 2019;

- Rosalind Pearce was asked if there had been any work done by HW0 on waiting times for GP practices, as this tended to increase numbers attending Accident & Emergency departments. She stated that HW0 had found that people were not happy if people had to wait for longer than one week and there was significant dissatisfaction after two weeks. It was the view of HW0 that there was a need to re-educate the public in order to change the way they booked appointments. For example, to encourage them to book a further appointment on their way out from an appointment, if appropriate, or to encourage them to see an alternative doctor sooner rather than later with their preferred one. Nowadays patients could see the practice nurse or the local pharmacist depending on the problem. She added also that now there was a GP service operating in the acute hospital;

- In response to a question about what HW0 planned to tackle next, she stated that HW0 had a rolling annual plan in place. She added that HW0 tried to state what they had heard from patients and the public and action taken by HW0 as a result, together with any action implemented by an organisation as a consequence. This assisted in HW0 gaining a better feel of its impact and the difference made;

- Rosalind Pearce confirmed that HW0 would accept anonymous accounts from the public, often of their experiences of the administration of services, not generally on the delivery of care. Ideally, this would come from the patients themselves, as the patients’ story was the most powerful voice. She added that often people did not understand that HW0 was an independent body and felt there needed to be a way of disseminating an understanding that what they had to say would not affect their care in any other way but a positive one;
- Rosalind Pearce was asked how could HWO engage in the reduction of poverty and in raising wages? She responded that whilst HWO was pleased that Oxfordshire was looking at and tackling health inequality issues, it had not been engaged in a campaign to reduce poverty as it was outside its remit of listening about existing services. However, HWO had recently appointed a project officer with a public health background who could assist with demand management. For example, HWO would be looking at the 111 service and its impact in a bid to understand the alternative ways to help people in providing their own support;

- In response to a question to Rosalind Pearce about whether HWO had a policy on home visits to patients by GPs, Paul Roblin, Local Medical Council, who was in the public gallery, informed the Committee that it was inappropriate to have a policy as each individual practice and GP had to make an assessment as to what was required. Over time there had been a move away from routine visiting. It was the best option if the patient could attend the surgery to access not only the GP but the equipment and support staff, but if not, the patients and triaging staff needed to use their own judgement on when a home visit was necessary. A member put forward the view of a Chipping Norton PPG which expounded the benefits of connecting people and letting them know what was the usual practice used by the surgery, via its website. He encouraged all GP forums to be much more active in a similar manner. He believed that HWO could apply some leverage on PPGs; and

- A member asked Rosalind Pearce for a view by HWO of the need to pre-book a place at a workshop on future planning of primary care in Witney and its surroundings, which had resulted in a feeling of exclusion. She responded that she understood it was due to the size of the venue.

The Committee thanked Rosalind Pearce for the report and for her attendance. It was AGREED to note the report.

58/17 BANBURY HEALTH CENTRE
(Agenda No. 8)

Information was sought by the Committee from the OCCG on its plans for future changes and consultation for Banbury Health Centre. The following reports from the OCCG were considered:

- Delivering primary Care at scale in Banbury (JHO8)
- Consultation Plan – Banbury Health Centre (JHO8)

The meeting was attending by the following representatives:

- Julie Dandridge, Ally Green and Dr Paul Park – OCCG
- Paul Roblin – Local Medical Council

A powerpoint presentation was given by Ally Green and Julie Dandridge on proposals for the practice.
Ally Green stated that the OCCG had learned from experience, had engaged with patients already via the PPG. They had also talked to members of the Community Partnership Network and shared the draft plans to consult online. The OCCG had also listened to feedback and had revised their consultation plans and options accordingly. Ally Green that the CCG had wanted to engage with HOSC early about the way it intended to consult.

The Chairman thanked Ally Green and Julie Dandridge for the presentations. He pointed out that the 8am – 8pm offered by the Centre was the result of a unique contract set up in 2009 as a Darzi Health Centre and it was a facility which was very much welcomed by patients. He began the discussion by asking why was it necessary to move away from these compelling characteristics when it had served the community so well?

Dr Park stated that he was one of the founding GPs of the Centre and had judged it to be a good place to work and gave good primary care service to patients. The question to be considered now was how the opening hours could be retained alongside the expansion of services in north Oxfordshire giving capacity in Banbury to treat unregistered patients, give coverage by the Neighbourhood Access Hub, plus a GP Out of Hours service. In addition, how to take north Oxfordshire forward in terms of health inequality issues with the catchment area containing two clusters with deprivation of illness, disease, cancer and stroke.

Responses to questions from the Committee were as follows:

- **Would Windrush and the drop-in centre at Bradley Arcade shops be included in the consultation?** – Julie Dandridge responded that Woodlands and West Bar surgeries would be integrated in an innovative piece of work creating a pathway for other practices to join in. She added that each practice was the GPs own business and each must agree the right way for their practice. However, proposals would allow individuals to join together to decide how to provide services. Dr Park pointed out that Bradley Arcade was a branch surgery of Windrush Surgery;

- **In response to a report about a certain amount of scepticism amongst the public that the Banbury Health Centre would be closed and the need for new GPs and trainees in the area, Dr Park agreed that there was a need for training practices and larger practices could encompass this;**

- **A local member of the Committee declared himself in support of the assimilation of smaller practices into larger practices which would offer the best IT services and deliver the best benefits for patients. However, his view was that he would like to see the retention of Banbury Health Centre where they were registered. He recognised that there were cost implications for retaining the centre as set out in the report, but did not feel that these were much higher than those for West Bar. He asked if there had been any discussion with Cherwell District Council (CDC). Ian Davies, Director of Operational Delivery, CDC, who was invited up to the table to respond, stated that CDC did not have any specific plans for the future of**
Banbury Health Centre building if it was to be closed. The Council regarded it as a local asset and would seek another tenant if it was vacated. Julie Dandridge stated that the OCCG would be willing to work with CDC to understand the costs of the building, adding that NHS premises business tended to be very complex. Dr Paul Park pointed out that the assimilation of the Centre with Woodlands Surgery would also address the health inequality concerns in that it was ideally situated near public transport links and it also accommodated an emergency dentist and a substance misuse service on another floor;

- A member commented that PML was a crucial factor for future development, asking how responsive it could be and how flexible and transparent was it? In addition, could it be understood where the drivers for decision making were being made? For example, if tenants were being sought, it would be important to know how secure the tenancies were and if they would cause difficulties regarding use. Paul Roblin responded that the modern scenario required organisations to look for economies of scale where larger units of delivery could also offer satellite working to provide resilience, as against the more vulnerable smaller units. Julie Dandridge added that the GPs now wanted to change from the historic model to one that was salaried. In relation to the issue of transparency, and the need to understand the governance of a larger organisation so that the public could have a meaningful interaction with discussion, Paul Roblin stated that the market would offer different solutions and anybody providing public services needed to provide this transparency. Whilst understanding this concern Dr Roblin stated that he did not agree that PML would have a dominant status and there was no reason why Oxfed GP Federation could not give services to Banbury as well as Oxford;

- A member asked the OCCG to remember the principles of inequality and, in particular, that extended hours were central to Darzi. He made a plea that this Committee and the OCCG keep the future use of the premises high up on the agenda. Dr McWilliam commented that the principles of Darzi were at the forefront of Health policy at the time, however, things had moved on with a 5 year forward view of the Government. However, he stressed the importance of this Committee keeping a handle on people’s differences and to encourage Health to have sight of this in the local design;

- A member asked if there could be an emphasis in the consultation document on the availability of appointments at Woodlands and West Bar practices if lists were to be dispersed. It was also vital that transport links be good. Ally Green responded that the OCCG had completed a transport survey of patients who used the Centre, the results of which would be included in the consultation document. This survey had indicated the high cost to patients of the current location due to the fact that there was no free parking for staff or patients. However, it was situated next to the station. The consultation document would also describe the population profile.
- In response to a comment by a Committee member that, whilst the consultation methodology was good, consultation meetings should be open to all and the premises should be large enough to accommodate all who wished to attend, Ally Green stated that the OCCG was aware of the need to engage the PPGs at the other practices as they were in a position to encourage engagement at those practices. This would be included in the consultation document itself. Furthermore, the OCCG would always arrange open meetings in conducive settings to encourage maximum engagement activity. Transport links and other forms of access would always be considered. It was anticipated that premises situated in the centre of Banbury would be utilised;

- In response to concerns voiced by a member about the future increase in population in the area and fears about the closure of a fully functioning surgery with access to public transport, Julie Dandridge assured the Committee that the physical estate would be taken into account by the locality planning, ensuring also that buildings had room to expand and were fit for purpose.

- In response to a question about whether the 8am – 8pm opening hours would be part of the consultation, Julie Dandridge stated that the OCCG would be bringing in extended hours. Currently this facility was only available to six thousand people in Banbury and an extension into the rest of the patch was required. If it was found that a 9am – 5pm was required in a certain area, then an explanation for that would be given. She added that sometimes staff were reluctant to work the additional hours, particularly on a Sunday and it had been found that appointments were currently not being used on a Sunday by patients. In this event, more appointments would be made available on a Saturday;

- A member of the Committee asked what would be delivered that was not currently delivered, what was the OCCG doing about workforce requirements and how would it manage increasing population needs? Ally Green responded that this information would be included in the consultation document which was currently being worked on. This would include information on gaps around options for extended hours and information on how the OCCG intended to deal with the growing population in the face of practices who currently had no capacity to expand. She added that re-procuring the Banbury Health Centre in its current form would not deliver a solution for a growing population. Dr Park added that a larger model specifying more flexible GP practices would be more attractive to GPs and their staff. The model would contain better facilities for clinicians, pharmacists etc. Moreover, it was hoped that the patients would not notice the changes – they would be receiving their usual GP service. He added that none of the Banbury practices had handed in their notice in the face of the impending changes;

- A member asked if there was any prospect of, or interest from other Trusts to enter into primary care, in light of the fact that GPs had now entered into the acute care field. Dr Roblin pointed out that the lack of expertise in the
primary care field was a problem and that working closely was not the same as integration into, and the running of a premises. Dr Park added that there were advantages and disadvantages to this and agreed that primary and secondary care needed to understand each other better but that it could be something for the future. Oxford Health were already working with GPs, but acute care practitioners would require a detailed knowledge of primary practice;

- A member asked for assurances that if patients were to be dispersed, they would not be left to drift and would be transferred to another surgery. Julie Dandridge responded that the OCCG were interested to hear from patients if the patient transfer process had denied them their patient choice. Dr Roblin stated that there would be a need to check the regulations in respect to this.

The OCCG was urged by the Committee to ensure engagement with CDC before the consultation began to answer questions on locality, rents, transport, future plans for the building etc. Julie Dandridge stated that this would be part of the consultation. She also confirmed that the final options would be considered by the Primary Care Commissioning Committee at the end of March, early April. The OCCG would be happy to discuss the outcomes of the consultation if time permitted. She confirmed also that the practices would decide what they considered right for their area. Dr Park added that the OCCG would take the opinions of rural practices also in relation to what was appropriate for their areas.

The Chairman thanked all for their attendance, stating that the Committee was looking forward to seeing the draft consultation document and incorporating their comments into it, as part of the decision - making process. He asked that timing be allowed for the draft consultation document to be shared with the Committee at its next meeting at the beginning of February.

59/17 MANAGING THE IMPACT OF WINTER ON OXFORDSHIRE’S HEALTHCARE SYSTEM
(Agenda No. 9)

Prior to consideration of this item, the Committee heard addresses given by Sarah Lasenby and Larry Sanders.

Sarah Lasenby expressed her general concern about winter care, believing that the present NHS systems were denying patients their health requirements. She made the following specific comments:

- Earlier this year Accident & Emergency had found itself so stretched it had introduced GP triage in hospitals. In her view, beds had been taken away before the outcomes of the changes had been evaluated in the knowledge that there were staff resourcing problems;
In her view the ambulatory units were working very well and it was a good scheme. Innovation was good but not when patients were being put into side corridors on trolleys because there were no beds for them; and

- She expressed her concern regarding the proposed transfer of services from the Horton Hospital to Witney.

Larry Sanders commented that he respected the work that was going on into innovations in the NHS, the outcomes of which held many interesting ideas. However, reading between the lines he believed it could not work and crises could happen. This was due to the lack of Government funding and the worsening of the manpower situation with shortages of social care workers and GPs. He believed that it was the responsibility of elected members and various professionals working in the services to speak out; the latter having a dual responsibility to patients and the public, as they were the people who knew the most. He made reference to the bed shortages in the UK being the second worst ratio in its European group. He also stated that in his view the lack of future sustainability of the Health system in Oxfordshire was based on constant reductions of beds which amounted to 300 lost. Moreover, it was his view that there had been no attempt to measure the problem of unplanned admissions or re-admissions, due to premature discharges. He made a plea therefore for people to speak out about their concerns, particularly those who had inside knowledge; and to look at the issues affecting the issues that arise, an example of this being unplanned admissions.

The Chairman welcomed the following representatives to the meeting:

- Diane Hedges – OCCG
- Dominic Hardisty – Oxford Health
- Richard McDonald and Dr John Black – South Central Ambulance Service
- Benedict Leigh – Adult Social Care, OCC

The above representatives commented on the issues important to their organisation prior to questioning from the Committee, with reference to report JHO9.

Diane Hedges stated that there was a need to be realistic, the simple opening of more beds being not straightforward. She pointed out the following:

- that the John Radcliffe Hospital was also a specialist centre which meant that demand was even higher than elsewhere. Thus, diversion to Southampton or London hospitals to service specialist demand would be required;
- significant workforce issues and the ensuing patient safety issues meant that beds could not be opened even though it was desired. She added that there was a need to break the cycle by sending home the medically fit;
- the means by which the level of increased need could be met was a complication question. People were living longer with more complex health issues; and
- the OCCG’s level of confidence in this Plan was cautious – it would like to see the formation of better ways of managing winter pressures, for example with more in-depth risk assessments in relation to bed closures.
Benedict Leigh echoed the concerns expressed in relation to the rise in demand for social care, recognising that workforce challenge was a particular problem particularly around domiciliary care. Adult Social Care was undertaking the following measures to give support:

- working jointly with the OCCG to fund flu jabs for all workers in a bid to sustain the workforce over the winter months;
- working across the whole system and alongside the OCCG on measures to support workforce recruitment. This was a challenge within Oxfordshire which was a wealthy county with low unemployment;
- working closely with a network of providers to tackle recruitment within Social Care to sustain the other more fragile providers. Also working with other healthcare providers to provide sustainability over the winter period. He added that more than 90% of providers were ‘good’ or ‘outstanding’; and
- purchasing more beds and more home care to manage people’s care through the system.

Dominic Hardisty listed the following measures being taken by Oxford Health to prevent pressure on acute care:

- the running of MIU’s which could demonstrate that A & E activity could be avoided;
- the running of EMU/RACU in Witney and Abingdon, the latter was a frailty assessment unit where older people could be seen by gerontologists – both of which could have scope for expansion;
- Oxford Health runs Out of Hours services, working closely with the South Central Ambulance Service on 111 services. 111 had been quite fragile last winter, but since then Oxford Health had undertaken some robust work to add resilience, putting the services in a far better position to cope;
- the proposed changes around stroke care had put resources closer to people in the communities; and
- piloting a rehabilitation service at home to test community service provision. This had helped to respond to out of hospital care inquiries.

Richard McDonald spoke of the SCAS transformation. Their core value in innovation was a new way of working to respond to the different expectations of the population. Innovations introduced were:

- as part of the 111 service and as part of a collaboration with Oxford Health, Buckinghamshire and Berkshire, clinicians had joined together to be at the end of a telephone to provide advice;
- stroke patients now had a first-time ambulance rather than a rapid response vehicle;
- patients were triaged in a better way in order that the right response be sent to move them to the right place to give the right care;
- the service would be changing the staff rostas/skill mix/vehicle mix for the winter; and
- trying to deal with patients closer in the communities. With regard to patients living in rural areas, the service was endeavouring to work out the correct
response needs to enable patients to be treated at the correct venue. SCAS had been the top performing service during the changeover period.

Dr John Black, Medical Director, SCAS, stated that there would be more integration on care with colleagues in other Trusts. For example, SCAS was working very closely with OUH sharing best practice in emergency care, reducing delays and ensuring that patients were treated and admitted appropriately to the correct clinician. This was an opportunity for further co-ordinated care at scale and an opportunity to run the service as efficiently as possible by getting decisions from partners quickly so that there were no inappropriate admissions.

Questions from the Committee were as follows:

- A member expressed concern that beds had been permanently closed and there would be further closure of beds in the future, in light of DTOC delays in community hospitals. She asked for reassurance that this tripartite, parallel approach model would also work in the community. Diane Hedges responded that in the past with DTOC, other beds were opened and the equivalent beds were opened in the community supported by clinicians and social workers. This was part of the ambulatory approach. She expressed her disappointment at the DTOC outcomes, emphasising the need to be looking at managing a high volume of patients going through the system. There had been a significant increase in the numbers of patients who were seeking treatment and the Health system had been trying a number of pilots recently in a bid to manage this. Dr Black confirmed the significant increase in demand over the last year with up to 8% requiring surgery. His view was that the wider system was working better together to access the services in community hospitals, ambulatory services and social care. There was a determination that patients would be supported at home, as this was what patients desired the most;

- A member declared himself a supporter of the 111 services to assist with winter pressures. There was nothing in the communication plan that directed people to this service, asking why this was. Dr Black agreed that there was a need to value the 111 service, and it was hoped that as people became used to using it there would be more activity;

- In respect of a question about whether the flu jab was a new initiative, Benedict Leigh stated that carers had always received flu jabs; but the free service for the social care workforce was a new initiative, partly because there was a need to support their resilience;

- A member asked if there was anything significant in place for patients with mental health illness during the winter, given that acute beds were fully stretched, and given the restraints on Health with the Act and the rigorous assessment process. Dominic Hardisty responded that there was significant underfunding of patients with mental health problems. He made reference to the 60-90 minute assessment facility if a person presented at the A & E department at the John Radcliffe Hospital. A new tele-psychiatry assessment was also available which was dependent on a
person’s needs. The outcomes of this was that the patient was either sent home or sent to a community hospital where the patient was cared for by staff trained in mental health. In some circumstances, a patient may need to go to a specialist mental health ward. He added that the occurrence of a mental health problem did not tend to be seasonal, although, in the same way as physically ill patients, some may suffer loneliness at Christmas.

- Pressure on wards was different for different age-groups, there being a major shortage of children and young people’s beds in the south region. NHS England had closed admissions due to acuity of patients. Beds in neighbouring counties were required.

- There was no choice but to admit adults of working age. In nine out of ten circumstances people were admitted within three days, or obtained an out of area bed. Over the past year performance had improved and managers had reduced the spend on out of area beds by 50%. Furthermore, there were few beds for older people with complex mental health/physical health needs. NHS services for older people was good but was not quite there yet for people who presented with challenging behaviour and who required specialist dementia care homes. Dr Black added that ambulance staff were permitted access to the patient records for people who presented with a mental health crisis.

- In response to a question about whether there were alternative services open to patients in the teenage unit at the Warneford or at Abingdon, given the workforce pressures mentioned in the report, Benedict Leigh described three main mitigations which had been put in place: 200 hours per week community reablement given by nursing staff; commissioning of additional interim beds in reablement; and more effective support for reablement ie. in funding for occupational therapy and physiotherapy support. He added that intervention in HART would help patients more quickly.

- A Committee member stated that she had been told by constituents that there was a high call volume for the 111 service and given a message to ring back later. She asked how the staff situation was, particularly at weekends. Richard McDonald responded that the Trust was in the process of recruiting for local staff, but there was a contingency arrangement with Milton Keynes when busy. If this was busy then the Trust used the national contingency to switch to another provider. A busy message was often in place if it was found necessary, but staff would still answer if they were free.

- In response to a question about what resilience was in place if there was a severe outbreak of flu, Diane Hedges stated that this could be a significant problem and there were a range of choices in place for such a situation. The OUH had taken a full capacity policy which extended a bed on each ward to stretch staff to nurse/treat more numbers. Buckinghamshire and Berkshire hospitals were able to open wards but Oxfordshire did not have the same facilities due to workforce issues. The OCCG had tried to identify when the busy times would be and in this situation would purchase
additional capacity for primary care. Additional home visits would be made by nurse practitioners in primary care on the days they would be required.

- In response to a question about whether the SoS bus would be rolled out elsewhere from Oxford, and if so, would adequate measures be put in place to direct extra clinicians to the Horton Hospital, Richard McDonald stated that this had been trialled in Oxford but it had only treated 8 patients during the past week. It had been restricted to Oxford due to the high population concentration and number demand. However, three clinicians to 8 patients was not deemed to be the best use of resources. Moreover there was not the appropriate level of activity in Banbury or Bicester for this ambulance service. Diane Hedges added that a national emergency care improvement team had observed that there was a need to be much tighter in matching staff to the anticipated patient footfall. The Team had also stated that it would expect to see more consultants on the ground. It had also implemented primary care streaming in order to increase capacity and to ease the pressure on consultants.

At the conclusion of the question and answer session, the Committee considered what action could be taken. Dr Cohen advised that the Committee had been appraised of a clear set of new interventions and new ideas and it would be helpful to know in the Spring which had proved to be most effective.

The Committee AGREED to thank all representatives for attending. Members welcomed the system-wide approach on reporting in respect of beds, including acute and community. The representatives were requested to:

(a) return and present an evaluation of the innovations once the winter was over and which were the most effective;
(b) give a presentation on plans for next year; and
(c) request Diane Hedges to check the number of beds currently available compared to the same period last year;
(d) request Diane Hedges to look at staff sickness levels overall and to report back.

60/17 CHAIRMAN’S REPORT
(Agenda No. 10)

Prior to consideration of this item, a statement produced by Jane Southworth on behalf of Deer Park Medical Centre Patient Participation Group (PPG), was read out by the Committee Officer, Julie Dean in her absence.

The statement made the following points:

- The Deer Park PPG felt duty bound to again voice their objections to the failure by the OCCG to properly implement the recommendations of the Independent Reconfiguration Panel (IRP). It was their view that the work the OCCG was currently undertaking on the wider Locality plan for West Oxfordshire (related to Phase 2 of the Oxfordshire Transformation Plan), had
nothing to do with the plan envisaged by the IRP, following the referral of the
department to the Secretary of State. This was to produce a
separate plan for primary care in Witney and its surrounds;

- The need to produce a separate plan for primary care in Witney and its
  surrounds, in accordance with the IRP report, was highlighted by this
  Committee at its 14 September 2017 meeting, the Chairman requesting the
  OCCG to produce a plan or ‘roadmap’ of the actions it was taking and
timeframes, which would be a separate piece of work from the detailed locality
  work. The Committee had agreed to the setting up of a working group to do
  this. She asked if the working group had met;

- The PPG called upon the Committee to enforce the OCCG’s duty to implement
  the IRP’s recommendations fully and correctly. Despite the OCCG
  representative assuring the Committee that they would do it as a separate
  piece of work, it had not happened. She pointed out that the OCCG had been
  recommended by the IRP that the public and patients be ‘at the heart’ of this
  project ‘in assessing current and future health needs, understanding what the
  options are and co-producing the solutions’. The public and patients of Witney
  had not been involved in producing this plan, to date, within the six-month
timeframe as envisaged by the IRP. Furthermore, the PPG remained
  concerned that no independent person had been appointed to oversee and
  review the OCCG’s compliance with the IRP plan;

- OCCG had declined to meet with the Deer Park PPG to enable it to share their
  proposals for the reconvening of GP services at or near the Deer Park Medical
  Centre. The IRP had recommended that this possibility should not be
  precluded;

- She also made reference in the statement to the two locality planning
  workshops held recently in Witney and Carterton which the PPG would not
  regard as ‘public open events’. People were required to pre-book and as a
  result of it being fully booked, some people had been turned away. There was
  also a change of both venues, causing confusion. The ‘round table’ format of
  both events was not agreed with the patient forum groups with no patient
  group input as to its format; and

- She stated that in her view there was public mistrust of the OCCG and public
dissatisfaction with the level of GP service in Witney which she stated was
  already overstretched (with significant housing growth already in progress and
  a reported 6 week waiting period for a GP appointment at a Witney surgery).

The Chairman, on behalf of the Committee, commented on the statement agreeing
that the situation had continued for far too long but that, for reasons of patient safety,
the surgery needed to remain closed. He also made reference to the fact that
Northamptonshire CCG had agreed to use Oxford Health as a referral for 111
services. He also informed members that he had personally written to
Northamptonshire’s HOSC pointing out that the public would have to travel 20 miles
to see a doctor. No response had been received as yet.
Diane Hedges, OCCG, attended for this item. She stated that the IRP had requested the OCCG to provide a plan for Witney and its surrounds in six months. This was in the course of production to a deadline of the third week in January 2018. She added that the primary care plan needed to cut across the county, looking at the needs of each locality and taking the emerging plans for that locality and supporting them with resources. She stated that the OCCG was meeting its requirements, was taking forward the plans for Witney and its surrounds, within the proper timescale; but was taking account of the whole system and available resources. She reported that there were a number of events planned, including a meeting with Witney Town Council that evening and a meeting with Deer Park PPG.

The Chairman asked if there had been any developments with regard to the appointment of the independent person from NHS England. Diane Hedges responded that they still awaited an allocation and as soon as this had taken place the OCCG would convene a working group.

The Chairman pointed out that the Committee had asked the OCCG to review the process followed during the closure of the Surgery, including engagement and availability, and this had not yet been carried out. Diane Hedges responded that the lesson learned was to expect the unexpected in the procurement process, adding that the OCCG should have expected the problems and further reflection was now needed on the fundamental issues to get right each time.

A member of the Committee commented that OCCG’s reaction to the spirit and letter of the IRP’s recommendation on the nature and engagement of the public was disappointing. Early and continuous engagement with the public and patients was required. Moreover, it was doubtful that public meetings held in November on the locality plans constituted early engagement. Diane Hedges responded that there was a significant amount of engagement being carried out. In respect of the Deer Park PPG, she expressed her fear that they would be disappointed because the level of engagement was not about the Deer Park Medical Centre alone. The OCCG had to plan for a population of 80k patients and it was not possible to find viable providers for such a small population. It would cause extra pressure on the GP population in light of the growing need in Witney and in light of the high level of GPs thinking about retirement. There was a need to think creatively across the practices in Witney. She wondered whether HOSC’s view on engagement was reasonable, stating that more round table events had taken place in a bid to develop that level of co-production. This showed that the OCCG was in this mindset. She reminded the Committee that a decision had already been taken about Deer Park surgery and that the OCCG would be interested to hear about any solutions that the Committee may have to this situation.

The Chairman commented that the issue was not about the number of meetings that had taken place, and he appreciated the efforts that had gone into arranging extra meetings. It was more about making the process followed a priority. The impression that the OCCG was giving was that engagement was not a priority, that the work had been done and the timescale had lapsed.

A member pointed out that there appeared to be a contradictory process for each of the Deer Park and Banbury Health Centre presentations, asking what process was
being followed for patients in the Banbury location. Diane Hedges responded that discussions were taking place in the north locality, as had happened for Witney and its surrounds, emphasising that each locality had a different set of circumstances.

Ros Pearce, was asked for a HWO viewpoint. She responded that the process of engagement on the part of the OCCG regarding locality planning for primary care appeared to be going well. She added that the meeting between the OCCG and the Deer Park PPG had now been arranged, which was what the IRP had asked for.

In response to a report from a member of the Committee that the midwives in the midwife-led unit at the Horton General Hospital were not being permitted to ask anybody at the Hospital for assistance with mothers who were presenting with complications, Diane Hedges advised that reference to clinical policy was needed which stated that these patients had to go to the John Radcliffe Hospital as soon as possible.

On the conclusion of the discussions with was AGREED that:

(a) the Chairman’s report be noted; and
(b) in respect of Deer Park, the Chairman would write to the OCCG giving the Committee’s views on the situation and asking for an urgent response.

61/17 ITEM FOR INFORMATION
(Agenda No. 11)

Noted.

............................................................................................................. in the Chair

Date of signing ............................................................
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<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
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<tbody>
<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>Circulate 'Oxfordshire Uncovered' report on inequalities published by the Community Foundation.</td>
<td>OCC - Sam Shepherd</td>
</tr>
<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>Criteria on how the Innovation Fund is to be spent on tackling local health inequalities to be shared with HOSC.</td>
<td>OCC - Jackie Wilderspin</td>
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<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>Timetable and roll out for social prescribing to be shared with the committee.</td>
<td>OCCG/OCC Ally Green/Jackie Wilderspin</td>
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<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>CCG to get a response from Joe McManners on questions from the Committee including how the STP will impact on health inequalities and interact locally.</td>
<td>OCCG - Ally Green</td>
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<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>Progress with Health Inequalities Commission report recommendations to come back to the Committee every six months. Add to forward Plan.</td>
<td>OCC - Sam Shepherd</td>
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<tr>
<td>56/17</td>
<td>Health Inequalities</td>
<td>Issues relating to housing need for older people in social housing to be circulated to the Committee when available.</td>
<td>OCC - Jackie Wilderspin</td>
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<tr>
<td>58/17</td>
<td>Banbury Health Centre</td>
<td>Share the Banbury Health Centre draft consultation document by email, before it's published (when shared with the BHC PPG)</td>
<td>OCCG - Ally Green</td>
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<tr>
<td>58/17</td>
<td>Banbury Health Centre</td>
<td>Feedback on the consultation to HOSC in February before the final decision with a detailed timeline of the decision-making process. Add to forward plan</td>
<td>OCC/OCCG - Sam Shepherd/Ally Green</td>
</tr>
<tr>
<td>59/17</td>
<td>Winter Plan</td>
<td>Check the number of beds currently available compared to the same period last year and to look at staff sickness levels overall and to report back.</td>
<td>OCCG - Diane Hedges</td>
</tr>
<tr>
<td>60/17</td>
<td>Chairman’s report</td>
<td>Following the committee’s consideration of a progress update, members agreed that the Chairman should write to CCG to request a priority response to questions and recommendations on Deer Park.</td>
<td>Cllr Arash Fatemian</td>
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The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The “PICK” methodology can help scrutiny committees consider which topics to select or reject. This is:

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

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<tr>
<th>Meeting Date</th>
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</table>
| April 2018   | Review of Winter Plan 2017/18 | • Winter Plan 2017/18 was presented to HOSC in Nov 2017, this is to review the subsequent effectiveness of that plan.  
• To include the success of some of the new initiatives, e.g. flu jabs for social care staff, to learn where system should be investing in the future | CCG          |
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<tr>
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<tbody>
<tr>
<td>April 2018</td>
<td>ASC CQC inspection</td>
<td>• Health and social care’s response to the outcomes of the CQC inspection and scrutiny of plans in respond to this.</td>
<td>CCG, OCC</td>
</tr>
<tr>
<td>June 2018</td>
<td>Health Inequalities</td>
<td>• Review of progress in the Health and Wellbeing Board’s progress with the Health Inequalities Commission recommendations. (request made on 16/11/17 that progress be reported to HOSC every six months to ensure health inequalities remains a priority).</td>
<td>HWBB</td>
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<td></td>
<td>Transition of LD Services to new provider</td>
<td>• Update on the transition of LD services from Southern Health to Oxford Health which took place in July 2017.</td>
<td>CCG</td>
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</tbody>
</table>
|              | Health in planning and infrastructure | • How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding  
• Learning from Healthy New Towns.  
• Impact on air quality and how partners are addressing this issue.  
• How can HOSC best support the planning function | CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure |
|              | Health visiting services            | • Impact of changes to children’s centres on provision of health visiting service  
• Scrutiny of newly commissioned service  
• 0-5 health visiting services | PH & OH & CEF                   |
|              | Health and social care workforce    | • Impact of workforce shortages in reablement & domiciliary care on acute services  
• Impact of ASC precept | OCC                           |
<p>|              | GP appointments                     | • Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored | CCG                           |
|              | Anaesthetist training at the        | •                                                                                                                                                    | OUH                           |</p>
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<tbody>
<tr>
<td>Horton General Hospital</td>
<td>Health Transformation Consultation Plans for Phase 2</td>
<td>• Committee scrutinises the health consultation plans for Phase 2</td>
<td>Whole System</td>
</tr>
</tbody>
</table>
|                     | Healthcare in Prisons and Immigration Removal Centres                      | • More in depth information on performance and how success is measured.  
• New KPIs in place from April 2017                                                                                                                                                                                  | NHS England              |
|                     | Health and Wellbeing Board                                                | • How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration?  
• Is there effective governance in place to deliver this?  
• How well is the Health and Wellbeing Board preparing Oxfordshire’s health and care system for greater integration?                                                                                     | Whole System             |
|                     | Stroke patients                                                           | • From intensive care in hospital to home care – occupational therapy services and plans for expanding ESD service – seek further evidence, facts and figures about points from HWO.                             | CCG, OH                  |
|                     | Oxfordshire’s Accountable Care Organisation                               | • Impact of an ACO on the Oxfordshire system  
• Erosion of referral targets – 18 weeks (national rules changed) – is this in line with NHS Constitution targets?                                                                                       | CCG, OH, OUH             |
|                     | Pharmacy                                                                   | • Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities                                                                                                    |                         |
|                     | Social prescribing                                                        | • The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell)                                                                                                  |                         |
|                     | School Health Nurses                                                      | • The impact of school health nurses in secondary schools and future service plans  
• This is being recommissioned by PH by March 2018                                                                                                                                     | PH, OH                   |
<p>|                     | Health support for children                                               | • How is Health contributing to improving outcomes for                                                                                                                                  | OH, OUH                  |</p>
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|              | and young people with SEND | children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care?  
- Linked to outcomes of SEND Local Area Inspection | CCG |
|              | Priorities in Health – Lavender Statements |  
- How the CCG manages competing priorities – Thames Valley Priorities Forum | CCG |
|              | Commissioning intentions |  
- Committee scrutinises the CCG Commissioning Intentions | CCG |
Your voice on health and social care

1 Healthwatch Oxfordshire update February 2018

The Healthwatch Oxfordshire (HWO) board last met on 9th January 2018. Papers presented at this meeting are on the Healthwatch Oxfordshire web page:
http://www.healthwatchoxfordshire.co.uk/healthwatch-oxfordshire-board-meetings-and-minutes

2 Oxfordshire Safeguarding Adults Board (OSAB)

We reported to OSAB in December on the updates on the latest outcomes and impact of our Dignity in Care Report 2015. The full report to the OSAB is available on our web site. To summarise:

The responses to the recommendations made by the trusts that run the hospitals, the county council and Oxfordshire Clinical Commissioning Group, which pays for most health services in the county, have been tracked over the past two years and show that many of the recommendations have been addressed and actions embedded in the organisations.

With this research and report we created a focus on the way that dignity in care is supported across the health and social care system. While there has been progress over the past two years both patients and providers should not be complacent that everything has been attended to satisfactorily. We urge service providers and commissioners to continue to review and evaluate actions, and constantly respond to what they hear from both patients and staff about improvements that can be made.

HWO Action: We will continue to monitor what patients report on their experiences of health and social care services and report back to service providers when we hear both positive and negative experiences.

3 Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP

In December the four Healthwatch organisations that cover the BOB area wrote to the lead officer David Smith raising our concerns about the lack of communication with the public and the inactivity of the BOB Stakeholder Engagement Group, the only route for two-way communication between the operational and governance areas. Both our letter and the reply from the programme director are available on our web site. In summary it appears from this reply that with the recruitment of a permanent lead officer BOB will increase engagement activity.
**HWO Action:** The four Healthwatch leads will be asking for a meeting with the new Chair and CEO at the earliest opportunity.

4  **NHS England South**

After being told by people in Bicester (see report below - Bicester Town) that many people were unable to access NHS dental appointments in Bicester, we met with the NHS England South Director and Commissioner for Dental services. The outcome of this meeting was two-fold:

1. The commissioners said they were aware of several areas within Oxfordshire where access to NHS dental services is limited, mainly in areas of housing and population growth, and that Bicester was one such area.
   a. **HWO Action:** We will conduct a county-wide survey to discover the extent of limited access to NHS dental services. NHS England have said they welcome any additional information and patient experience reports from Healthwatch.

2. NHS England made a commitment to the commissioning of additional dental services in the Bicester area in early 2018. During these discussions NHS England agreed to our suggestion that there should be patient involvement in the commissioning process.
   a. **HWO Action:** We will continue to monitor progress.

5  **Care Quality Commission (CQC) review of Oxfordshire’s health and social care system**

The purpose of the CQC review is to understand how people move through the health and social care system. This is one of twenty reviews across the country. The CQC is focussing on the crossing points between health and social care systems during the review and looking at what improvements can be made. The CQC want to understand the maturity, capacity and capability of the Oxfordshire system. The review will focus on older people aged 65 and over, they will not be looking at people who have a mental illness, but will review people who have a diagnosis of dementia. It is expected the Commissioner’s report will be published at the end of January 2018.

The Healthwatch Oxfordshire Chair and Executive Director attended meetings with the lead inspector and the whole system briefing to the lead inspector.

Healthwatch promoted and recruited six people to attend a focus group facilitated by the Clinical Quality Commission (CQC) inspectors. HWO subsequently reported to the CQC Lead Inspector concerns regarding the short notice given to members of the public for such focus groups and as such has a negative impact on the capacity and ability of carers to attend.

As of 22\textsuperscript{nd} January 2018 Healthwatch Oxfordshire has yet to see a copy of the review report, originally promised by 15\textsuperscript{th} January 2018. This delay by the CQC in publishing
the report will compromise our ability to give a considered response to the findings and recommendations in the report to the CQC Summit planned for 29th January 2018. **HWO Action:** We will participate fully in the CQC Summit Meeting.

6 Bicester Town survey

The report on our Bicester town survey was published in December 2017. The key findings were:

- People value the quality of care and the staff that deliver services.
- However, people feel concerned about the availability of adequate health and social services and their ability to access them. People told us about their difficulty in getting an appointment with GPs, and about the lack of NHS dentists and mental health services in Bicester. They also expressed consternation about the changes to day centre services that were taking place at the time of the project.
- People also questioned the current range of services provided at the community hospital in Bicester and said they wanted an increase in access to minor injuries services including X-ray facilities at the hospital. They reported also that travel to Oxford and Banbury for accident and emergency services and other hospital services causes many difficulties for many in Bicester, which has been made worse by the decrease in public transport services.
- We also told that adults and children with additional needs in Bicester, such as military veterans, older people with care needs, people with substance misuse problems and children with special educational needs, often struggle to access adequate help and support.

6.1 Next steps

Where we could, we have already acted to highlight some of the concerns we have heard in Bicester with the relevant authority even before this report was finalised.

- We met with NHS England to discuss the difficulties people have in accessing NHS dentists in Bicester. NHS England has said it was looking to commission additional dentists in Bicester in 2018 and has committed to involving patients in the process.
  - **HWO Action:** Our own research activities in 2018 will also cover people’s access to NHS dentists across Oxfordshire.
- We fed back the comments and concerns about the day centre services to the Director of Adult Social Care at Oxfordshire County Council. We received a response from Oxfordshire County Council that is on our website.
  - **HWO Action:** We will undertake more research into people’s experiences of day centres in 2018.
• **HWO Action:** We are already working with the Oxfordshire Clinical Commissioning Group to provide support to strengthen the patient participation groups based at GP surgeries in Oxfordshire. We noted the lack of mention of the patient participation groups when talking to people in Bicester and see strengthening involvement in them as a key means of ensuring people can have their concerns and comments heard directly by staff at GP surgeries.

• **HWO Action:** We will be offering all the relevant organisations, including the Oxfordshire Clinical Commissioning Group, County Council, District and Town Councils, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust, voluntary sector groups and community interest groups, an opportunity to discuss this report at an event in February 2018.

7 Voluntary Sector Forum - 7th December 2017.

Following the Health Inequalities Forum in August, the December Forum meeting focused on co-designing the Healthwatch Oxfordshire offer to the sector to:

- Have their voices and their members’ voices heard by decision makers, commissioners and providers of health and social care services in the county.
- Stay informed about future events, meetings, policies, and decisions of significance that have an impact on their role.
- Network with each other on key matters of interest.

The notes of the meeting have been published and circulated to attendees. Key points of agreement were:

- **HWO Action:** Development of the Healthwatch Voluntary Sector Hub web page
- **HWO Action:** Quarterly Forum meetings to continue - with the next on in March 2018 to focus on Social Prescribing
- **HWO Action:** Greater access to a comprehensive directory of services and sector organisations including Patient Participation Groups

8 Community activities

At the end of January 2018, we will focus our community and voluntary sector activity around the Rose Hill, Littlemore, Cowley and Blackbird Leys communities in Oxford.

**HWO Action:** From January 2018 we will have a monthly stand in one of the four Oxford hospitals - starting with John Radcliffe. The Oxford University Hospital Foundation Trust is keen to hear what we gather and is providing space for the stand, and links to appropriate trust staff to support us while we are at the hospitals. The results of our research from patients and public will be presented to the trust’s quality committee on a regular basis.
9  Project Fund 2018

In January we launched our project fund for 2018. This enables voluntary sector and self-help groups to gain funding to carry out small pieces of research with our support.

Research proposals in 2018 will be considered if they explore any of the following themes:

- What is the experience of access to health and social care by local communities?
- Areas of health and/or social care development and how services can work better to improve patient experience.
- The impact of changes in health and/or social care services on local communities.
- Health and social care experiences and needs facing communities in areas of social deprivation or inequalities in health in Oxfordshire.

**HWO Action:** For 2018 Healthwatch Oxfordshire welcomes any research that feeds into our work looking at patient experiences of:

- access to local NHS dentists,
- young people’s mental health and wellbeing,
- experience of using Day Care Services across the county.

There are two deadlines for completed applications: 8th February 2018 and 8th March 2018. All work must be completed by 28th September 2018. The maximum amount of grant is £5,000 and the application forms and our criteria are downloadable from our web site or by telephoning the office on 01865 520 520.

10  Healthwatch Oxfordshire Web development

Healthwatch Oxfordshire is developing a new web site, the key feature being a ‘feedback centre’ where people can leave their views on individual services they have used. The feedback centre will improve our reach and understanding of people’s experiences of services. We will share anonymised analysis from the feedback centre with individual service providers and commissioners; increasing our input into informed service development and delivery.

**HWO Action:** The site will be launched in February 2018.
Healthwatch Oxfordshire Report on activity in Q2 2017/18

The tables below show progress against the agreed four key performance indicators.

Overview

Quarter 2 of 2017/18 has been a busy time with much activity by all members of staff. We have heard from 556 people during the quarter giving us a half year total of 1228. I propose to produce an impact report by the end of 2017 to address the statement and question: activity is spending money - what difference is it making?

KPIs that have not been met by 10% or more are:

KPI 1 - questionnaires completed - explained by Bicester Town event straddling Q2 and Q3

KPI 4 - publications and newsletters explained by no longer producing a quarterly newsletter as we move to a fortnightly electronic briefing circulated to a wider audience. The target for Q3 onwards has been revised upwards to reflect the increased activity.

KPIs that have exceeded their targets are:

KPI 2 - reports to committees, commissioners. The reporting includes verbal reports as well as written reports. The increase in the number of committees and meetings attended accounts for the level of activity. I will continue to review the number of meeting attended to ensure that they add value to our work and HWO makes a positive contribution at meetings.

KPI 3 - Public contact by phone, mail, email, web site, face to face. The target was exceeded by 10% due to the level of activity with groups over this period. The target for Q3 of 200 has been retained.

KPI 4 - Web site hits exceeded the target by 16%. Which is most likely related to our high level of media coverage during this period.

KPI 4 - Media hits - I have changed the way of measuring this to reflect both media enquiries and media coverage as this gives us a conversion rate. A high conversion rate shows that what we say, and how we say it is of public interest - we should always aim to achieve at least an 85% conversion rate; in Q2 our conversion rate was 94%.
NOTE

The predicted impact on our agreed KPIs caused by failure to recruit to the post of COI - Outreach will be on KPI 1 - Listening well to people, especially the most vulnerable, to understand their experiences and what matters most to them. However, the team is committed to running the planned town event at the end of January, and I anticipate the impact will be mitigated by the new website coming on stream in February 2018 including the Feedback Centre together with the start of the monthly HWO presence in OUHT hospitals in January.

Review of KPIs for 2018/19

I will conduct a review of the KPIs and report to the GSF and Board at the end of 2017/18 Q3.
KPI 1  Listening well to people, especially the most vulnerable, to understand their experiences and what matters most to them
Outreach, Enter & View, town events

<table>
<thead>
<tr>
<th>KPI 1</th>
<th>Target 2017/18</th>
<th>Q1 actual</th>
<th>Q2 actual</th>
<th>Q3 actual</th>
<th>Q4 actual</th>
<th>Comment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Town events</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Bicester Town event 29/9</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Review of Witney forced greater lead in time so plan 2 town events in 2017/18</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27/10/2017 Planned Oxford Town event Jan/Feb ’18</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22/8/2017 Bicester event straddles Q2 &amp; Q3</td>
<td></td>
</tr>
<tr>
<td>People heard</td>
<td>1100</td>
<td>500</td>
<td>238</td>
<td>300</td>
<td>271</td>
<td>300</td>
<td>Fewer groups and people heard at Town event as reduced time spent in area from 4 to 2 weeks. Outreach &amp; groups – revised target from 2000 to 1100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27/10/17</td>
<td></td>
</tr>
<tr>
<td>Surveys</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Questionnaires completed</td>
<td>1750</td>
<td>950</td>
<td>285</td>
<td>250</td>
<td>136</td>
<td>300</td>
<td>Bicester Town event 272 in total with 50% completed in Q2 No town event in Q1 – moved to Q2. Figures include the Travel survey activity. Revised target down to 1750</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>27/10/17</td>
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<td></td>
<td></td>
<td></td>
<td>22/8/17</td>
<td></td>
</tr>
<tr>
<td>Enter &amp; View activity</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>Two planned, one unplanned (Q4) – linked to town events. Revised down to 2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22/8/17</td>
<td></td>
</tr>
</tbody>
</table>
KPI 2  Influencing those who have the power to change services so that they better meet people’s needs now and into the future

<table>
<thead>
<tr>
<th>KPI 2</th>
<th>Target 2017/18</th>
<th>Q1 actual</th>
<th>Q2 actual</th>
<th>Q3</th>
<th>Q4</th>
<th>Comment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports published</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>Stroke Report &amp; Voluntary Sector Forum report</td>
<td>27/10/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reports published include those supported by the Project Fund</td>
<td></td>
</tr>
<tr>
<td>Reports to committees, commissioners</td>
<td>80</td>
<td>10</td>
<td>30</td>
<td>43</td>
<td>20</td>
<td>HWO Board, Oxfordshire County Council, Oxfordshire Health &amp; Overview Scrutiny Committee, Oxfordshire Health &amp; Wellbeing Board, Health Improvement Board, Oxfordshire Adult Safeguarding Board, CQC, Oxfordshire Health Transformation Board, Thames Valley NHS Committees. Includes verbal reports to NHS Thames Valley Committees that were not originally included; OCC monitoring, increased CQC contact/reporting; Locality Forum Chairs included; A&amp;E Delivery Board, Witney/Deer Park, Health Inequalities Commission, Oxfordshire Primary Care Commissioning Committee, OUHT, OHT, 111 Mobilisation Board, JSNA Steering Group, Bicester Healthy New Town Partnership, Home Care Board, Children Trust, TV Healthwatch,</td>
<td>27/10/17</td>
</tr>
</tbody>
</table>
KPI 3 Empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same

<table>
<thead>
<tr>
<th>KPI 3</th>
<th>Target 2017/18</th>
<th>Q1 Actual</th>
<th>Q2 Actual</th>
<th>Q3</th>
<th>Q4</th>
<th>Comment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector forum</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>27/10/17</td>
</tr>
<tr>
<td></td>
<td>Voluntary Sector Forum – July – Health Inequalities. Planned Forum for 6th December (Q3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q1 Forum to be run in Q2 so still on track to achieve 3 / annum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public contact by phone, mail, email, web site, face to face</td>
<td>700</td>
<td>250</td>
<td>149</td>
<td>150</td>
<td>165</td>
<td>200 200</td>
<td>27/10/17</td>
</tr>
<tr>
<td></td>
<td>Level of activity affected by holiday month August balanced by Voluntary Sector Forum in July.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes groups. Target needs to be revised down. Revised annual target to 700.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22/08/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22/08/17</td>
</tr>
</tbody>
</table>
### KPI 4

The development of the Healthwatch brand and brand values, to reflect Healthwatch Oxfordshire’s ambition as THE health and care champion for Oxfordshire

<table>
<thead>
<tr>
<th>KPI 4</th>
<th>Target 2017/18</th>
<th>Q1</th>
<th>Q1 actual</th>
<th>Q2</th>
<th>Q2 actual</th>
<th>Q3</th>
<th>Q4</th>
<th>Comment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved web site</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Revised to Q4 as impacted by decision to purchase new system with longer implementation time than previously estimated for revamp of existing web site. Now likely to be Q3</td>
<td>28/11/17</td>
</tr>
<tr>
<td>Publications – newsletter, updates</td>
<td>17</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>Planned fortnightly electronic Briefing to commence in Q3 – target figures adjusted up from 8 – 17.</td>
<td>27/10/17</td>
</tr>
<tr>
<td>Web site hits</td>
<td>7900</td>
<td>1600</td>
<td>1588</td>
<td>1800</td>
<td>2,100</td>
<td>2000</td>
<td>2500</td>
<td>Q2 – exceeded target by 16% base line Q4 2016/17 = 1474</td>
<td>27/10/17</td>
</tr>
<tr>
<td>Media hits Base line Q4 2016/17 = 35</td>
<td>200</td>
<td>30</td>
<td>45</td>
<td>35</td>
<td>68</td>
<td>40</td>
<td>60</td>
<td>Q2 Activity measured to include media enquiries (35) and coverage (33). Reviewed Q1 figures and revised Q3 &amp; Q4 figures to reflect change in measurement. Revised target up from 135 to 213. No town event affected level of activity. Q2 as of 22/8 activity 44 Cyclic, dependent on external activity</td>
<td>27/10/17</td>
</tr>
<tr>
<td>Twitter impressions Base line Q4 2016/17 = 9794</td>
<td>35000</td>
<td>1000</td>
<td>7200</td>
<td>7000</td>
<td>6,799</td>
<td>10000</td>
<td>10000</td>
<td>Activity reflects Bicester town event but still not reaching levels achieved during Witney Town event. Review target and gain understanding in Q3. No town event affected level of activity. Revised target 35000. Cyclic, dependent on external activity</td>
<td>27/10/17</td>
</tr>
</tbody>
</table>
Deer Park Medical Centre Secretary of State Referral – progress report on implementation of recommendations

1. Background

A referral was made to the Secretary of State for Health (SoS) by the Oxfordshire Joint Health Overview & Scrutiny Committee (OJHOSC) in February 2017 relating to the decision by Oxfordshire Clinical Commissioning Group not to re-procure the Deer Park Medical Centre contract following the failure to award the contract in the first attempt. In March 2017 the referral was passed to the Independent Review Panel for initial assessment in line with the protocol for handling contested proposals for the reconfiguration of NHS services.

In a letter to the SoS, the Panel concluded that the referral was not suitable for full review because further local action by the NHS with the OJHOSC could address the issues raised. The SoS responded to OJHOSC on 3 July 2017 with a copy of the IRP review and confirming he had accepted their recommendations in full. This letter was shared with OCCG (by OJHOSC), but initially there was no direct communication from the SoS with OCCG.

On 25 July 2017 NHS England wrote to OCCG confirming expectations that OCCG would address the recommendations from the IRP and in particular:

- The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible
- The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. This needs to be linked to, and integrated with, the wider CCG and STP plans for the whole of Oxfordshire. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future.

This paper reports on the work undertaken by OCCG to address these recommendations.
2. Specific recommendations and action taken

1. **NHS England to monitor the performance of the CCG, including ensuring provision of primary medical services for Deer Park patients yet to register elsewhere and the urgent action required to secure the services needed now and in the future.**

   As at 18 January 2018, 285 patients on the Deer Park list had not yet registered elsewhere. As agreed with the OJHOSC at their September meeting an additional (fourth) letter was sent to those who had not yet registered with another practice.

2. **CCG should commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. Engagement with the public and patients is required in assessing current and future health needs, understanding options and co-producing the solutions. This should not preclude the possibility of providing services from DPMC in the future. To be completed in 6 months and reviewed by a third party identified by NHS England so that residents can see a credible plan for delivering the services they need.**

   This was part of the work that OCCG was already taking forward in planning for primary care services in and around Witney through the locality group (as part of the overall work being undertaken on development of place based plans for all parts of Oxfordshire).

   OCCG representatives attended the meeting of the OJHOSC on 14 September 2017 to share the proposed approach to addressing the recommendations and in particular the approach to engagement with patients and public.

   The report on the engagement (attached) indicates that we carried out our plan in full and adapted it to respond to requests for meetings; for example with the Deer Park Campaign group, Witney Town Councillors and West Oxfordshire District Councillors.

   The first version of West Oxfordshire Locality Plan was published on 25 January 2018 and is attached. This has incorporated views that were heard during the engagement period and highlighted where further work is needed. The plan will remain iterative: as the population changes and the way we deliver healthcare evolves, we will continue to work with patients and clinicians to ensure that primary care remains responsive, accessible and of high quality. As and when more specific changes (such as site options for a relocated and/or new practices) might be needed then further engagement (and consultation if necessary) will be undertaken.

   NHSE were required to identify an independent third party to review the plan. They commissioned North East London CSU to carry out this review and are presenting this to the OJHOSC.
3. **OJHOSC to review its working practices with the NHS to develop and sustain an open, no surprises, productive and effective working relationship required to command public confidence.**

A productive workshop was held on 18 January which the OJHOSC Chairman will be reporting on. There was good NHS input to the workshop with the following individuals attending:

OCCG:
Lou Patten, Interim Chief Executive; Catherine Mountford, Director of Governance and Ally Green, Head of Communications and Engagement

Oxford University Hospitals NHS Foundation Trust:
Eileen Walsh, Director of Assurance; Susan Polywka, Head of Corporate Governance and Trust Board Secretary and Matt Akid, Head of Communications

Oxford Health NHS Foundation Trust:
Kerry Rogers, Director of Corporate Affairs and Company Secretary and Lorcan O’Neill, Head of Communications.

NHS England:
Olivia Falgayrac-Jones, Director of Commissioning; Frances Fairman, Head of Clinical Programmes; Ginny Hope, Head of Primary Care and Annie Tysom, Communications Manager.

3. **OCCG assurance and oversight of work undertaken**

The Oxfordshire Primary Care Commissioning Committee has responsibility for OCCG’s work on commissioning primary care. The work undertaken to address the IRP recommendations to the SoS have been reported to the Committee meetings in September 2017, November 2017 and January 2018. These meetings are held in public and all papers are on the OCCG website.

4. **Query raised by OJHOSC on decision making process**

At their meeting in September the OJHOSC asked that OCCG reviewed its decision making processes in order to build a more meaningful relationship and genuine engagement with the community. In response to this OCCG shared a link to a paper presented to the Oxfordshire Primary Care Commissioning Committee in January 2017; this was intended to show that OCCG take learning very seriously and had undertaken a review of practice and made changes very early on. This change of approach has been successfully used in two specific practice examples;

- Firstly for Kennington Surgery after the practice gave notice on its contract, leading to a merger with another practice and services continuing to be provided from the original surgery.
• Banbury Health Centre (where a contract was coming to an end); early and ongoing engagement with the practice PPG led to revisions to proposals to have the preferred option being to continue to provide services from that site.

The OJHOSC is asked to acknowledge the work completed to address the outcome of the referral to the SoS.

Catherine Mountford, Director of Governance
29 January 2018
Locality Place Based Primary Care Plan: West Oxfordshire Locality
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Foreword

The NHS is facing challenging times: There is growing demand, constrained resources and workforce shortages at every level in both the health and social care systems.

West Oxfordshire faces specific challenges:

- Population increase of 20,000 over the next 10 years due to housing growth
- An older population than the Oxfordshire average which is expected to continue to grow at a higher rate than other parts of the county
- For the rural cluster of West Oxfordshire, 43% of GPs are aged over 55 and potentially nearing retirement
- General practice is becoming a more stressful and a less attractive career option resulting fewer GPs working full time and practices struggling to recruit new GPs and other staff
- There is limited practice space
- Resources are not keeping pace with soaring demand.

The traditional primary care model has worked well over the years. However, with all these challenges, we, as local GPs and patients, recognise that the traditional model needs adaptation if it is to survive.

We want to build on the strengths of the services already available in West Oxfordshire. We plan to improve urgent same day access so patients can see a healthcare professional urgently when needed, to boost the workforce by diversifying the team so that patients can benefit from a range of different skills, to optimise the management of our growing elderly population and to develop our buildings to meet the needs of the increasing demand.

As local GPs, we do not want to miss this opportunity to improve local services for our growing population. With the multiple challenges we face there is not one easy solution. Through sharing resources across the locality, coordinating services and using the expertise of local clinicians and patients, we can all work together to strive for a system that is both resilient and excellent for the future.

This plan also addresses the recommendation of the Independent Reconfiguration Panel (IRP) to the Secretary of State for the development of a plan to ensure sustainable primary care in Witney and surrounds.

We congratulate Dr Kiren Collison, Deputy Locality Clinical Director of the West Locality, who was elected to the position of chair of Oxfordshire CCG and was instrumental in the development of this plan, and welcome Dr Amar Latif as the new Deputy Locality Clinical Director.
West Oxfordshire Locality Executive Summary

Locality overview:
West Oxfordshire Locality is home to a registered patient population of 81,638 (January 2018). The locality is made up of market towns and villages. Witney is the main urban area (over 27,000 people), and Carterton the second largest town (16,000 people). West Oxfordshire is the most rural district in the county and residents are older than average. This creates specific challenges around transport links and access.

What is working well:
- Extended access hubs in Witney
- Use of broader skillmix, including emergency care practitioners and pharmacists
- Activity-led website signposting patients in Windrush
- Optimised reception rostering to improve retention recruitment
- Longer appointments in some practices

Key locality challenges:
- Estates that can match the pace of their growing population, in particular Witney, Carterton and Eynsham
- Parts of the locality have a significantly older population, which causes challenges for access to services
- Recruiting enough staff for the growing ageing population

Key Priorities for the West Oxfordshire Locality

We have identified four key priorities for the locality and thirteen specific workstreams which will support us to deliver each priority.

Successful delivery of the plan will depend on local and Oxfordshire wide planning for future workforce, estates and technology that will deliver the changes needed for a sustainable primary care that can meet the needs of the population in West Oxfordshire.

<table>
<thead>
<tr>
<th>#</th>
<th>Workstreams</th>
<th>Meet the healthcare needs of the ageing population in the locality</th>
<th>Ensuring safe and sustainable primary care that delivers high quality services</th>
<th>Improving prevention services</th>
<th>Planned care closer to home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maximise benefits of Emergency Multidisciplinary Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Locality diabetes service, and extend to other conditions, such as heart failure and COPD</td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td>Increased primary care visiting service</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td>Same-day care services in Witney and Carterton with increased capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Urgent Treatment Centre in Witney, integrating current services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Practice based mental health practitioners for rural West</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Enhanced signposting role for receptionists and development of practice websites for signposting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Development of practice website</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Development of social prescribing model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Shared back office prescribing model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Estates prioritisation</td>
<td></td>
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</tr>
</tbody>
</table>
Note on the geography of the West Oxfordshire Locality

The West Oxfordshire locality (WOLG) is contained entirely within the West Oxfordshire District Council area. However, localities do not map onto constituency or district council boundaries. This is because Oxfordshire CCG’s localities reflect patient flow and long standing working relationships of GP practices that pre-date the formation of OCCG in 2013. A number of services are arranged around or report on the basis of these well-established boundaries.

All references to West Oxfordshire in the plan are to the locality as described in figure 1, unless otherwise explicitly indicated. A summary of key challenges and priorities for practices and patients in the area covered by West Oxfordshire District Council is set out in table 1.

Plans for primary care in the northern part of West Oxfordshire District Council (Chipping Norton and surrounds) are covered in the North Oxfordshire Locality Place Based Primary Care Plan.

Plans for primary care in the eastern part of West Oxfordshire District Council (Woodstock) are covered in the North East Oxfordshire Locality Place Based Primary Care Plan.

All locality plans are on the Oxfordshire CCG website at: [http://www.oxfordshireccg.nhs.uk/about-us/locality-plans.htm](http://www.oxfordshireccg.nhs.uk/about-us/locality-plans.htm)
Table 1: Summary of the Locality Place Based Plan for patients resident in West Oxfordshire District Council boundaries

<table>
<thead>
<tr>
<th>Locality Plan</th>
<th>Part of West Oxfordshire covered by the locality plan</th>
<th>Key challenges</th>
<th>Key priorities and how we will address them</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Oxfordshire Locality</td>
<td>Aston, Bampton, Burford, Carterton, Charlbury, Eynsham, Stonesfield, Witney (Patients who live in West Oxfordshire and are registered at Bampton Surgery (including Carterton Health Centre), Broadshires Health Centre, Burford Surgery (including Carterton Health Centre), Charlbury Medical Centre, Cogges Surgery, Eynsham Medical Group and Long Hanborough Surgery, Nuffield Health Centre, Windrush Medical Practice)</td>
<td>Estates that can match the pace of their growing population, in particular Witney, Carterton and Eynsham Parts of the locality have a significantly older population, which causes challenges for access to services Recruiting enough staff for the growing ageing population</td>
<td>1. <strong>Meet the needs of the ageing population in the locality:</strong> Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living Increased primary care visiting service 2. <strong>Ensuring safe and sustainable primary care that delivers high quality services:</strong> Estates prioritisation Wider primary care clinical skill mix delivered through practice-based and clusters, including clinical pharmacists 3. <strong>Improving prevention services</strong> Social prescribing and community activation 4. <strong>Planned care closer to home</strong> Urgent treatment centre in Witney and more planned care services in the locality</td>
</tr>
<tr>
<td>North Oxfordshire Locality</td>
<td>Chipping Norton, Kingham, The Wychwoods (Patients who live in West Oxfordshire and are registered at Chipping Norton Health Centre and Wychwood Surgery)</td>
<td>High number of care homes increasing the number of complex patients in the area Significant housing growth projected, in particular around Chipping Norton Rurality of these areas poses access challenges</td>
<td>1. <strong>Safe and sustainable primary care services for the population:</strong> Clinical Pharmacist support in practices Social prescribing and support 2. <strong>Improving outcomes for the complex and frail / elderly:</strong> Expanding the primary care visiting service for frail patients Coordinating care home support from practices 3. <strong>Ensuring that patients can access the right primary care at the right time:</strong> Additional access services in the North Locality Review of primary care infrastructure in Chipping Norton in line with growth</td>
</tr>
<tr>
<td>North East Oxfordshire Locality</td>
<td>Bladen, Tackley, Woodstock (Patients who live in West Oxfordshire and are registered at Woodstock surgery)</td>
<td>Additional 824 housing capacity projected by 2031 Woodstock has a significantly older population which causes challenges for access to services Access challenges at Woodstock due to lack of parking</td>
<td>1. <strong>Increased capacity in primary care to meet housing and population growth:</strong> Estates prioritisation Expansion of primary care visiting services 2. <strong>Sustainability of Primary Care:</strong> Primary Care Urgent Access Hubs 3. <strong>New models of clinical care</strong> Deliver prevention services through the wider primary care community team 4. <strong>Increased self-care and promotion of health and wellbeing:</strong> Explore benefits of social prescribing to support patients with non-medical needs.</td>
</tr>
</tbody>
</table>
Part A: Introduction: Approach to developing the plan for the West Oxfordshire Locality

1. The purpose of this locality place based plan

Good primary care is the bedrock of a high-quality and cost-effective health system, and the NHS has traditionally prioritised primary care compared to many other health systems worldwide, which is generally accepted as key to its success and pre-eminence internationally in effective, safe, coordinated, patient-centred care and in efficiency.

The Oxfordshire Primary care Framework highlighted the importance of investing in the sustainability of General Practice, and supporting it to be the lynchpin in our health and care services. Transformation of these services will require new thinking and new models of care and delivery. The new model of primary and community care in Oxfordshire will be based on a number of operational principles:

- Delivering appropriate services at scale
- Organised around geographical population-based needs based on the practice registered list
- Delivering care closer to home
- A collaborative, proactive system of care
- Delivered by a multidisciplinary neighbourhood team
- Supported by a modernised infrastructure.

The Oxfordshire Primary Care Framework seeks to describe a framework for GPs and their teams, working with their patients, to describe how this model and the specific actions can work for their own local populations. The result of this is detailed in this locality place based plan clearly describing the future model for delivery of primary care across the locality.

This together with the GP Forward View (GPFV) and local implementation plan will ensure Primary Care remains the cornerstone of the NHS going forward. The plans will remain iterative: as the population changes and the way we deliver healthcare evolves, we will continue to work with patients and clinicians to ensure that primary care remains responsive, accessible and of high quality.

Gap analysis and prioritisation:

The plans have been tested against the priorities set out in the Oxfordshire CCG Primary Care Framework, the opportunities outlined in the GP Forward View and local transformation programmes. Proposals with funding consequences have been further assessed according to need across Oxfordshire. A sustainable model of primary is dependent on releasing funding from secondary care to invest into primary care.
2. Who helped to inform our plan?

This document draws on the knowledge and experience of Oxfordshire’s clinical community and patients to both describe and develop a West locality place based plan for the delivery of sustainable primary care and support for the model of moving care closer to home. It involves using the Oxfordshire CCG Primary Care Framework and opportunities outlined in the GP Forward View to achieve this aim. This process included:

**West Oxfordshire Locality Group (WOLG) meetings:**
- Membership includes GP commissioning leads from all 8 practices, some practice managers, patient representatives and district council officers
- Substantial discussions at West Oxfordshire Locality Group meetings on 20 April, 11 May and 8 June 2017
- Locality workshop with independent facilitator focusing on key questions 13 July
- 14 Sept. - detailed discussion of proposed workstreams, including ranking of priority.

**Assessment of public health information:**
- The data to assess health needs has come from numerous sources including:
  - Oxfordshire Joint Strategic Needs Assessment (JSNA)
  - NHS Digital
  - Oxfordshire County Council housing projections submitted to the Oxfordshire Growth Board by West Oxfordshire District Council.
- The JSNA examines the current and future health and care needs of the local population to inform and guide the planning and commissioning of health, well-being and social care services. It was developed in consultation with patients and other stakeholders. Elements of the JSNA that were applicable and appropriate for West Oxfordshire were shared with the public in draft plans and in presentations at public events.

**Patient participation:**
- Patient engagement is an integral part of developing the locality plans. In particular meetings with:
  - Stakeholders organised by Healthwatch
  - PPG groups of West Oxfordshire to plan engagement
  - Robert Courts MP
  - Witney town councillors
- Workshop session with councillors from West Oxfordshire District Council
- West Oxfordshire Economic and Social Overview and Scrutiny Committee
- Former patients of Deer Park Surgery
- The locality patient forum (Public & Patient Partnership West Oxfordshire) discussed the draft priorities at their meeting on 13 June 2017. In addition, the forum chair and vice-chairs participated in the discussions at the locality group meetings listed above.

- In addition, Oxfordshire CCG has held events in Witney and Carterton in November 2017. The workshops gave local people the opportunity to share their views on how GP and primary care services in their localities could be organised. These workshops and an online survey (for anyone unable to attend the workshops) follow and expand the work involving the CCG, local GP practices and patient representatives, who have been discussing plans for the future of primary care services in Oxfordshire for the past six months.

- This feedback has helped to shape and inform the locality plans, in particular:
  - strengthening the role of prevention, including with partners in the voluntary sector, the council and schools
  - further clarity on the decisions regarding future primary infrastructure for new estates
  - inclusion of funding implications
  - additional information on greater skillmix, in particular through clinical pharmacists, and training for non-clinical staff
  - proposals to reduce waiting times for routine appointments through expansion of the urgent access hubs and making more use of the emergency multidisciplinary unit in Witney.

- A full summary of themes identified through engagement is included in Appendix 1. This includes comments from the patient forum, the meetings with patients of former Deer Park surgery, the workshops in Witney and Carterton, written feedback and other contacts.

- If any proposals require significant changes that could adversely impact patients a more formal consultation will be undertaken for the specific service area.

Key messages:
The West Oxfordshire locality based primary care plan builds on the principles identified by the Oxfordshire Primary Care framework to create a 5 to 10 year strategy for the locality.

The plan has received significant input from clinicians, patients and other stakeholders to ensure future health services best reflect our local community.
Part B: The demographics of the West Oxfordshire locality population

1. Summary

1.1. Population

- The registered patient population at 1 January 2018 was 81,6381.
- The locality is contained entirely within the West Oxfordshire District Council area. It is made up of market towns and villages. Witney is the main urban area (over 27,000 people), and Carterton the second largest town (16,000 people). Other settlements are much smaller.
- West Oxfordshire is the most rural district in the county – more than half the residents live in an area classified as rural.
- Known transport issues for village residents are made greater by recent reductions in rural bus services. Bampton and other villages are significantly affected. Carterton is currently well-connected by bus to Witney and onwards to Oxford.
- Public transport access to Oxford hospitals are more challenging especially for patients and carers with limited mobility. Long journey times and the costs and difficulty of parking are a major public concern.
- There is a significant armed services population associated with RAF Brize Norton, with approximately 1,000 civilians registered with the base medical practice in addition to service personnel. Health services for service personnel are commissioned by NHS England.

1.2 Age

Patients registered with West Oxfordshire practices are older than average, as indicated in table 2 and figure 2.

ONS estimates from 2015 indicate that the total estimated population in wards covered by the West OCGG locality as of mid-2015 was 81,500 residents of which 2,200 were aged 85 or over with the ward of Burford having a significantly higher proportion of the population aged 85+ (6%). In the 5 year period between 2017 and 2022, the age group with the highest

<table>
<thead>
<tr>
<th>Area</th>
<th>% of population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>aged over 65</td>
</tr>
<tr>
<td>Rural West</td>
<td>19.3%</td>
</tr>
<tr>
<td>Witney &amp; East</td>
<td>20.8%</td>
</tr>
<tr>
<td>West Locality</td>
<td>20.2%</td>
</tr>
<tr>
<td>Oxfordshire CCG</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

Table 2: % of patients aged 65+ and 85+ (source: NHS Digital, January 2018)

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1 Data from NHS Digital January 2018: [http://content.digital.nhs.uk/gppatientsregistered](http://content.digital.nhs.uk/gppatientsregistered)
growth in all districts and Oxfordshire County is expected to be aged 75 to 84 (+23% in Oxfordshire and +27% in the district of West Oxfordshire).  

Figure 2: Age distribution of population registered in West Oxfordshire practices and all Oxfordshire practices (data from NHS Digital January 2018)

1.3 Care home population

- As of June 2017 there was a total of 18 care homes with 647 care home beds in wards in the West locality.
- The ward with the greatest number of care home beds was Witney East.

2 Source: 2014 ONS estimates. Housing projections set out below indicate that growth in the younger age groups is expected to significantly exceed ONS estimates.
1.4 Housing growth

ONS population projections do not take into account the significant housing growth expected in Oxfordshire over the coming years. Based on district council data collated for the Oxfordshire Infrastructure Strategy\(^3\), there are 3,600 dwellings expected in the locality over the next 5 years and over 8,000 in the next 10 years. At an average rate of 2.4 occupants per dwelling, estimated occupancy for these new homes is 8,700 in 5 years and nearly 20,000 in 10 years as shown in table 3. Most development will be in the Witney, Carterton and Eynsham areas. This includes two schemes with capacity for over 500 homes in West Oxfordshire with planning permission, in North Curbridge (West Witney) and on land at east Carterton.

<table>
<thead>
<tr>
<th></th>
<th>Housing growth – 5 years</th>
<th>Population Growth 5 years</th>
<th>Housing Growth – 10 years</th>
<th>Population growth 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural West Cluster</td>
<td>167</td>
<td>328</td>
<td>405</td>
<td>314</td>
</tr>
<tr>
<td>Witney and East Cluster</td>
<td>115</td>
<td>254</td>
<td>496</td>
<td>473</td>
</tr>
<tr>
<td>Total West Oxfordshire</td>
<td>282</td>
<td>582</td>
<td>901</td>
<td>787</td>
</tr>
</tbody>
</table>

Table 3: Housing growth in West Oxfordshire locality to 2026/27

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\(^3\) The Oxfordshire Infrastructure Strategy is published by the Oxfordshire Growth Board at: [https://www.oxfordshire.gov.uk/cms/content/oxfordshire-growth-board](https://www.oxfordshire.gov.uk/cms/content/oxfordshire-growth-board). The West Oxfordshire District Local Plan 2031 is currently at examination: [http://www.westoxon.gov.uk/localplan2031#](http://www.westoxon.gov.uk/localplan2031#)
1.5 The health of our community in West Oxfordshire locality

Health outcomes are generally better than average in the West Oxfordshire locality. A summary of West Oxfordshire’s health needs analysis for the locality (June 2016)\(^4\) is as follows:

- Although the rates of poverty affecting children and older people in the West locality were lower than the OCCG average and national average, deprivation data shows there were areas of Witney that had the highest rates of poverty affecting children and older people.
- The following health outcomes were higher than the OCCG average:
  - Deaths from All Causes under 75 years
  - Alcohol related hospital admissions
- The Freeland & Hanborough ward had a higher death rate from stroke than predicted by the age of the local population, but outcome may have been influenced by the 65 care home beds within Freeland and Hanborough ward.
- The Witney South ward had a standardised admission ratio for intentional self harm above the England average.
- West Oxfordshire locality patients have a slightly higher prevalence of long term conditions than average, which reflects the higher age of the population (table 4). Practices manage chronic diseases of their patients extremely well, with QOF achievement (quality measure of managing long term conditions) near 100%.

### Table 4: Disease and LTC Prevalence QOF data 2016/17

<table>
<thead>
<tr>
<th></th>
<th>2015/2016 Disease and LTC prevalence QOF data 2016/17 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>Rural West</td>
<td>2.1%</td>
</tr>
<tr>
<td>Witney &amp; East</td>
<td>2.2%</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>2.2%</td>
</tr>
<tr>
<td>England</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

**Key messages:**

Health outcomes are generally better than average in the West Oxfordshire locality. Patients in West Oxfordshire are older than average and the age group with the highest growth is expected to be aged 75 to 84.

In addition, there is significant housing growth in Witney, Carterton and Eynsham, which will have an impact on the use of services.

\(^4\) Source: Public Health England Public Outcomes Framework unless otherwise specified
Part C: How our population in West Oxfordshire accesses services

Part C outlines how current services are used by the population in West Oxfordshire. This includes A&E and MIU attendances, current workforce and primary care provision as well as an overview of urgent and community care.

- 6 practices have above average GP-referred first outpatient appointments compared to the OCCG average (figure 5). This means the locality average is slightly above the OCCG average. However, the email service to secondary care consultants is used a lot in West (with significant variation across practices). There is some evidence that it can reduce referrals and this is recognised by GPs.
- Half the practices show a higher usage than OCCG average for out of hours (OOH) GP services and overall OOH use is slightly above the OCCG average.
- Use of A&E activity in West Oxfordshire is much lower than the CCG average (figure 6). This is associated with successful earlier campaigns to direct patients to the MIU as a better and more cost effective alternative to A&E and effective signposting in primary care.
- Urgent care emergency admissions are just below OCCG average.

Figure 5: GP-referred first outpatient appointments among practices in West locality and Oxfordshire average, standardised rate per 1,000

Source: SUS data March 2017

Figure 6: A&E attendance across Oxfordshire, rate per 1,000 2016/17

Source: SUS data March 2017
1. Overview of Primary and Community Care

The West locality has 8 GP practices, working in two clusters, offering primary care from 10 locations.

1.1 Access to primary care in West Oxfordshire Locality

Core primary care services are delivered Monday-Friday from 0800-1830 hrs by all practices in the locality. Feedback from the GP Patient Survey and the process of patient engagement to support the development of this plan indicate a high level of satisfaction with primary care services. Patients commented that services are responsive and provide excellent continuity of care.

In common with national trends, the average number of appointments per year is consistently increasing, putting pressure on the capacity to meet demand\(^5\). GP Federations provide additional GP and nurse appointments outside of normal practice opening hours, which are funded by the GP Access Fund scheme. These appointments are pre-bookable and are intended to provide routine appointments to those patients for whom normal practice opening hours are not convenient. This service is delivered in rotation from practice sites and appointments are available from 6:30-8pm Monday-Friday. These additional hubs are popular with patients and GPs in West Oxfordshire. There is also availability for several hours on a Saturday. Sunday appointments are provided by a hub in Banbury but are open to West Oxfordshire patients. The appointments are available to patients registered at any practice in the federation, regardless of the location of the clinic. There is currently little demand for routine weekend appointments but there is a national requirement to deliver them.

Table 5: Practices and branch surgeries in the West Oxfordshire Locality

<table>
<thead>
<tr>
<th>#</th>
<th>Neighbourhood /Practice</th>
<th>List Size (1st Jan 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 1a</td>
<td>Bampton Surgery and Carterton Health Centre (branch)</td>
<td>8,474</td>
</tr>
<tr>
<td>2</td>
<td>Broadshires Health Centre</td>
<td>10,476</td>
</tr>
<tr>
<td>3, 3a</td>
<td>Burford Surgery and Carterton Health Centre (branch)</td>
<td>5,542</td>
</tr>
<tr>
<td>4</td>
<td>The Charlbury Medical Centre</td>
<td>5,372</td>
</tr>
<tr>
<td></td>
<td>Witney &amp; East cluster</td>
<td>50,774</td>
</tr>
<tr>
<td>5</td>
<td>Cogges Surgery</td>
<td>7,657</td>
</tr>
<tr>
<td>6</td>
<td>Eynsham Medical Group and Long Hanborough Surgery</td>
<td>13,916</td>
</tr>
<tr>
<td>7</td>
<td>Nuffield Health Centre</td>
<td>12,037</td>
</tr>
<tr>
<td>8</td>
<td>Windrush Medical Practice</td>
<td>17,164</td>
</tr>
<tr>
<td></td>
<td>West Oxfordshire Locality Total</td>
<td>81,638</td>
</tr>
</tbody>
</table>

Figure 7: Map of practices in West Oxfordshire locality

1.2 Primary care in care homes

For patients in care homes, the CCG commissions an enhanced service for Proactive Care Home Support from primary care. This is an optional scheme which involves a practice forging a closer working relationship with one or more care homes, and providing GP services to the majority of the residents in these homes. Almost all care homes in the West Locality are covered either by the CCG scheme or a separate arrangement and it is a priority for the Locality in the next year for all patients in care homes to have proactive care and support.

1.3 Out of hours

Outside normal practice opening hours, all patients have access to GPs and nurses working in the Out of Hours Urgent Care Service. Oxford Health NHS Foundation Trust holds the contract for delivery of this service and the service is delivered from the Witney Hospital site. Appointments are accessed via the NHS 111 service, and cannot be booked in advance or for routine problems.

1.4 Urgent Care

1.4.1 Minor Injuries Unit (MIU)

The MIU is a nurse-led service delivered from Witney Community Hospital from 10:00 to 22:30 Monday to Sunday. It is a walk-in service (meaning patients do not need to be referred). It also provides access to x-rays from 10:00 to 19:30 both to MIU patients as well as to patients referred directly by their GP.

1.4.2 Urgent Access Hubs

The GP federation, PML, provides additional urgent same-day GP and nurse appointments at a ‘hub’ based at the Windrush Health Centre in Witney. There are also routine pre-bookable physiotherapist appointments for assessment of musculoskeletal problems. The patient must be registered at any practice in the federation and the appointments can only be accessed through their practice (it is not a walk-in service). It is open from 9:00 to 18:00 Monday to Friday and funded through a national initiative and the GP Access scheme.

This service increases the capacity of primary care to manage urgent non-housebound patients. It is suitable for patients who require same-day attention but where continuity of care by their own GP on that particular occasion is not paramount to their effective management. This service increases access for urgent patients, whilst also freeing up additional time in practices for GPs to spend with complex patients where continuity of care is important.

Urgent access hubs are popular with both patients and GPs. Capacity is, however, limited and an increase in appointment availability would be beneficial to match demand. In addition, as the hub is located in Witney, it is predominantly used by those practices based in and around Witney.
Witney whilst more rural practices (particularly Burford, Charlbury and Bampton) use it less frequently. This rural cluster is interested in developing a second hub in Carterton. This would be closer to their patients and offer equity of urgent access, in line with the Witney practices.

1.4.3 Primary Care Visiting Service (PCVS)

The Primary Care Visiting Service is led by Emergency Care Practitioners (ECPs). They visit acutely unwell housebound patients at the request of the patient’s GP. This service runs in-hours from Monday to Friday and increases the capacity of primary care to manage urgent housebound patients. Capacity is currently 5 WTEs shared across 3 of the CCG localities (West, North and North East). Increased capacity will be required to match the demand from an increasing elderly and housebound population.

1.4.4 Emergency Multidisciplinary Unit (EMU) in Witney

The Witney EMU is a great asset to the current local services and has been well received by both patients and the locality GPs. Local GPs and other community services can refer adults who are acutely unwell who require investigation and treatment but are unlikely to need overnight admission. In this way, it provides a less acute medical setting than the hospital and is closer to home. Oxford Health NHS Foundation Trust holds the contract and the unit is staffed by both physicians and nurses.

1.4.5 Future plans for urgent care

As part of the Urgent and Emergency Care Review, NHS England intends to establish commonality in the specification for urgent care through urgent treatment centres (UTCs) by December 2019. There are multiple urgent care services based in Witney and a wide range of discrete primary, community and secondary care health services already available on the “health campus” formed by Witney Community Hospital and Windrush Health Centre. However, there is currently little integration. Looking towards an Urgent Treatment Centre (UTC) model which coordinates these services may facilitate sharing of staff, buildings and resources and may also allow for a more streamlined, more efficient, and less confusing service.

1.5 Community elective services

Community health services on the Witney Community Hospital and Windrush Health Centre “health campus” include:

- Community hospital including therapies and in-patient care
- Range of outpatient clinics

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5 https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres
- Endoscopy (independent provider)
- Podiatry clinic
- Sexual health clinics
- Independent audiology clinics
- GP out of hours service base
- Bladder & bowel service
- Community ultrasound
- Community midwife clinics.

The MSK Assessment, Triage and Treatment (MATT) service is provided from the former Deer Park Medical Centre building on the west side of Witney, by an independent provider, Healthshare. District nurses are mostly based at the hub offices on the edge of Witney, with some health visitor teams working across the area and based at Cogges Surgery and Carterton Health Centre.

<table>
<thead>
<tr>
<th>Service</th>
<th>Hours M-F</th>
<th>Hours w/e</th>
<th>Staff</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor injuries unit</td>
<td>1000-2230</td>
<td>1000-2230</td>
<td>Nurse/HCA</td>
<td>Self</td>
</tr>
<tr>
<td>GP Access Fund Hub</td>
<td>9 hrs / week</td>
<td>Sat am</td>
<td>GPs, ANP</td>
<td>Practice</td>
</tr>
<tr>
<td>GP Access Fund practice</td>
<td>1830-2000</td>
<td>-</td>
<td>GP &amp; Nurse</td>
<td>Practice</td>
</tr>
<tr>
<td>Primary Care Visiting service</td>
<td>0800-1800</td>
<td>-</td>
<td>ECPs, ANPs</td>
<td>Practice</td>
</tr>
<tr>
<td>Out of hours GP service</td>
<td>1830-0800</td>
<td>24 hours</td>
<td>GPs</td>
<td>NHS 111</td>
</tr>
<tr>
<td>EMU</td>
<td>0800-2000</td>
<td>1000-1630</td>
<td>Medic, Nurses</td>
<td>Clinician</td>
</tr>
<tr>
<td>District nursing hub</td>
<td>0800-1630</td>
<td>0800-1630</td>
<td>Nurses</td>
<td>Practice, self</td>
</tr>
<tr>
<td>Hospital at Home</td>
<td>0800-2200</td>
<td>0800-2200</td>
<td>Nurses, ECPs, APs</td>
<td>Clinician</td>
</tr>
</tbody>
</table>

Table 6: Summary of primary care services in West Oxfordshire locality

---

7 X-ray available 1000-1930 only
8 Not available at Witney for last 18 months
9 “Interface medic” – experienced gerontologist or GP with special interest
Focus on primary care in Witney

Witney is the largest town in the West Oxfordshire locality. It has a population of approximately 28,000 and is served by 3 practices located in the town following the closure of Deer Park Medical Practice earlier this year (see appendix 3 for more detail) – Nuffield Surgery and Windrush Medical Practice in the town centre and Cogges Surgery in East Witney. Windrush Health Centre is part of a “health campus” on the same site as Witney Community Hospital. A full list of services provided at Witney Community Hospital is provided on pages 17-18.

Practices in Oxfordshire have been working together to provide pre-bookable and same day, evening and weekend appointments within general practice since 2015, strengthening the support available for those with the most complex needs and introducing new ways of accessing services. This service is delivered from 6:30-8pm Monday-Friday at practices across West Oxfordshire and on Saturday at Windrush Health Centre. The CCG also commissioned over 1,000 additional appointments per month for patients in West Oxfordshire to be delivered during core GP hours by GPs, advanced nurse practitioners and physiotherapists – these are all provided at Windrush Health Centre and are available to all patients registered in West Oxfordshire practices. The weekday services have received positive feedback from patients. The locality plan for West Oxfordshire indicates an intention to increase capacity in the locality – with options for locations to be considered by practices to ensure maximum utilisation. In addition, an Urgent Treatment Centre model on the site of the current Minor Injuries Unit at the Community Hospital, if it meets the appraisal process to be carried out by March 2018, will ensure a consistent route to access urgent appointments, over time to be booked through NHS 111 and GPs.

The West Oxfordshire Local Plan 2031* identifies Witney as a key area for future development with an identified housing need of 4,400 homes to 2031 shown in figure 7. This includes:

- Confirmed developments in West Witney of 1,000 dwellings (A) and in Burford Road of 260 dwellings (B)
- Strategic Development Areas on the eastern side of Witney of around 450 dwellings (C) and to the north of Witney of around 1,400 dwellings (D)
- Non-strategic housing allocations on Woodford Way Car Park of 50 dwellings (E) and on land west of Minster Lovell of 85 dwellings (to the North West of the map).

Land to the west of Down’s Road (F) has additionally been identified as an ‘area of future long-term development potential’ to include consideration of opportunities for new housing and employment to meet identified development needs beyond 2031.

Future primary care infrastructure in Witney will need to respond in a timely and appropriate way to future housing growth. The Cogges Surgery has recently received funding from NHS England’s Estates and Technology Transformation Fund to improve clinical capacity. In the longer term, Nuffield Health Centre has indicated its intention to relocate and expand capacity and Cogges Surgery will consider increasing capacity further with the possible need to relocate. This will ensure that patients from a much wider area will be able to access primary care services at the surgery. The future location of the surgery will be subject to an options appraisal which will include considerations regarding accessibility, capacity and expected utilisation, and will be subject to consultation with its registered patients. An options appraisal will also be completed on how best to provide services.

*To read the West Oxfordshire Local Plan 2031 visit West Oxfordshire District Council website: https://www.westoxon.gov.uk/media/1037296/Local-plan-2011-2031.pdf
2. Primary care workforce

2.1 General practitioners

Practices responded to a survey in September 2017 regarding capacity details, gaps in current staffing and known/planned for retirements. Table 7 indicates the number of sessions currently delivered, the future number of sessions required and the number of GPs required to continue delivering the same level of service. Future projections do not account for the number of GPs that are expected to retire in the next 5-10 years, although it is expected that up to 30% of the current workforce will retire in the next 3 years.

Future numbers of GPs is likely to be impacted by:
- Intentions across Oxfordshire to move to longer 15 minute appointments for patients with greater needs
- Potential changes in skillmix and a greater role for signposting and community champions to support patients in managing their long term conditions.

Table 7: GP workforce in North Oxfordshire locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Current number of sessions delivered*</th>
<th>Number of sessions required in the future</th>
<th>Number of additional GPs required (FTE) – assumes 8 sessions per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5 years**</td>
<td>10 years**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 years*</td>
<td>10 years*</td>
</tr>
<tr>
<td>Rural West</td>
<td>134</td>
<td>150</td>
<td>159</td>
</tr>
<tr>
<td>Witney &amp; East</td>
<td>204.25</td>
<td>225</td>
<td>258</td>
</tr>
<tr>
<td>West Locality</td>
<td>338.25</td>
<td>374</td>
<td>417</td>
</tr>
</tbody>
</table>

* Data from workforce survey; **Data calculated from housing projections (table 3 above)

2.2 Other primary care workforce

In terms of other general practice in the locality, table 8 indicates current sessions offered by treatment room nurses, advanced nurse practitioners, healthcare assistants and phlebotomists taken from the workforce survey. Plans for future recruitment of staff are unlikely to meet future demands from population growth.
As indicated in tables 8 and 9, practices in West Oxfordshire have not yet begun to employ a broader skillmix to deliver primary care in the future, with the exception of 2 practices that employ advanced nurse practitioners. There is some interest in employing pharmacists, mental health practitioners; practices have expressed concern about indemnity and employment models as a barrier to working across practices.

Table 9: Practice intentions to employ or share clinical staff (ANPs, ECPs, APs, PAs)

<table>
<thead>
<tr>
<th>Locality</th>
<th>Advanced Nurse Practitioner</th>
<th>Emergency Care Practitioner</th>
<th>Assistant Practitioner</th>
<th>Physician's Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Maybe</td>
<td>Already in place</td>
</tr>
<tr>
<td>Rural West</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Witney &amp; East</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>West Locality</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 10: Practice intentions to employ or share clinical staff (pharmacists, physiotherapists, phlebotomists, mental health practitioners)

<table>
<thead>
<tr>
<th>Locality</th>
<th>Pharmacist</th>
<th>Physiotherapist</th>
<th>Phlebotomist</th>
<th>Mental health practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Maybe</td>
<td>Already in place</td>
</tr>
<tr>
<td>Rural West</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Witney &amp; East</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>West Locality</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Key messages:

There is currently good access to primary and urgent care in West Oxfordshire. It is intended to increase urgent access through the hubs, particularly in the rural West and to develop an urgent treatment centre in Witney with better integration of services.

There is significant growth in West Oxfordshire which will have an impact on primary care services and future workforce. Growth projections suggest that a further 11 GPs (FTE) will need to be recruited to meet demand in the next 10 years (this does not account for retirements). Practices will therefore need to consider employing a broader skillmix to ensure a more sustainable workforce for the future.
Part D: How we will meet the needs of our community

Part D outlines the highest priority areas for primary care in West Oxfordshire, describing both the current challenges and objectives for improvement. This section also outlines our proposed initiatives that will support us to deliver our key priorities. These form the key recommendations for developing primary care in the locality.

Priority 1 – Meet the healthcare needs of the ageing population in the locality

Background
West Oxfordshire has among the oldest population in Oxfordshire, which is set to grow rapidly in the coming years. As the older population increases, so will the population living in nursing and residential homes.

Objectives:
- Prevention of, and early identification of, health and social care crises in frail adults, both at home and in care homes.
- Care of frail adults in the least acute setting which is appropriate to their needs.
- Move more acute services from the John Radcliffe Hospital to EMU and community settings in the locality.
- Support the needs of housebound patients or those living in assisted living accommodation.

Plans:
- **Build on the current EMU model:** The Witney EMU is a great asset to the current local services. Local GPs and other community services can refer adults who are acutely unwell who require investigation and treatment but are unlikely to need overnight admission. In this way it provides a less acute medical setting than the hospital and is closer to home. We plan to meet clinicians from Witney EMU to explore the factors currently limiting their capacity and ensure that primary care and other community services are making most efficient use of this resource.
b) **Virtual ward rounds:** We will work with EMU to develop a plan for virtual ward rounds of identified frail or medically unstable patients. This would aim for prevention or early identification of health or social crises and to forward plan. This could include input from a gerontologist or interface physician, social worker, nurse and GP.

c) **A weekly community pre-bookable gerontologist clinic** to review the most medically complex or frail elderly, as requested by their GP. We plan to work with EMU to develop a plan that uses EMU as a base and will allow sharing of resources, staff and space. A business case will need to be developed.

d) **Care/nursing homes:** Some local practices welcome a plan for a gerontologist or interface physician to manage their care home patients. This could be an extension of the current hospital outreach programme and involve both virtual and real ward rounds. This would allow preventative measures for keeping patients well, early identification and management of physical or mental health deteriorations and greater support to care home staff by having a direct link with medical support. In turn, these measures may reduce inappropriate acute hospital admissions and keep patients closer to home. As some practices are keen to continue to manage their care home patients themselves this would be an optional service. The patient would remain on the practice list. A business case will need to be developed.

e) **Increasing the capacity of the primary care visiting services:** Emergency care practitioners visit acutely unwell housebound patients at the request of the patient’s GP. This service increases the capacity of primary care to manage housebound patients with medically urgent conditions. However, capacity is currently limited to 5 practitioners across 3 localities. Increased capacity will be required to match the demand from an increasing elderly population.

Plans for other services set out in subsequent priorities, in particular social prescribing and urgent access hubs, will also support care for the older population.
Priority 2 – Ensuring safe and sustainable primary care that delivers high quality services

Background

The traditional primary care model has worked well over the years. However, the demand for primary care services is increasing: patients are visiting their GP more frequently each year and, as set out in table 2, the number of patients in West Oxfordshire is increasing, with 20,000 more patients expected over the next 10 years (and the 5,000 additional patients in Witney and the East of the locality over the next 5 years). A future model of primary care will rely on adequate workforce, building space and resources.

It is predicted nationally that 30% of GPs are planning to retire in the next 5 years. For the rural cluster of West Oxfordshire, this figure may be even higher, with 43% of GPs aged over 55. With the challenges around GP recruitment, limited practice space and resources not keeping pace with soaring demand, we recognise that the traditional model needs adaptation. Without this, primary care will not be sustainable longer term.

Objectives

- Sharing of resources, staff and knowledge across practices
- Streaming of patients to the most appropriate service to meet their needs
- Boosting the primary care workforce, both GPs and other healthcare professionals
- Optimising space within practices and expanding buildings to manage the population growth
- Patient education about the services available and that a GP will not always be the first or only port of call.

Plans

a) Increasing the capacity of the urgent access hubs: Different dimensions of access are valued differently, with some people preferring rapid access to any clinician and some requiring continuity of care with the same clinician. Increasing the capacity of the urgent access hubs will provide additional same day access. This is particularly beneficial for patients of working age and for children who, except in specific circumstances, do not need to see the same GP each time for episodic conditions. In turn, this releases GP time in practices to reduce the demand on waiting times for routine appointments and devote more time to those requiring longer appointments and greater continuity of care. However, capacity is currently limited and an increase in appointment availability would be beneficial to match demand. There is also an issue of inequity of use of the urgent access hub. As it is located in Witney, it is predominantly used by those practices based in and around Witney.

10 General and Personal Medical Services, England High-Level March 2017, Provisional Experimental statistics, NHS Digital
while more rural practices (particularly Burford, Charlbury and Bampton) use it less frequently. If a hub were to be located closer, the rural cluster practices have stated that they would use it more. Therefore, they propose that we plan for a second hub in Carterton, with the number of appointments for core general practices increasing each year.

b) Workforce: All practices are potentially vulnerable because of difficulty recruiting staff, a high proportion of retirements in the next few years and increasing list size. The roles of allied health professionals need to be developed in order to support the GP workforce. The workforce model will be based on GP-led multi-disciplinary teams and include nurses, healthcare assistants, physiotherapists, clinical pharmacists and mental health workers. The allied health professionals will work either at practice level or at neighbourhood level depending on local need. The WestMed urgent access hubs and the primary care visiting services are successful examples of this at federation level.

The locality is currently testing a model of employing a pharmacist and potentially a pharmacy technician to work across the whole locality. Clinical pharmacists can have a valuable in role in general practice. In addition to freeing GP time, benefits include timely medication changes following discharge from hospital, safer prescribing across the locality and potentially suggesting medication changes more quickly than individual GPs.

Training of allied health professionals to increase their skills will be needed. This may include upskilling of healthcare assistants to perform duties traditionally performed by practice nurses, such as wound care or ECGs, or it may include training in nurse prescribing. The CCG’s practice nurse educational coordinator will help practices across the locality to find appropriate training and mentoring for HCAs wanting to develop new skills. This training could be delivered at neighbourhood to locality level. Practices may also be able to provide some training “in house”.

Development of portfolio roles for GPs. This may include a post rotating between a practice (or a set of practices), the urgent access hub, interface medicine or GP-specialist clinic (for example, the GP-cardiologist clinic). These posts will be developed at federation level according to local need and then advertised to all GPs, but with a particular focus on GP trainees and newly qualified GPs.

Workforce development is a priority across Oxfordshire. More detail on CCG wide support is provided in part E.

c) Estates development and infrastructure

Investment in GP practices to increase capacity for the rising population will be required and practices may consider merges where this makes sense logistically and financially. Current use of space, such as the community hospital, Deer Park site and Windrush Health Centre, needs to be reviewed to optimise space usage and boost joint working, for example, by co-locating urgent services on one site. Further intentions on estates prioritisation to support the plans is provided in part E.

d) Involvement of patients: engagement with practice PPGs as well as the locality forum to:
- publicise important health messages
- publicise the range of services available to patients and what the most appropriate setting is for their need e.g. MIU, pharmacist, minor eye conditions service (MECs).
- share the pressures faced by the local NHS
- Educate and manage patient expectation around a changing healthcare model. This may include seeing a nurse or being referred to the urgent access hub when they may have traditionally seen their own GP.

e) Development of practice websites: Windrush Medical Practice website is already an excellent example of enhancing signposting of information to patients, improving access as well as being an effective way of streaming the requests to the most appropriate person within the practice. Other practices are keen to learn from their experiences. Investment will be needed to set up the sites. NHS England is supplementing this through providing training for receptionists to become skilled and confident in sensitively ascertaining the nature of the patient’s need and exploring with them safe and appropriate options. This is being delivered locally through the Oxfordshire Training Network. These initiatives have also been shown to reduce demand on services and decrease waiting times for appointments.
Priority 3 – Improving prevention

Background

A central tenet of the GP Feltham is commitment to more initiatives around preventative care. Clear signposting and increased access to self-care information and resources can empower patients to play a more pro-active role in their healthcare. The benefits of this are that patients are less reliant on acute services and feel confident using services such as pharmacies to control their symptoms where appropriate. A Kings Fund report identifying priority areas for Clinical Commissioning Groups states that expenditure on prevention is ‘an excellent use of resources’. In a review of more than 250 studies published on prevention in 2008, nearly 80% were within the National Institute for Health and Care Excellence’s threshold for cost effectiveness.

There is good evidence that social isolation impacts on people’s health and also uses up a huge amount of scarce GP time. In addition, many patients with chronic diseases need extra support with their management and this can often be provided by trained volunteer peers, rather than healthcare professionals. Many patients with chronic diseases will also suffer social isolation due to the real, or perceived, effects of their illness. For this reason, combining self-management and social prescribing hubs makes good economic sense, as there will be some overlap of skills and resources.

Objectives

- Development of social prescribing and health and wellbeing model: System wide approaches to health promotion recognise that individual behavioural change is sustained through social influences of family, friends, school and work colleagues, which primary care is well placed to support through practice-held registered lists of all patients. There are numerous successful examples of social prescribing schemes across the country that are often run in conjunction with third sector organisations, and in West Oxfordshire there are many associations run by community groups including volunteering, arts activities and social groups that help people live healthier lives.

We will harness the enthusiasm of these community-led examples in West Oxfordshire to promote healthier lifestyles and make healthy living the norm. This includes:

- Partnering with local organisations and established groups to create better connected communities and to ensure any social prescribing schemes that can link patients in primary care with non-medical sources of support are embedded in the community,
- Considering ways to work with schools, nurseries, colleges and families to get young people to be more active and increase their physical and mental wellbeing, and
- Developing a proactive physical activity referral scheme(s) in partnership with West Oxfordshire DC and integrated with other health prevention activity. The scheme would target people before they develop a long term condition, people identified at risk of developing such a condition, as well as patients already identified on chronic disease registers.

- **Enhanced signposting role for receptionists**: As part of the General Practice Forward View, CCGs have been allocated funding to support practices to train reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This provides patients with a first point of contact which directs them to the most appropriate source of help. Receptionists acting as care navigators can ensure the patient is booked with the right person first time.

- **Making Every Contact Count**: Oxfordshire CCG is also supporting all interactions across healthcare with a strategy for “Making Every Contact Count”. This is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. This approach will be rolled out across all health and social care services in Oxfordshire.
Priority 4 – Planned care closer to home

Background

We are integrating care between primary, community & secondary care for patients with diabetes enabling patient empowerment and self-management with a focus on population health outcomes. Pilots have commenced in the North East locality with practice diabetes multi-disciplinary team meetings and in the next year it is planned to have an alliance contract between the GP federation Oxford University Hospitals NHS Foundation Trust, and Oxford Health NHS Foundation Trust to deliver an integrated diabetes service co-ordinated by a locality clinical board with an outcomes based contract and resources and responsibility share between the alliance parties. Effective use of ICT and data sharing for a diabetes dashboard, screen sharing between primary and secondary care - enabling joint consultations and earlier specialist intervention – will be integral to the success of the project.

As part of the planned care programme, there are now musculoskeletal hubs running across the county, with a bladder and bowel service and a local optometrists offering a minor eye condition service. This improves care closer to home and promotes prevention.

Objectives

Following the success of the local diabetes pilot in the North East, we plan to introduce this into the West locality. If successful, we will build on the model to bring chronic disease management closer to home, extending to other conditions, including cardiology and COPD.
In response to the key objectives outlined in each of the priorities, we have recommended 13 workstreams. Each workstream responds to the challenges of at least one priority. The chart below indicates how each initiative aligns to the different priorities.

<table>
<thead>
<tr>
<th>#</th>
<th>Workstreams</th>
<th>Meet the healthcare needs of the ageing population in the locality</th>
<th>Ensuring safe and sustainable primary care that delivers high quality services</th>
<th>Improving prevention services</th>
<th>Planned care closer to home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maximise benefits of Emergency Multidisciplinary Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Locality diabetes service, and extend to other conditions, such as heart failure and COPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Increased primary care visiting service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Same-day care services in Witney and Carterton with increased capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Urgent Treatment Centre in Witney, integrating current services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Practice based mental health practitioners for rural West</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Enhanced signposting role for receptionists and development of practice websites for signposting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Development of practice website</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Development of social prescribing model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Shared back office services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Estates prioritisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The table below provides additional detail for each workstreams. Each row summarises how each workstream would be implemented, what it will do and benefits to the locality.

<table>
<thead>
<tr>
<th>Proposed solutions</th>
<th>Delivery scope</th>
<th>Benefits</th>
<th>Implementation steps</th>
<th>Duration</th>
<th>Priority level</th>
</tr>
</thead>
</table>
| Maximise benefits of EMU | Build on the current EMU model to ensure that primary care and other community services are making most efficient use of this resource. | - Prevention or early identification of health or social crises and to forward plan.  
- Reduce emergency admissions | Work with OH to assess number of sessions required and amend contract | Ongoing | 1 |
| Community gerontologist or interface physician for complex multi-morbid patients | Develop a plan for virtual ward rounds of identified frail or medically unstable patients. This could include input from a gerontologist or interface medic, physician, social worker, nurse and GP.  
Weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly, as requested by their GP. | Closer working with community services including district nursing and Hospital at Home.  
- Greater support to high-need patients following hospital discharge. | Development of proposal and business case | Ongoing | 1 |
| Locality diabetes service, and extend to other conditions, such as heart failure and COPD | Integrated care between primary, community & secondary care with locality based diabetes clinical boards following success of pilot in North East Oxfordshire; roll out to West Oxfordshire. | Consistent service across the locality. Supports bringing care closer to home. | To be agreed with planned care team | 2 years | 1 |
| Expansion of primary care visiting service | Increase the capacity of the visiting service  
Palliative care training  
Continuing the care homes support in its present form – to discuss | Supports primary care sustainability, allows assessment of frail elderly patients earlier in the day, supporting early assessment in an ambulatory care centre supporting care at home.  
Can help support care at home for frail elderly | To recruit additional emergency care practitioners from current provider | 5 years | 1 |
| Same-day care services in Witney and Carterton with increased capacity | - Integrated pathway for patients who need a same-day clinical response.  
- All services based on use of EMIS patient record  
- Common policies and practices across the cluster.  
- Consider integration of service with out of hours GP service and Minor Injuries Unit  
- Consider mix of pre-booked appointments and walk-in access.  
- Consider links between primary care visiting service and community services such as Hospital at Home and District Nursing Urgent Hub. | - An agreed definition of urgent / same-day care across the locality.  
- Consistent level of care across same day care services; avoiding gaps, duplications and hand-offs.  
- Efficient use of clinical workforce.  
- Wider range of services provided for patients: GP, nurse, mental health worker and others including potentially pharmacy and physiotherapy.  
- Increased same-day capacity for local patients within existing resources of clinical staff and funding e.g. by focusing on Advanced Nurse Practitioners (prescribing) | To agree with federation | Ongoing | 2 |
<table>
<thead>
<tr>
<th>Wider Primary Care</th>
<th>Clinical Skill Mix Delivered through Practice-Based and Cluster Services to Supplement Existing GP and Practice Nurse Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTC in Witney</strong></td>
<td>Develop MIU to have full UTC capabilities, including: Access 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics. Consistent route to access urgent appointments, including booked through NHS 111, ambulance services and general practice with a walk-in access option retained. Integration over time with other urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&amp;E services and other local providers.</td>
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<tr>
<td><strong>Wider Primary Care</strong></td>
<td></td>
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<tr>
<td><strong>Clinical Skill Mix</strong></td>
<td></td>
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<tr>
<td><strong>Delivered through Practice-Based and Cluster Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To Supplement Existing GP and Practice Nurse Staffing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Practice Based: Mental Health Practitioners</strong></td>
<td>- Pharmacists (practice/cluster or locality level). - Diagnostic physiotherapy (note self-referral to MSK Assessment &amp; Treatment Service expected from April 2018). - Physician associates, social community nurses. - Other clinical roles (NB OCCC sourcing further evidence-based guidance).</td>
</tr>
<tr>
<td><strong>Enhanced Signposting Role for Receptionists</strong></td>
<td>- Enhanced signposting role for reception/admin teams (including face to face, telephone, other)</td>
</tr>
<tr>
<td><strong>Development of Practice Websites</strong></td>
<td>Following success of Windrush practice website that provides enhanced signposting information, support other practices that wish to adopt similar model.</td>
</tr>
<tr>
<td><strong>Offering a Minor Ailments Service, with GP Oversight (May be Remote)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Clarity for Patients on Urgent Access</strong></td>
<td>- Improved range of services offered to patients. - Reduced pressure on GP capacity, freeing up time for 15 minute appointments with complex patients. - Alleviates pressure on recruitment of GPs.</td>
</tr>
<tr>
<td><strong>To Confirm with Provider Capacity and Utilisation</strong></td>
<td>By December 2019</td>
</tr>
<tr>
<td><strong>1) Agree Funding</strong></td>
<td>1 year</td>
</tr>
<tr>
<td><strong>2) Set Out Scope of Work for Pharmacists and Employment Model</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>3) Recruit</strong></td>
<td>Non-recurrent initially</td>
</tr>
<tr>
<td><strong>1) Agree Funding</strong></td>
<td>1 year</td>
</tr>
<tr>
<td><strong>2) Set Out Scope of Work for Mental Health Worker and Employment Model</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>3) Recruit</strong></td>
<td>Non-recurrent initially</td>
</tr>
<tr>
<td><strong>Training in Place</strong></td>
<td>Initial Training</td>
</tr>
<tr>
<td><strong>To Confirm with Provider</strong></td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

- Improved range of services offered to patients.
- Reduced pressure on GP capacity, freeing up time for 15 minute appointments with complex patients.
- Alleviates pressure on recruitment of GPs.
- Improved access to service information for patients.
- Enhanced information to patients and education (including work in schools).
- Improved access to service information for patients.
**Development of social prescribing model and prevention for children and young people**

Social prescribing scheme for patients referred by GP to a Wellbeing adviser and onto community services. People will be encouraged to get involved in activities that match their needs – they may promote physical exercise or social integration.

A secondary aim includes community activation – helping people live healthier lives with the support of community associations, schools and employers.

**Reduced pressure on GP appointments**
Reduced obesity and social isolation; more sustainable use of primary care

**Agree scheme with West Oxfordshire District Council**
July – Sept 2018: soft launch
Oct 2018 onwards: service fully operational
Sept 2019: review to assess impact

---

**Shared back office services**

- Shared back-office functions.
- Support with policies, recruitment and payroll

- Better use of practice resources of space and staff by sharing back office resource.

**Scope programme**
Recruit resources
1 year

---

**Estates**

Investment in GP practices to expand/increase capacity for rising population.

Practices might consider mergers where it makes sense for logistical and financial reasons. Particularly large growth is expected in Witney, Carterton and Eynsham.

Review use of space in Windrush Health Centre and Witney Community Hospital to boost joint-working and maximise use of this health campus.

Identify needs and opportunities for primary care infrastructure growth to meet future requirements

Carterton: identify suitable infrastructure to meet forecast population growth and any additional local services for the cluster.

Work with developers and the district council to ensure infrastructure across new and existing sites, including Deer Park, meets future growth and is accessible.

**Sustaining Primary Care and meeting the needs of a growing population**
Continue to provide care closer to home

**Options Options**
Appraisal Implementati
on in line with CCG priorities
Continuous

---

**Key messages:**

**West locality priorities:**

1. Meet the healthcare needs of the ageing population in the locality
2. Ensuring safe and sustainable primary care that delivers high quality services
3. Improving prevention services
4. Planned care closer to home

The 13 workstreams above each respond to at least one of the 4 locality priorities and operate as the core recommendations of this plan.
Part E: Making a success of our plan

Delivery of this plan represents a significant ambition for service improvement and requires strong collaboration from all parts of the NHS, local authorities, Health Education Thames Valley, the Oxford Health Science Network and the voluntary sector. This section sets out the support the CCG will provide, working with partners, across all localities and how they will apply in West. A key aim across all enablers is to strengthen practice sustainability.

1. Workforce:

A workforce of appropriate number, skills and roles is essential for delivery of the plans in the context of significant housing growth across Oxfordshire and an ageing population. In line with the Oxfordshire Primary Care Framework, the CCG is developing a workforce plan across the staff groups with the aim of:

- increasing capacity in primary care;
- upskilling existing staff; and
- bringing in and expanding new roles.

This includes concrete working with partners to:

- Make Oxfordshire an attractive place to work, in particular areas that have had historical difficulties in recruiting
- Facilitate a flexible career path through developing specialist roles and encouraging professional integration
- Increase training capacity and encourage GPs to remain in the area where they have trained
- Consider implementing a local bursary or training and refresher scheme
- Recruit internationally
- Develop a career development framework for staff working in primary care
- Implement mentoring schemes for all staff groups with the support of experienced professionals
- Continue to support the introduction of new general practice support staff to take workload off GPs, such as physician associates, medical assistants, clinical pharmacists and advanced practitioners, building on the success of pharmacist and mental health workers in general practice
• Develop a standardised approach to the development and training of healthcare assistants
• Increase community-based academic activity.

Federations will have an important role in ensuring resilience in primary care and enabling practices to work at scale, for example offering employment models that enable practices to use resources flexibly across clusters and neighbourhoods.

Effective workforce planning requires:

• a detailed understanding of the health and wellbeing needs of the population
• opportunities to develop and design roles that are fit for the demand and needs of the population.

The CCG will provide support at locality level for practices to model and plan the workforce appropriate for populations of 30-50,000. This may include sharing staff across practices as set out in priority 2 above or providing support for mergers, where requested by practices, to provide a greater level of sustainability.

2. Estates

The Primary Care estate across Oxfordshire needs considerable investment to make it fit for the future: some practices require capital investment now and large areas of housing growth will mean that infrastructure will need to be improved in order to deal with the population increase. As set out in the Oxfordshire Primary Care Framework, capital investment will only be partially through NHS sources and we will need to consider other sources (e.g. local authority bonds, developer contributions).

The CCG will need to prioritise schemes for estates developments in line with the overall resourcing available. Some practices need to improve or extend their premises so that they can continue to deliver mainstream primary care more sustainably and to a larger number of patients. Other practices have larger-scale ambitions to deliver services over and above what is generally provided in general practice, often in collaboration with other practices and in partnership with other NHS organisations, local authority and voluntary sector agencies. Both types of scheme will need to demonstrate innovation and maximise opportunities to work collaboratively, but for the larger-scale schemes, which are likely to come at a higher cost, a more comprehensive range of criteria will be used for prioritisation that are in line with the CCG’s estates strategy and plans for primary care.

The CCG will additionally provide support for appraisal of estates solutions together with community health and local authorities, where relevant. This includes solutions that respond to developments in new models of care, or which have the potential to deliver direct financial efficiencies, for example through digitisation of notes or merged partnerships.
In the West locality key estates priorities include:

- Review use of space in Windrush Health Centre and Witney Community Hospital to boost joint-working and maximise use of this health campus. Looking towards an Urgent Treatment Centre (UTC) type model which coordinates these services may facilitate sharing of staff, buildings, records and resources and may allow for a more streamlined, more efficient and less confusing service.

- Identify needs and opportunities for primary care infrastructure growth to meet future requirements. Specifically this includes:
  - Replacement of Long Hanborough Surgery (project agreed following developer agreement)
  - Minor improvement to clinical capacity of Cogges Surgery in Witney (ETTF funding allocated)
  - Expansion of Eynsham Medical Centre
  - Expansion of Broadshires Health Centre or redevelopment of Carterton Health Centre
  - Expansion and relocation of Nuffield Health Centre and / or Cogges Surgery within Witney, including development of criteria for the options appraisal, identification of appropriate sites and consultation with current patients.

3. Digital

‘Digital’ has a significant role to play in sustainability and transformation, including delivering primary care at scale, securing seven day services, enabling new care models and transforming care in line with key clinical priorities. In line with Oxfordshire’s Local Digital Roadmap, the CCG’s focus will be to support:

1. Records sharing for cross-organisational care, in particular Advanced CareNotes which are used by community and mental health services and are currently not interoperable with any other health record used by general practice (EMISweb and Vision) or secondary care (Cerner Millennium)
2. Citizen facing technology, including aligning portal plans and auditing apps that empower patient self management
3. Risk stratification and modelling to support care co-ordination, clinical decision support and referral management tools
4. Infrastructure and network connectivity, including shared network access and access to records by care home staff
5. Information Governance, developing confidence in primary care over how data is accessed.
Key digital priorities for the West locality include:

- **Shared patient record accessible to all local services.** In future, community and mental health workers in the locality would be able to at least access the EMIS GP record via EMIS Clinical Services, allowing them to see valuable clinical information about patients in their care and to enter their own information into those records for other clinicians (such as GPs) to see. This would significantly reduce the status quo problem of patients expecting GPs to be updated on their recent discussions with, for example, the mental health team and lead to more streamlined and more effective care for all patients.

- **Access for care homes.** All care homes Oxfordshire will be encouraged and supported to obtain HSCN access, which will allow sharing of clinical record data directly with care home computers. This would not only mean that care home staff could access GP records for their patients, but also that visiting clinicians (whether GPs, clinical pharmacists, Hospital at Home, primary care visiting service, community nurses, or others) would be able to access GP records on-site and be able to use the care home HSCN wi-fi to access their own record systems on their own devices.

- **Use of websites and directory of services for signposting,** such as the excellent example at Windrush Medical Practice.

- **Use of ICT to maximise efficiency of clinical triage.**

4. **Funding**

Implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister’s Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. Remaining funding will be allocated to the plans according to agreed criteria for prioritisation, including:

- Patient outcomes and experience
- Primary care sustainability
- Health inequalities and deprivation
- Alignment with national and regional strategies and other transformation programmes
- Whether they are able to be delivered successfully within the required timeframes, and
- Population coverage.

The CCG will support future investment in workstreams that are intended to deliver savings elsewhere in the system subject to a robust business case. This will provide a significant step forward in delivering accountable care, in which resources are allocated according to the
needs of the population of Oxfordshire and in which partners in the health and social care system share financial and clinical accountability to deliver better outcomes.

Oxfordshire CCG has responsibility for the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England. The Oxfordshire Primary Care Commissioning Committee (OPCCC) carries out these functions and is chaired by a lay member. Funding recommended by OPCCC for delivery of the plans across Oxfordshire in addition to current funding in the initial years is set out in table 11 below. This covers part of a longer term investment over the period of the plans and does not include investment in estates or future demographic growth, which is determined nationally.

Table 11: Funding approved for initial delivery of the locality plans across Oxfordshire:

<table>
<thead>
<tr>
<th>Priority areas</th>
<th>Examples of schemes to be funded and relevant localities</th>
<th>Benefits for patients</th>
<th>Recurrent (full year) (£000)</th>
<th>Non-recurrent (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainable primary care</td>
<td>New posts for mental health workers and clinical pharmacists in practice (all localities)</td>
<td>Improved outcomes for patients with mental health conditions and support for family members; Proactive reviews for patients with asthma, diabetes and other conditions, better treatment coordination.</td>
<td>£850</td>
<td></td>
</tr>
<tr>
<td>Caring for the frail / elderly</td>
<td>Expansion or introduction of Primary Care Visiting service (N, NE, W, City, SW) Additional proactive support in care homes (all localities)</td>
<td>More patients at point of crisis assessed in their homes and less likely to be admitted to hospital</td>
<td>£531</td>
<td></td>
</tr>
<tr>
<td>Access to the right care at the right time for a growing population</td>
<td>Additional overflow appointments (NE, W)</td>
<td>Additional same-day appointments to ensure that patients who need to can be seen on the same day.</td>
<td>£189</td>
<td>£25</td>
</tr>
<tr>
<td>Prevention, self-care and health and wellbeing</td>
<td>Social prescribing initiatives (City, N, NE, W, SE) Health and wellbeing hub (City)</td>
<td>Patients better able to care for their own conditions, reduced social isolation, improved prevention</td>
<td>£337</td>
<td>£55</td>
</tr>
<tr>
<td>Reduction in deprivation and inequalities</td>
<td>Expansion of services to address deprivation (all localities) Expansion of minor ailments scheme (City)</td>
<td>Improved access for patients who do not need to see a GP through pharmacy consultations; Improved outcomes for patients in most deprived parts of the county</td>
<td>£100</td>
<td>£36</td>
</tr>
<tr>
<td>Workforce redesign</td>
<td>Headroom to design new teams (all localities)</td>
<td>Workforce more responsive and better designed around patient needs</td>
<td>£300</td>
<td></td>
</tr>
<tr>
<td>Physical infrastructure</td>
<td>Digitisation of notes (all localities) Efficient use of space through different work patterns (SW)</td>
<td>Better use of estates for delivery of front line services</td>
<td>£410</td>
<td></td>
</tr>
</tbody>
</table>

Total                                                                 | £1,157                                                                                                                                     | £1,676                                                                                                                                                    |                              |                    |

12 The papers and minutes of the OPCCC are available at: [http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-(opccc)-meetings](http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-(opccc)-meetings)
5. Outline mobilisation plan

See following page.

Key messages:
In order to deliver this plan, there are 4 key enablers that must be considered:

- **Workforce** – focus on retention and recruitment as well as utilising different staffing skill-mixes to meet community demand
- **Estates** – ensuring that services are delivered from appropriate venues in terms of geographical location, size and upkeep
- **Digital** – utilise digital technology to improve access and help deliver patient centric care through increased technological capability and improved interoperability
- **Funding** – understanding where funding can be allocated most efficiently to meet the needs of the community outlined in this plan
### Outline mobilisation plan

<table>
<thead>
<tr>
<th>Priority Areas</th>
<th>Workstream</th>
<th>17/18 Q4</th>
<th>18/19 Q1</th>
<th>18/19 Q2</th>
<th>18/19 Q3</th>
<th>18/19 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet the healthcare needs of the ageing population</td>
<td>Primary Care Visiting service</td>
<td>Confirm service spec</td>
<td>Recruit and implement</td>
<td>Review Emu Services</td>
<td>Business case</td>
<td>Prepare new agreed service</td>
</tr>
<tr>
<td>Ensuring safe &amp; sustainable primary care that delivers high quality services</td>
<td>Frailty pathway</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Clinical Pharmacists</td>
<td>Agree funding distribution</td>
<td>Develop spec and support</td>
<td>Recruit</td>
<td>Roll out. Integrate plan for MHFV into workstream for mental health workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Workers</td>
<td></td>
<td></td>
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<tr>
<td>Preventing Services</td>
<td>Social prescribing</td>
<td></td>
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</tr>
<tr>
<td>Planned Care Closer to Home</td>
<td>Access Hubs NE &amp; W</td>
<td>Options appraisal</td>
<td>Agree spec</td>
<td>Roll out changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extend diabetes model to services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Urgent Treatment Centre in Witney</td>
<td>Options appraisal on UTCs</td>
<td></td>
<td>Implement agreed changes</td>
<td>Timetable subject to options appraisal</td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td>New workforce models</td>
<td>Develop workforce model</td>
<td>Integrate with Oxon plan</td>
<td>Rollout</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enablers</td>
<td>Estates Plan</td>
<td>Options appraisal</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Notes digitisation</td>
<td>Options appraisal</td>
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</table>
Appendix 1: Patient and Public engagement and involvement

Public & Patient Partnership West Oxfordshire (PPPWO) steering group - Discussion of WOLG primary care priorities

Fergus Campbell (Locality Coordinator) attended the PPPWO steering group meeting on 13 June 2017 to discuss the West Oxfordshire Locality Group draft priorities for primary care (version 2). He had circulated these to all members following the WOLG meeting on 8 June.

The PPPWO meeting suggested the following:

- Meeting the needs of the growing and ageing population should be a very high priority
- GPs having access to faster and more accessible diagnostics closer to home for the patient (avoiding journeys to Oxford hospitals)
- Explicit focus on reduced time to access routine appointments
- Add a focus on prevention and public health improvement
- More clearly addressing the needs of isolated rural populations
- Expand the scope of integrated working to reference ambulance services, social care and voluntary sector.

The meeting also discussed that:

- As patients we recognize that things need to change and understand the need to use non-GP clinical staff for many routine things
- Equipping GPs to manage mental illness in the community more effectively. This is especially important in those with serious mental illness who fall outside the community-based psychological support services.

Key themes from the meetings with former patients of Deer Park Medical Practice (see appendix 3 for more detail regarding the practice):

- Queries and reminders that the IRP advice was to not preclude having a GP practice in Deer Park Medical Centre (DPMC)
- Lack of confidence that OCCG is following the IRP advice
- Concerns from previous DPMC patients about waiting times at their new practices and difficulties with online appointment availability and impact of closing Deer Park has had on this
- When looking at expansion of primary care / new premises will the DPMC building be considered?
- Concern raised that the IRP response was focussed on Witney and surrounds but the CCG plans address wider West Oxon issues
- Concern raised that there needs to be more engagement in the development of the Locality plan
- Proposal for services to be re-opened at Deer Park or somewhere in West Oxfordshire - more doctors to allow more appointments available. The hub appointments not sufficient for population
- Recognise there is a conflict of interest with GP practices; APMS contracts are different and challenges of recruiting GPs are not as big.

**Key themes from the patient engagement: November – December 2017**

A period of engagement was undertaken between 3 November 2017 and 3 December 2017 for each of the locality plans. The plans were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings including Witney on 1 November 2017 and Carterton on 8 November 2017. An online/paper survey was available on OCCG’s engagement website - Talking Health. People also had the opportunity to give direct feedback via email, letter, phone, or freepost. Following this period of engagement the draft plans were published and were available for further comment until 17 December 2017.

In the West Oxfordshire locality, 51 people registered and followed this engagement activity on Talking Health. Of these 51 people, 21 people then responded to the survey. In addition, the CCG received responses relevant to the West Oxfordshire locality from:

- Keep our NHS Public
- Robert Courts MP
- Windrush Practice Patient and Participation group
- Several members of the public.

Although respondents agreed with our proposals and approach, there is continued concern in West Oxfordshire about the closure of Deer Park Medical practice and the lack of engagement from the CCG on the future of primary care services in Witney, specifically relating to Deer Park and the future of the premises. People are aware of the challenges facing primary care and the increased housing growth planned for the area. People are concerned about waiting times for non-urgent appointments, reception staff triaging patients and if there is a risk in using less qualified staff instead of GPs for some work.

However, in general people were positive about their practices, and appear to have a sympathetic understanding of the pressures facing GPs in primary care. The wider issues that were identified related to GP recruitment, lack of funding of the NHS, closer working with local authorities around planning and housing developments and improving infrastructure. Concern was raised about the rurality of the locality and lack of public transport. Communication between health professionals and different NHS organisations could be improved, using better technology. For those that were involved in this engagement, they wanted to know how the plans would be funded and how the plans would be
implemented. Specifically raising concerns around the recruitment and retention of staff and the impact that this would have on the development of services. Some of the themes included:

- Improve staff training
- Local Authorities should provide infrastructure
- Increase the opening hours of the Witney MIU to reduce pressure on primary care
- Re-instate Deer Park practice
- Make hospital service local
- Triage minor illness using nurses
- Improve communication between health professionals
- Reduce the number of referrals to Oxford
- Evaluate the services you have already.

This feedback, together with the feedback from the stakeholder events and the meetings with stakeholders set out on page 8 has been incorporated into the revised plan. A summary of the responses is set out below:

<table>
<thead>
<tr>
<th>Key Themes</th>
<th>Summary of issues</th>
<th>CCG response</th>
</tr>
</thead>
</table>
| Readability | • The plans are long  
• How do we know how to navigate the plans? | Alongside the locality plans, OCCG will also publish short summaries for each of the localities, in addition to an Oxfordshire-wide document, which draws out the key priorities in each locality and our approach to delivering the plans in a coherent and planned way. The CCG will consider other comments relating to readability in future versions of the plans. |
| Relationship between the plans and BOB STP and Accountable Care Systems | • Are the aims of the plans consistent with the BOB STP objectives?  
• Do the plans aim to contribute to the BOB STP objectives  
• Are the plans part of a process to turn Oxfordshire into an ACS | The Oxfordshire-wide plan sets out how the plans integrate with the wider OCCG strategy and documents such as the BOB STP and the Oxfordshire Primary Care Framework. Of the 8 STP objectives the plans contribute to achieving 6 of them directly. The Oxfordshire Summary document also highlights how the plans have been developed from both a population based, locality driven perspective as well as a ‘top down’ county wide perspective. In this way the plans provide a holistic strategy for primary care in the county. The CCG will support future investment in workstreams that are intended to deliver savings elsewhere in the system subject to a robust business case. This will provide a significant step forward in delivering accountable care, in which resources are allocated |
### Funding Implications

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<tr>
<td>•</td>
<td>There is no indication of how much the plans cost</td>
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<td>•</td>
<td>Is there enough funding for the recommendations in the plans to be implemented?</td>
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<td>•</td>
<td>To what extent is the feasibility of the plans unknown / unlikely?</td>
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The funding consequences of the first year of the plans is now included in part E. Not all aspects of the plans require long term investment. Some elements include, for example, different ways of working or delivering efficiencies that reduce bureaucracies. However, full implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister’s Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. In the longer term, the sustainability of health and social care in Oxfordshire will be dependent on releasing funds from secondary care and investing this into primary and community care.

### Phase two STP transformation programme

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<td>•</td>
<td>Why are you producing the plans now when the consultation on phase 2 of the STP transformation programme has not yet started?</td>
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The plans aim to set out how primary care can best meet the needs of the local population and remain resilient and fit for the future, building on the national GP Forward View and Oxfordshire Primary Care Framework. They also aim to provide a locality plan for health services drawing out key components from other work streams in Phase 2 of the Transformation Programme. This is an iterative process, as the plans will both inform the work to develop options for services within the scope of phase 2 and respond to the outcomes of the consultation process related to the transformation programme. We will provide a clear narrative of this in future versions of the plans.

### West Oxfordshire locality boundaries

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<td>•</td>
<td>As the locality does not align with the district council it is not possible to see whether the plan is relevant to all patients in West Oxfordshire</td>
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</table>

The West Oxfordshire locality (WOLG) is contained entirely within the West Oxfordshire District Council area. However, localities do not map with constituency or district council boundaries. This is because Oxfordshire CCG’s localities reflect patient flow and long standing working relationships of GP practices that pre-date the formation of OCGC in 2013. A number of services are arranged around or report on the basis of these well-established boundaries. This also aligns with the National Association of Primary Care recommendation of designing services at a population level of around 30-50,000 patients. This enables a robust, high quality of services that remain local to patient need. Plans that relate to patients in other parts of West Oxfordshire council are set out on page 6.

### Population growth/housing development

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<tr>
<td>•</td>
<td>OCCG must cooperate more with the councils to get funding for health infrastructure</td>
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<td>•</td>
<td>Work with developers</td>
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<td>Need to be planning ahead</td>
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We are working closer with planning authorities at West Oxfordshire District Council to secure land and financial contributions to assist with estates growth across the locality and linking in with all local Neighbourhood Development Plans (NDP) to ensure Primary Care Services are on the agenda for planning decisions.
Future primary care infrastructure in the area will need to respond in a timely and appropriate way to future housing growth. Any decision will be subject to consultation with local patients. An options appraisal will also be completed on how best to provide services.

| Access to GP appointments | The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider skill mix in practices and increasing overflow appointments for patients who prefer rapid access over continuity enables GPs to concentrate resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible. Our plans look at how this may be done. Additional appointments have been introduced in the locality at evenings and weekends and also during the day at hubs in the county. Due to the success of these appointments, more will be introduced during the year, ensuring patients will have rapid access to appointments and enable patients who prefer continuity of care to see their own GP. |
|---------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Not acceptable to wait two - three weeks | • Not acceptable to wait two - three weeks | • Not acceptable to wait two - three weeks |
| Poor experience – had to go home to phone for an appointment even though I was already at the surgery | • Poor experience – had to go home to phone for an appointment even though I was already at the surgery | • Poor experience – had to go home to phone for an appointment even though I was already at the surgery |
| Appointments – some practices have a phone-back system which works well | • Appointments – some practices have a phone-back system which works well | • Appointments – some practices have a phone-back system which works well |
| Want continuity of care but difficult to get appointment with named GP | • Want continuity of care but difficult to get appointment with named GP | • Want continuity of care but difficult to get appointment with named GP |
| Important for people with LTC to see own GP who knows you well | • Important for people with LTC to see own GP who knows you well | • Important for people with LTC to see own GP who knows you well |
| Phoned 111 and saw doctor in Witney, experience very good | • Phoned 111 and saw doctor in Witney, experience very good | • Phoned 111 and saw doctor in Witney, experience very good |
| Early visiting service works well | • Early visiting service works well | • Early visiting service works well |

| Access to other clinicians/pharmacists | Future sustainability of primary care will be dependent on increasing the contributions from a wider range of staff than the traditional model of GPs and practice nurses. Some practices are already seeing the benefits of employing, for example advanced nurse practitioners and social prescribers. Pharmacists can play a valuable role in general practice, including managing adherence to medicines and holding clinics for patients with specific long term conditions; some are also registered prescribers. We aim to support these other health care professionals have the right skills such as the ability to prescribe (which is permitted for some allied health professionals). NHS England has made funding available for training in active signposting so receptionists can be skilled and confident in sensitively ascertaining the nature of the patient’s need and exploring with them safe and appropriate options. Oxfordshire Training Network is delivering the training by March 2018. |
|-------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Should be able to book to see a nurse, not just GP | • Should be able to book to see a nurse, not just GP | • Should be able to book to see a nurse, not just GP |
| Pharmacies could be used more as a first point of contact | • Pharmacies could be used more as a first point of contact | • Pharmacies could be used more as a first point of contact |
| Pharmacists have skills but not authority to prescribe? | • Pharmacists have skills but not authority to prescribe? | • Pharmacists have skills but not authority to prescribe? |
| More use of triage | • More use of triage | • More use of triage |
| More training of receptionists | • More training of receptionists | • More training of receptionists |
| May not need to see a GP – other professionals could be first point of contact e.g. physio | • May not need to see a GP – other professionals could be first point of contact e.g. physio | • May not need to see a GP – other professionals could be first point of contact e.g. physio |

| Recruitment/retention of staff | The CCG agrees that there is increasing pressure on the GP workforce through changes in working patterns and an ageing workforce. NHS England is working with partners to increase medical school places, recruit from overseas and offer incentives for returning GPs. The CCG is also developing a countywide workforce plan with the aim of increasing capacity in primary care; upskilling existing staff; and bringing in and expanding new roles. |
|---------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Shortage of clinical workers is a problem for the proposals | • Shortage of clinical workers is a problem for the proposals | • Shortage of clinical workers is a problem for the proposals |
| Provide affordable accommodation to help recruit more GPs | • Provide affordable accommodation to help recruit more GPs | • Provide affordable accommodation to help recruit more GPs |
| Recruitment vital to sustain services | • Recruitment vital to sustain services | • Recruitment vital to sustain services |
| Important for patients to raise funding/investment in GP services issues with their MPs | • Important for patients to raise funding/investment in GP services issues with their MPs | • Important for patients to raise funding/investment in GP services issues with their MPs |
| Upskilling workforce | • Upskilling workforce | • Upskilling workforce |
**IT**

- Patients’ notes: not everyone can see them, would assist continuity
- Electronic conversations – better use of email and website communications
- Don’t assume everyone has internet or mobile access. Need paper versions of information
- Online booking/ access to notes / prescriptions is good
- Integration of IT systems to encourage more use of computers
- Potential for skype consultations

Greater use of technology will be a key enabler in connecting primary care with others, for patients to manage their own conditions and for the provision of timely advice. This is included in the plan, with clear timelines set out in the countywide plan to be published alongside the 6 locality plans in January 2018.

Making the most of opportunities for greater use to technology are intended to enable the CCG to provide care to different patients in different ways. Practices will need to work with their patients and patient participation groups to ensure that all patients have the same chance to contact their practices, whichever mode of access they choose.

We will introduce the online consultation initiative across Oxfordshire practices in three phases which will allow patients to be signposted to the most appropriate service.

**Prevention/social prescribing**

- Not enough emphasis on keeping well
- More education in schools about staying healthy
- Need to focus on younger generation
- Invest time with young people
- Social prescribing is a good idea e.g. walking groups
- Age UK offers exercise to prevent falls
- Paid person to be a befriender or supporter for social prescribing
- Keep older people active
- It is important to build on the examples already in place in West Oxfordshire

There are some excellent examples from across the county of working with schools to promote healthy lifestyles and increase health literacy, which we will aim to build on. As part of the plans, we are piloting a social prescription model, which will enable clinicians to refer for non-medical issues such as isolation and financial advice that can have an impact on people’s wider health and wellbeing needs and we will work with patients and their carers to consider the most appropriate model for patients in the West locality, including the suggestions provided as part of the consultation.

**Witney Community Hospital**

- EMU works well
- Better use of Witney hospital – gerontologist used to be based there – why was this stopped
- Maintain and expand Witney Hospital; expand the MIU so it can stay open longer and increase capacity

The Witney EMU is a great asset to the current local services and is popular among patients and practices. We will work with clinicians from Witney EMU to explore the factors currently limiting their capacity and ensure that primary care and other community services are making most efficient use of this resource. We will also work with the providers to consider how to build on this, for example developing a plan for virtual ward rounds of identified frail or medically unstable patients or a weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly.

**Mental Health**

- Not enough support for young people
- School counsellors have long waiting lists
- A mental health nurse should be attached to each practice
- Need to look at self harm rate in south Witney which is above average
- People with mental health issues need more support

Mental health services are a key priority across the county, and we recognise that there are pockets across the West locality that have a high prevalence of patients with severe and enduring mental illness, depression and other common complex mental health problems. We are considering a programme of enhanced support for mental health workers in practice, which may include link workers, based in neighbourhoods who have a track record in mental health and knowledge of the services available in the wider
| **Communication** | Better communications between OUH FT, GP Surgery, patients at pharmacist without discharge summary  
Language about the elderly - it's not our fault  
Website improvement and communication | The CCG recognises that communications between different healthcare professionals is essential in providing good integrated care. Records sharing for cross-organisational care, in particular between primary care, community and mental health services and secondary care is a key focus across the county to deliver more joined-up care.  
There are excellent examples in the locality of websites that provide enhanced signposting information, such as that of the Windrush practice. We will aim to support other practices that wish to adopt similar model. |
| **Link to Adult social care** | How do the plans sit in relation to adult social care?  
Needs to be good integration between different care providers in social care and primary care | There are some challenges working with social care and better integration between social care and the primary care team are a key focus of the plan.  
Records sharing is an essential component of good joined-up care delivered across organisations and there is a programme for records to be interoperable across primary care, community and mental health services and secondary care. |
Appendix 2: Examples of what is working well in West Oxfordshire

What is working well:

- Range of services available close together in Witney including EMU and MIU
- Primary Care Visiting Service – valued by patients and clinicians, and is very effective in identifying patients who would benefit from EMU.
- Neighbourhood Access Hub has provided helpful extra capacity, and the recent addition of a physiotherapist has been very successful and popular in meeting patient need.

At practice level, highlights include:

- 2 practices have successfully introduced 15 minute appointments (Burford, Windrush)
- Windrush Medical Practice has developed a new signposting website with its patient group and including an e-consultation option
- Clinical pharmacists starting at Eynsham and Windrush following successful bid to NHS England
- Well-developed recall approach for patients with long term conditions at Burford.
Appendix 3: Deer Park Medical Practice & Independent Reconfiguration Panel Advice

Following an unsuccessful procurement process, Deer Park Medical Practice in Witney closed on 31 March 2017. Its patient list was dispersed to surrounding practices. OCCG worked with the GP practice and its 4,399 patients to ensure that the list dispersal was managed in a safe and orderly way. OCCG also worked with the other practices in Witney to help minimise any impact on their services as Deer Park closed. This included extra investment over the transition period to support practices registering large numbers of patients and to fund additional appointments in the local GP access hub.

In December 2016 a member of Deer Park Medical Practice Patient Participation Group requested a judicial review on the decision to close services at Deer Park Medical Centre. The judge hearing the case in February 2017 refused permission to bring a judicial review, however the Oxfordshire Health Overview and Scrutiny Committee referred the matter to the Secretary of State (SoS) for Health on the grounds that the closure was a substantive change in service. In March 2017 the referral was passed to the Independent Reconfiguration Panel (IRP) for initial assessment in line with the protocol for handling contested proposals for the reconfiguration of NHS services.

The IRP concluded that the referral was not suitable for a full review because further local action by the NHS with the HOSC could address the issues raised. The SoS responded to HOSC on 3 July 2017 with a copy of the IRP review confirming he had accepted their recommendations in full. This letter was shared with the OCCG by HOSC.

On 25 July 2017 NHS England (NHSE) wrote to the CCG confirming their expectations that OCCG would address the recommendations from the IRP and in particular:

1. The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible.

2. The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. At the heart of this must be the engagement of the public and patients in assessing current and future health needs, understanding what the options are for meeting their needs and co-producing the solutions. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future. (NHSE added that this needs to be linked to, and integrated with, the wider OCCG and Sustainability & Transformation Programme plans for the whole of Oxfordshire).

OCCG had already written to Deer Park Medical Centre patients advising them of the closure and alternative practices in their local area. In response to the IRP’s recommendations OCCG has continued to encourage patients who had not yet registered with another practice to do so.

IRP initial review is available at: https://www.gov.uk/government/publications/irp-deer-park-medical-centre-witney-initial-assessment
In total four letters have been sent to patients who remain on the Deer Park patient register with advice about how to register with another practice and the importance of doing so. Telephone advice and help has also been made available and information has been shared widely with the local media, Healthwatch, local GP practices and their PPGs and on the CCG website. On 18 January 2018, there were 285 Deer Park Medical Centre patients who had not yet registered elsewhere.

As outlined in this locality plan, along with GP colleagues, OCCG have developed a Primary Care Framework to provide strategic direction for a sustainable GP service in Oxfordshire. As the IRP recommendations were published, work was already underway to develop a locality place based plan for West Oxfordshire; patient and stakeholder engagement and involvement is an integral part of this process and the developing plan is being tested with the public, PPGs, local councillors and wider stakeholders. The development of this plan incorporates the IRP recommendations; engagement activity with the local community is outlined in appendix 1 above. Whilst the plan will be published as a first version in January 2018, the process of engagement on the long term future of primary care in the West locality is iterative and will continue as primary care starts to address in more detail long term sustainability of premises, practice size and workforce.
Appendix 4: References

1. Oxfordshire CCG Primary Care Framework, Oxfordshire CCG, March 2017
2. GP Forward View, NHS England, April 2016
3. Transforming our health care system, Kings Fund, March 2011
4. Berkshire, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan, October 2016
5. Patients registered at GP practices by age and gender, NHS Digital, updated quarterly
6. Oxfordshire Joint Strategic Needs Assessment, March 2017
7. Oxfordshire Growth Board, including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment
8. West Oxfordshire Local Plan 2031, on West Oxfordshire District Council website
9. QOF, 2016/2017
### Appendix 5: Glossary of Abbreviations

<table>
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<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>A&amp;E</td>
<td>Accident and emergency department in hospital that deals with life threatening emergencies. In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.</td>
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<td>BOB STP</td>
<td>The Sustainability and Transformation Partnership for Buckinghamshire, Oxfordshire and Berkshire West NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.</td>
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<td>CCG</td>
<td>Clinical Commissioning Group Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible. Oxfordshire CCG also has delegated responsibility from NHS England for commissioning primary care services.</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CSU</td>
<td>Commissioning Support Unit CSUs provide a range of support services to clinical commissioners. They were established in April 2013 as part of the NHS reorganisation.</td>
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<td>DC</td>
<td>District Council</td>
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<td>DN</td>
<td>District Nursing</td>
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<td>ECPs</td>
<td>Emergency Care Practitioner</td>
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<tr>
<td>ED</td>
<td>Emergency department The emergency department assesses and treats people with serious injuries and those in need of emergency treatment. In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.</td>
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<td>EMU</td>
<td>Emergency Multidisciplinary Unit</td>
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<tr>
<td>EOL</td>
<td>End of Life</td>
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<td>ETTTF</td>
<td>NHS England’s Estates and Technology Transformation Fund A multi-million pound investment (revenue and capital funding) in general practice. CCG’s bid on an annual basis for capital funding from the scheme.</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GPAF</td>
<td>General Practice Access Fund</td>
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<td>GPFV</td>
<td>General Practice Forward View</td>
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The GP Forward View was published in April 2016 and sets out NHS England’s commitment to improving patient care and access, and investing in new ways of providing primary care.

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<tr>
<th>Abbreviation</th>
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| HAH | Hospital at home  
Service provided by Oxford Health for patients as an alternative to hospital admission support earlier discharges from hospital for people who are well enough to return home. The plan proposes neighbourhood community teams in place of HAH, providing a more robust clinical decision-making and risk-holding capability. |
| HGH | Horton General Hospital |
| HSCN | Health and Social Care Network |
| HOSC | Oxfordshire Health Overview and Scrutiny Committee |
| ILT | Integrated Locality Team |
| IRP | Independent Reconfiguration Panel  
The Independent Reconfiguration Panel is the independent expert on NHS service change. IRP is an advisory non-departmental public body, sponsored by the Department of Health. |
| ISTC | Independent Sector Treatment Centre |
| MIU | Minor Injuries Unit |
| MSK | Musculoskeletal |
| NAH | Neighbourhood Access Hubs |
| WOLG | West Oxfordshire Locality Group |
| OCC | Oxfordshire County Council |
| OCCC | Oxfordshire Clinical Commissioning Group |
| OHFT | Oxford Health Foundation Trust  
provides mental health and community services in Oxfordshire. OHFT also holds the contract for the Luther Street homeless service in Oxford. |
| OOH | Out of Hours services |
| OT | Occupational Therapist |
| OUHFT | Oxford University Hospitals Foundation Trust, includes the John Radcliffe Hospital and the Churchill Hospital in the City and the Horton General Hospital in Banbury |
| PCVS | Primary Care Visiting Service  
A service run by emergency care practitioners to provide emergency assessment and treatment of patients in the working day in addition to home visits. |
| PMCF | Prime Ministers Challenge Fund |
| PPG | Patient Participation Group  
All practices have, or are setting up, a PPG. Their role is to advise practices on the patient perspective and providing insight into the responsiveness and quality of services. They may also encourage patients to take greater |
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<th>Acronym</th>
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| QOF     | Quality and Outcomes Framework  
An annual reward and incentive programme for practices, the QOF also provides registers for practices and the public of numbers of patients with specific conditions to support better management of these patients. |
| SCAS    | South Central Ambulance Service |
| SoS     | Secretary of State for Health |
| SUS     | Secondary User Services  
The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services |
| UTC     | Urgent Treatment Centre  
Under NHS England plans, urgent treatment centres will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for. By December 2019 all services designated as urgent treatment centres will meet the guidelines issued by NHS England. |
| WTE     | Whole Time Equivalent / Full Time Equivalent |
Developing GP services and locality place based plans for Witney and West Oxfordshire Engagement Report

Date: 10 January 2018
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1. Purpose of report

The purpose of this report is to outline the public engagement undertaken from 16 October to 17 December 2017 to co-produce the Locality Place Based Plan for primary care in Witney and West Oxfordshire. It describes the engagement, outlines key themes and identifies concerns and issues expressed by members of the public.

2. Background
   
a. Primary Care in Oxfordshire

It is recognised nationally and locally, that primary care, and particularly general practice, is under pressure. With a growing population and increasing life expectancy, demands on primary care have increased with people living longer and living with more long term conditions. In the next five years 30% of GPs plan to retire in Oxfordshire, while the numbers of trainees wanting to work as GPs or practice nurses is declining nationally; this is leading to problems in recruitment in GP practices. Workforce issues, together with increased demand for services are making GP services vulnerable.

The general practice system in Oxfordshire faces challenges common to practices elsewhere in the UK:

- An increase in the number of potentially avoidable non-clinical consultations (up to 27% of all consultations for GPs and other clinicians).
- The need to improve premises and other infrastructure.
- Increasing demand as a result of patients requesting same-day access for urgent care, who are generally ‘low-intensity patients’ or ‘low complexity patients’.
- The shortage in workforce and difficulty in recruiting staff contributes to problems of access for patients.
- Increasing pressure in managing complex, frail, or elderly patients who require continuity and co-ordination of care, who are generally ‘high-intensity patients’ or ‘high-complexity patients’.
- The increasing administrative burden in general practice, as practice teams (including GPs and other clinicians) are required to spend more
time on administrative tasks as well as supporting patients to navigate the NHS.

- A lack of integrated working and co-ordination so information about a patient’s condition and their care is not available to all those who provide their care because the information is not shared between different parts of an organisation or between different organisations
- A lack of investment to allow general practice to thrive

b. Primary care in Witney and surrounding areas

In Witney, following an unsuccessful procurement process, Deer Park Medical Centre closed on 31 March 2017. Its patient list was dispersed to surrounding practices. Oxfordshire Clinical Commissioning Group (OCCG) worked with the GP practice, its 4,399 patients and neighbouring practices to ensure that the list dispersal was managed in a safe and orderly way.

In December 2016 a member of Deer Park Medical Centre Patient Participation Group requested a judicial review on the decision of OCCG to close services at Deer Park Medical Centre. The judge hearing the case in February 2017 refused permission for a judicial review.

However, the Joint Oxfordshire Health Overview and Scrutiny Committee (JHOSC) agreed to refer the matter to the Secretary of State for Health on the grounds that the closure was a substantive change in service. As a result:

- The Secretary of State passed the referral to the Independent Review Panel (IRP) in March 2017.
- The IRP concluded that a full review was not required but wrote to the Secretary of State with advice for the NHS and JHOSC
- The Secretary of State responded to Oxfordshire JHOSC on 3 July 2017 with a copy of the IRP review, confirming he had accepted the panel’s recommendations in full.
- On 25 July 2017 NHS England (NHSE) wrote to OCCG confirming their expectations that OCCG would address the recommendations from the IRP.

The IRP recommended that:
The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. At the heart of this must be the engagement of the public and patients in assessing current and future health needs, understanding what the options are for meeting their needs and co-producing the solutions. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future. (NHSE added that this needs to be linked to, and integrated with, the wider OCCC and STP plans for the whole of Oxfordshire).

3. Where are we now?

As demand on GP services continues to increase, there is a need for change and to encourage patients to self-care and access health services at the most appropriate point. Together with GP colleagues, OCCC has developed a Primary Care Framework to provide strategic direction for a sustainable GP service in Oxfordshire. It describes a number of operational principles all of which will be important to the sustainability of GP care in the county. These include practices working together to share resources and share workload to provide a better service and manage demand; delivering care closer to home via a multidisciplinary neighbourhood team, supported by a modernised IT system and investment in estates.

The aim of the Framework is to set the strategic direction for Primary Care, across Oxfordshire, over the next five-10 years so that it can steer localities in achieving sustainable primary care to best meet the needs of the local populations, which will result in a general practice that is fit for the future and at the heart of the NHS in Oxfordshire. Work is currently being undertaken to develop plans to implement this framework at a locality level; the Locality Place Based Plans. This requires new thinking and new models of care and delivery. The new model of primary and community care in Oxfordshire will be based on:

- delivering appropriate services at scale
- organising around geographical population-based need
- delivering care closer to home
• a collaborative, proactive system of care
• delivery by a multidisciplinary neighbourhood team
• support by a modernised infrastructure

4. Purpose of the public engagement

OCCG wanted to hear the views of local people relating to services provided at their GP practice and in their local community to help inform the development of the Locality Place Based Plan for primary care in the West of the county\(^1\). This included feedback on ideas put forward by GPs and Patient Participation Groups, what worked well in their GP practice, what could be improved and any suggestions for how services could be improved and / or developed in the future.

It is important to note that the work undertaken over the past few months was not a formal consultation; the work concentrated on involving the public and stakeholders in the development of plans to address challenges in primary care across Witney and West Oxfordshire. The development of primary care in West Oxfordshire will continue and over the coming year OCCG will be looking more at the estates and premises – the published plans will be iterative and updated over time. In the meantime OCCG would like to continue talking to patients and the public about healthcare in the community. Much of the plan will not require formal public consultation however if significant change is proposed OCCG would consult formally.

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\(^1\) OCCG have undertaken engagement across Oxfordshire as each of the six Localities will have a plan for their specific area based on the needs of the local population. Engagement around the plan for the West was also a key part of the IRP recommendations.
5. **Process and methodology**

A period of engagement was undertaken between 16 October 2017 and 3 December 2017. The approach to the engagement was agreed with representatives of patient participation groups in the West Locality. Draft proposals for Witney and surrounding areas were presented and discussed at three public workshops and discussed at various stakeholder meetings. An online/paper survey was available on OCCG’s engagement website - Talking Health. People also had the opportunity to give direct feedback via email, letter, phone, or freepost. Following this period of engagement the draft plan was published and was available for further comment until 17 December 2017.

a. **Public Workshops**

Three public workshops were held, as follows:

1. 1 November 2017 – West Oxfordshire Locality (Witney) 70 attendees
2. 8 November 2017 – West Oxfordshire Locality (Carterton) 35 attendees
3. 7 December 2017 – West Oxfordshire Locality (Witney) 45 attendees

The workshops (and stakeholder meetings) covered discussion around:

- Challenges facing primary care in Witney and the surrounding area
- Health needs in the area informed by Oxfordshire’s Joint Strategic Health Needs Assessment
- Expected population and housing growth
- Ideas previously put forward by patients and GPs
- What could be improved at local GP practices
- Suggestions for how GP services could be improved across the area

(See appendix 1 for the presentation)

b. **The survey**

To support those that were unable to attend the workshops a short online survey was provided, asking the same questions that were posed in the workshops; a breakdown of responses is shown below in appendix 2. The draft plan was published
on 4 December incorporating the initial public feedback and was made available for further comment until 17 December 2017.

For Witney and the surrounding areas, 51 people registered to the Talking Health website to access the documentation, 21 people then responded to the survey and a further 9 took part in the second survey, following the publication of the plan.

Full details of the survey results are shown in the appendix 2.

In addition to the OCCG survey, the Deer Park campaign group also held a public meeting and encouraged people to complete their survey. They received 15 responses which were passed to OCCG.
c. **Stakeholder meetings / discussion groups**

In addition to the public workshops and the survey, OCCG discussed the plans at various stakeholder meetings around Witney and West Oxfordshire. These meetings included:

- Deer Park Patient Participation Group (PPG) / Former patients of Deer Park
- Public and Patient Partnership West Oxfordshire
- West Oxfordshire District Council, Economic Overview and Scrutiny Committee
- Deer Park Campaign Group
- West Oxfordshire District Councillors
- Witney Town Councillors
- Oxfordshire Health Overview and Scrutiny Committee
- Local stakeholders in Witney and surrounding area with an interest in Deer Park Practice (organised by Healthwatch Oxfordshire)
- Witney MP Robert Courts

d. **Emails / correspondence**

Further to the engagement methods above, the public and stakeholders were also encouraged to submit their views and ideas in writing. We received 4 responses from:

- Keep our NHS Public
- Robert Courts MP
- Patient/public member of the Primary Care Co-commissioning Committee
- Locality Forum Chair representatives

Themes that were raised in the letters included:

- Concern about waiting times for routine appointments
- The need for care to be local and not centralised in Oxford
- Rurality and lack of public transport
- Importance of continuity of care
- Concern about GP recruitment

e. Promotion

The engagement events and online survey were promoted to:
- Witney Gazette – paid for advertising
- OCCG public website with links to Talking Health web pages
- OCCG Facebook
- OCCG Twitter
- West Oxfordshire District Council
- West Oxfordshire Parish Councils
- Previous attendees at Transformation events in West Oxfordshire
- All West Oxfordshire Locality GP practices and Healthshare Physiotherapy clinic in Witney
- Carers Oxfordshire
- Age UK West Oxfordshire Community Information Network
- Communityfirstoxon.org
- Healthwatch Oxfordshire
- Oxford University Hospitals NHS Foundation Trust for cascade to patient members
- Oxford Health NHS Foundation Trust for cascade to patient members
- Cottsway Housing (social housing providers in West Oxon)
- Oxfordshire County Council
- Social media groups in Carterton and Witney
- West Oxfordshire libraries
- West Oxfordshire MS Society
- Through all local media (TV, radio and print newspapers).
- Direct emails to head teachers in Oxfordshire’s primary, secondary and special schools in West Oxfordshire
- Voluntary sector organisations were notified of the events via Oxfordshire Community and Voluntary Action (OCVA)
- OCCG staff, and staff and Foundation Trust members at Oxford Universities Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust were notified via email and through the staff intranet
- West Oxfordshire District Council, promoted the consultation through their communication channels.
- Partner organisations including all the district councils, Oxfordshire County Council (OCC), and Oxford City Council were asked to promote the events to their staff (via meetings, intranet and newsletters) and on their websites
- All Parish Councils, Town Councils and County and District Councillors were asked to promote the events in their communities
- Oxfordshire MPs and MEPs
- Deer Park Campaign Group
- GP practices across Oxfordshire were kept updated on a weekly basis via the GP Bulletin and were asked to share the information with their patients and patient participation groups.

6. Key themes

Key themes from the engagement are outlined below:

Some respondents to the survey felt that they had insufficient time to respond in details to the published draft plans. Respondents also felt that the language in the plans made them difficult to understand and meant they were not accessible to the general public, citing that there was too much jargon, many acronyms and insufficient information about how the plans would be developed.

An over-arching question was how the plans fit with Phase 2 of the Oxfordshire Transformation Programme and the wider Sustainability and Transformation Plans for Oxfordshire, Buckinghamshire and Berkshire.

Fifty one people registered and followed this engagement activity on Talking Health. Of these 51 people, 21 people then responded to the survey. 20 people agreed or strongly agreed with the ideas and suggestions for the priorities in West Oxfordshire, specifically ‘Community clinics for diabetes and respiratory services providing more integrated care closer to home and meaning fewer visits
to Oxford hospitals. 20 people responded to this question, whilst the majority agreed with the approaches identified, three people disagreed with 'Improve information and services available online for patients, and enhance practice receptionists' role in signposting patients to services to meet their needs'.

Although respondents agreed with the proposals and approach, there is continued concern, from a small number of people, in West Oxfordshire about the closure of Deer Park Medical practice and the lack of engagement from the CCG on the future of primary care services in Witney, specifically relating to Deer Park and the future of the premises.

People are aware of the challenges facing primary care and the increased housing growth planned for the area. People are concerned about long waiting times for non-urgent appointments, the role of reception staff in triaging patients and if there is a risk in using less qualified staff instead of GPs for some work.

However, in general people were positive about their practices, and appear to have a sympathetic understanding of the pressures facing GPs in primary care.

The wider issues that were identified related to GP recruitment, lack of funding of the NHS, closer working with local authorities around planning and housing developments and improving infrastructure.

Concern was raised about the rurality of the locality and lack of public transport. Communication between health professionals and different NHS organisations could be improved, using better technology. For those that were involved in this engagement, they wanted to know how the plans would be funded and how the plans would be implemented. Specifically raising concerns around the recruitment and retention of staff and the impact that this would have on the development of services. Some of the themes included:

- Improve staff training
- Local Authorities should provide infrastructure
- Increase the opening hours of the Witney MIU to reduce pressure on primary care
• Re-instate Deer Park practice
• Extend services provided at Witney Community Hospital
• Triage minor illness using nurses
• Improve communication between health professionals
• Reduce the number of referrals to Oxford
• Evaluate the services you have already

Whilst we have summarised the key themes that were received from all the engagement responses, some people provided very detailed feedback which has been shared with the colleagues working directly on these plans over the forthcoming months. It is important to note that these are working plans, so ideas and points raised through this engagement process will be explored further as part of our ongoing work and engagement with local communities. For those groups, organisations or individuals that provided detailed responses, we will endeavour to engage directly with you to explore your thinking further.

7. **Next steps:**

• All of the feedback provided has been reviewed to identify the key themes and these have been addressed in the revised locality plan.

• The full detail of the feedback received has been shared with the West Locality group and the plan will continue to be developed further over the coming months and years.

• On the 2 January 2018, Oxfordshire Primary Care Commissioning Committee received the report on the engagement across Oxfordshire including the findings presented in this report.

• This engagement report and the plan will also be shared with Oxfordshire Health Overview and Scrutiny Committee at their meeting on 8 February 2018.

• Some elements of the plan that can start to be implemented in early 2018/19 will be initiated and appropriate support and funding will be made available.

• The ongoing engagement with patients, the public and clinicians will allow further refinement and development of the plans throughout the following year and beyond.
The West Oxfordshire Locality Place Based Plan\textsuperscript{2}, this report and appendices and any further documents that will be developed in the future supporting locality plans and their implementation, will all be made available on OCCG’s website.

In response to some of the feedback received OCCG will also prepare a public version of this plan and publish it towards the end of January 2018.

\textsuperscript{2} The plan references the feedback from engagement and how it has been used and taken into account within the plan.
Appendix 1: Public presentation

Developing GP services and a locality plan for West Oxfordshire

Wednesday 1 November 2017

Programme

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.30pm</td>
<td>Arrival and Introductions</td>
</tr>
<tr>
<td>6.35pm</td>
<td>Presentation; Developing GP services and a Locality Plan for West Oxfordshire</td>
</tr>
<tr>
<td>6.50pm</td>
<td>Panel Questions and Answer session&lt;br&gt;Panel&lt;br&gt;• Dr Miles Carter, Clinical Locality Director&lt;br&gt;• Dr Kiren Collison, Deputy Clinical Locality Director&lt;br&gt;• Catherine Mountford, Director of Governance for Oxfordshire Clinical Commissioning Group&lt;br&gt;• Julie Dandridge, Deputy Director, Head of Primary Care and Localities</td>
</tr>
<tr>
<td>7.15pm</td>
<td>Workshop around tables to discuss:&lt;br&gt;• Do you agree / disagree with the suggestions / ideas above?&lt;br&gt;• What do you like / works well at your GP practice?&lt;br&gt;• What could be improved at your GP practice?&lt;br&gt;• Do you have any suggestions for how services could work / be improved?</td>
</tr>
<tr>
<td>8.00pm</td>
<td>Closing remarks and next steps</td>
</tr>
</tbody>
</table>
GP practices face challenges

- Shortage in workforce and difficulty recruiting staff
- Increasing demand for same-day access for urgent care
- Increasing pressure in managing complex, frail or elderly patients
- Small practices finding it increasingly challenging to be sustainable
- Premises requiring improvement
- Increasing administrative burden
- Increase in the number of non-clinical consultations
- Lack of integrated working

Primary Care for Oxfordshire

The new model of primary and community care in Oxfordshire will be based on:

- delivering appropriate services at scale
- organising around geographical population-based need
- delivering care closer to home
- a collaborative, proactive system of care
- delivery by a multidisciplinary neighbourhood team
- support by a modernised infrastructure
GP practices in West Oxfordshire Locality

There are currently eight GP practices in the West locality with a total population of 81,000 patients.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number of patients registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bampton Surgery</td>
<td>8,428</td>
</tr>
<tr>
<td>2. Broadshires Health Centre</td>
<td>10,346</td>
</tr>
<tr>
<td>3. Burford Surgery</td>
<td>6,525</td>
</tr>
<tr>
<td>4. The Charlbury Surgery</td>
<td>5,322</td>
</tr>
<tr>
<td>5. Cogges Surgery</td>
<td>7,617</td>
</tr>
<tr>
<td>6. The Eynsham Medical Group</td>
<td>13,924</td>
</tr>
<tr>
<td>7. The Nuffield Health Centre</td>
<td>12,097</td>
</tr>
<tr>
<td>8. Windrush Medical Practice</td>
<td>16,982</td>
</tr>
</tbody>
</table>

The Deer Park context

- Deer Park Medical Centre was closed on 31 March 2017 and 4,399 patients asked to register with another GP practice
- Following a referral to Secretary of State for Health the following advice was given to Oxfordshire CCG and to Oxfordshire HOSC:

The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. At the heart of this must be the engagement of the public and patients in assessing current and future health needs, understanding what the options are for meeting their needs and co-producing the solutions. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future.

NHS England added that this needs to be linked to, and integrated with, the wider OCCC and STP plans for the whole of Oxfordshire.
Developing the plan

We have been engaging people as we develop the plan for West Oxfordshire:

- GP practices have told us about their challenges and ideas for the future
- Patient representatives have told us about the experience of using primary care in west Oxfordshire
- Patient survey data has helped us understand the experience patients have of using local services.
- West Oxfordshire District Council and other organisations have helped us understand the expected growth in housing and future needs.
- Public Health at Oxfordshire County Council have helped us understand the health needs of west Oxfordshire and whether these are different from elsewhere.

Housing growth

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr-17</td>
<td>5 year growth</td>
</tr>
<tr>
<td>West</td>
<td>81,585</td>
<td>90,266</td>
</tr>
<tr>
<td>Rural West</td>
<td>30,413</td>
<td>33,490</td>
</tr>
<tr>
<td>Witney and East</td>
<td>51,172</td>
<td>56,776</td>
</tr>
</tbody>
</table>

- Based on planning permission at August 17 granted for new housing development, there are 3,600 dwellings expected in the locality over the next 5 years and over 8,000 in the next years.
- This does not take into account any rebasing as a result of the new formula
2.7% of the population is aged 85 and over, just above the Oxfordshire average (2.4%)

The ward of Burford had a significantly higher proportion of the population aged 85 and over

Areas of Witney had the highest rates of child and older people poverty in West Oxfordshire

Health outcomes were generally better than average for Oxfordshire and country.

The 2 wards highlighted as above average on health indicators:
- Freeland & Hanborough – death from stroke (all ages)
- Witney South - hospital admissions for self harm

The ranking of Freeland & Hanborough ward on stroke deaths (all ages) may have been influenced by the number of care home beds in this area

**West Oxfordshire Locality**

**Challenges:**
- Rapidly growing population, in particular Witney, Carterton and Eynsham
- Parts of the locality have a significantly older population, which challenges for access to services as very rural
- Shortage of staff to meet changing demographics

**What are our priorities?**
1. Meet the needs of the ageing population
2. Ensure safe and sustainable primary care
3. Support access for an increased population
4. Deliver improved prevention

**How will we meet our priorities?**
- Gerontologists in the community and proactive care in care homes / assisted living
- Increased primary care visiting service
- Improved self-care and social prescribing
- Additional extended access in Rural West
- Enhanced signposting roles for receptionists
- Estates prioritisation
The developing plan

We would like to expand some services, such as:

- Better care for the highest-need patients including:
  - care home residents - more co-ordination and specialist medical input
  - include residents in assisted living developments
  - extend Primary Care Visiting service

- Community clinics for diabetes and respiratory services - fewer visits to Oxford hospitals.

- Clearer and more integrated same-day services building on services such as the Minor Injuries Unit, the Neighbourhood Access Hub and GP Out of Hours.

- Ensure a high standard of end of life care.

- Increase in self-care and social prescriptions.

- Develop services, staff and buildings to meet the needs of an ageing population and future population growth.

How?

To do this we would like to:

- Develop a wider skill mix of staff, e.g. pharmacists, mental health workers and others working alongside GPs and nurses in local surgeries.

- Develop closer working with community based teams.

- Review and change practices’ handling of letters, clinical results and requests to make best use of GP time.

- Assess opportunities for shared back office facilities to aid efficiency.

- Look to Oxfordshire-wide support for recruitment and retention of GPs.

- Improve information and services available online.
Questions to discuss

1. Do you agree with the suggestions and ideas above?
2. What do you like and what works well at your GP practice?
3. What could be improved at your GP practice?
4. Do you have any suggestions for how services could be improved?
Appendix 2 Witney and surrounding area - Survey Results and Demographics

51 people registered and followed this engagement activity on Talking Health. Of these 51 people, 21 people then responded to the survey.

Demographics

The demographics for the 21 people that responded to the survey are shown below:

*Respondent Age Range*
Gender of Respondents

- Female: 15 (75%)
- Male: 5 (24%)

Disability status of respondents

- Yes: 5
- Not stated: 3
- No: 13
Survey Results

20 people responded to this questionnaire. The map below shows where the responses came from:
1. To what extent do you agree or disagree with the ideas/suggestions below:

**Detailed breakdown for 'Better and more proactive care for care and nursing home residents including more co-ordination of care and specialist medical input'**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>55%</td>
<td>11</td>
</tr>
<tr>
<td>Agree</td>
<td>35%</td>
<td>7</td>
</tr>
<tr>
<td>Neutral</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

**Detailed breakdown for 'Better and more proactive care for residents in assisted living developments'**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>55%</td>
<td>11</td>
</tr>
<tr>
<td>Agree</td>
<td>40%</td>
<td>8</td>
</tr>
<tr>
<td>Neutral</td>
<td>5%</td>
<td>1</td>
</tr>
<tr>
<td>Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

**Detailed breakdown for 'Extend Primary Care Visiting service to provide urgent visits to more patients who need it, including later in the day than currently provided.'**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>60%</td>
<td>12</td>
</tr>
<tr>
<td>Agree</td>
<td>30%</td>
<td>6</td>
</tr>
<tr>
<td>Neutral</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>
Detailed breakdown for ‘Community clinics for diabetes and respiratory services providing more integrated care closer to home and meaning fewer visits to Oxford hospitals.’

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>75% (15)</td>
</tr>
<tr>
<td>Agree</td>
<td>25% (5)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Detailed breakdown for ‘Clearer and more integrated same-day services available to patients across the whole locality. This will build on current well-used services such as the Minor Injuries Unit in Witney, the Neighbourhood Access Hub and GP Out of Hours.’

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>75% (15)</td>
</tr>
<tr>
<td>Agree</td>
<td>15% (3)</td>
</tr>
<tr>
<td>Neutral</td>
<td>10% (2)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Detailed breakdown for ‘Ensure a high standard of end of life care.’

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>85% (17)</td>
</tr>
<tr>
<td>Agree</td>
<td>15% (3)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Detailed breakdown for ‘Increase in self-care and social prescriptions directing patients to resources in the local community which can help address their needs to reduce the frequency of patients visiting GPs unnecessarily.’

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>65% (13)</td>
</tr>
<tr>
<td>Agree</td>
<td>20% (4)</td>
</tr>
<tr>
<td>Neutral</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Disagree</td>
<td>10% (2)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Detailed breakdown for ‘Develop services, staff and buildings to meet the needs of an ageing population and future population growth.’

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>70% (14)</td>
</tr>
<tr>
<td>Agree</td>
<td>25% (5)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>
2. Please could you tell us if you agree or disagree with our approach on how to do this?

Detailed breakdown for 'Develop a wider skill mix of staff, e.g. pharmacists, mental health workers and others working alongside GPs and nurses in local surgeries.'

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>65% (13)</td>
</tr>
<tr>
<td>Agree</td>
<td>30% (6)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>

Detailed breakdown for 'Develop closer working with community based teams to further improve care for the highest-need patients.'

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>65% (13)</td>
</tr>
<tr>
<td>Agree</td>
<td>30% (6)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>

Detailed breakdown for 'Review and change practices' handling of letters, clinical results and requests to make best use of GP time.'

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>60% (12)</td>
</tr>
<tr>
<td>Agree</td>
<td>30% (6)</td>
</tr>
<tr>
<td>Neutral</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>
3. **What do you like / works well at your GP Practice?**

Eighteen people responded to this question. The key points made related to:

- Two respondents felt unable to answer this question as they have no relationship with their surgery following the closure of Deer Park
- Some people felt that it was easy to get an appointment if the issue was urgent, but that generally waiting times had increased
- Some felt that staff were polite and friendly
- Online bookings, face to face appointments, drop-in clinics, onsite pharmacy, Saturday clinics, self monitoring equipment were all cited as positive things.
4. **What could be improved at your GP Practice?**

   Nineteen people responded to this question. The key themes raised were:
   
   - Capacity is an issue – suggestion to re-open Deer Park
   - Lack of GPs and consequent waiting times, need more funding for GPs
   - Reception area cramped
   - Reception staff not approachable
   - Better collaboration/communication amongst health professionals

5. **Do you have any suggestions for how services could work/be improved?**

   Seventeen people answered this question. The key themes raised were:
   
   - Improve staff training
   - Local Authorities should provide infrastructure
   - Increase hours of the MIU to reduce capacity on primary care
   - Reinstate Deer Park
   - Make hospital service local
   - Triage minor illness using nurses
   - Improve communication between health professionals
   - Reduce referrals to Oxford
   - Evaluate the services you have already

6. **If there is anything else that you would like to tell us about primary care services in West Oxfordshire, please do so.**

   Sixteen people responded to this question. The points raised were:
   
   - Nurses need training/development
   - Facilities need to be developed closer to home
   - Expand community hospitals, rehab, EMUs
   - Ambulatory care relies on improve transport networks
   - Improve IT systems
   - What about community hubs based around an agreed population – where do these BOB STP plans fit in this?
- Concern that intermediate care beds are at risk in Witney Community Hospital
- Cost and resource impact on these plans
- Consultation on Deer Park failed
- Continuity of care is important
Appendix 3: Feedback from the events

Oxfordshire CCG held two events in Witney and Carterton in November 2017 and another follow up event in Witney in December to share the engagement feedback and draft plans. The workshops allowed local people to share their views on how GP and primary care services in their localities could be organised.

The key themes highlighted are below:

Witney Event

<table>
<thead>
<tr>
<th>Key Themes</th>
<th>Summary of issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population growth/housing development</td>
<td>• OCCG must cooperate more with the councils to get funding for health infrastructure</td>
</tr>
<tr>
<td></td>
<td>• Work with developers</td>
</tr>
<tr>
<td></td>
<td>• Need to be planning ahead</td>
</tr>
<tr>
<td>Access to GP appointments</td>
<td>• Not acceptable to wait two - three weeks</td>
</tr>
<tr>
<td></td>
<td>• Poor experience – had to go home to phone for an appointment even though I was already at the surgery</td>
</tr>
<tr>
<td></td>
<td>• Appointments – some practices have a phone-back system which works well</td>
</tr>
<tr>
<td></td>
<td>• Want continuity of care but difficult to get appointment with named GP</td>
</tr>
<tr>
<td></td>
<td>• Important for people with LTC to see own GP who knows you well</td>
</tr>
<tr>
<td></td>
<td>• Phoned 111 and saw doctor in Witney, experience very good</td>
</tr>
<tr>
<td></td>
<td>• Early visiting service works well</td>
</tr>
</tbody>
</table>
| Access to other clinicians/pharmacists | • Should be able to book to see a nurse, not just GP  
  • Pharmacies could be used more as a first point of contact  
  • Pharmacists have skills but not authority to prescribe  
  • More use of triage  
  • More training of receptionists  
  • May not need to see a GP – other professionals could be first point of contact e.g. physio |
|----------------------------------------|--------------------------------------------------------------------------------------------------|
| Recruitment/retention of staff         | • Shortage of clinical workers is a problem for the proposals  
  • Provide affordable accommodation to help recruit more GPs  
  • Recruitment vital to sustain services  
  • Important for patients to raise funding/investment in GP services issues with their MPs  
  • Upskilling workforce |
| IT                                     | • Patients’ notes: not everyone can see them, would assist continuity  
  • Electronic conversations – better use of email and website communications  
  • Don’t assume everyone has internet or mobile access. Need paper versions of information  
  • Online booking/ access to notes / prescriptions is good |
| Prevention/social prescribing | • Integration of IT systems to encourage more use of computers  
|                             | • Not enough emphasis on keeping well  
|                             | • More education in schools about staying healthy  
|                             | • Need to focus on younger generation  
|                             | • Invest time with young people  
|                             | • Social prescribing is a good idea e.g. walking groups  
|                             | • Age UK offers exercise to prevent falls  
|                             | • Paid person to be a befriender or supporter for social prescribing  
|                             | • Keep older people active  
| Witney Community Hospital   | • EMU works well  
|                             | • Better use of Witney hospital – gerontologist used to be based there – why was this stopped  
|                             | • Maintain and expand Witney Hospital ; expand the MIU so it can stay open longer and increase capacity  
| Mental Health               | • Not enough support for young people  
|                             | • School counsellors have long waiting lists  |
## Carterton – 8 November

<table>
<thead>
<tr>
<th>Continuity of Care</th>
<th>People want to know they can talk to someone when vulnerable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport</td>
<td>Getting to hospitals in Oxford - time is so difficult and parking so stressful. Couldn't we set up a skype consultation/video - even if people went into Witney to do this? It would save on transport/ time / stress and make use of technology to cut down on people going</td>
</tr>
<tr>
<td>Money/Charging</td>
<td>People coming from abroad should pay for treatments.</td>
</tr>
<tr>
<td></td>
<td>• Think it reasonable to be charged housekeeping for food - the money should go to medical care. But some people find it hard to feed themselves anyway - means testing nightmare.</td>
</tr>
<tr>
<td></td>
<td>• Money to pay for services is limited to patients need to be given choices</td>
</tr>
<tr>
<td></td>
<td>• Are these plans affordable</td>
</tr>
<tr>
<td></td>
<td>• Government need to put more money in the NHS</td>
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<tr>
<td></td>
<td>• Agency staff are better paid - bad for patient.</td>
</tr>
<tr>
<td></td>
<td>• Better pay would help recruitment and staffing. There is no pay rise.</td>
</tr>
<tr>
<td></td>
<td>• Money - Go regularly to eye hospital/JR. It costs £68m p.a. for patients not turning up - patients should be charged for this.</td>
</tr>
<tr>
<td>Housing</td>
<td>Housing development - In this area are they looking at creating a new surgery?</td>
</tr>
</tbody>
</table>
| Structure of GP Practices | • Why can't we require GPs to work in NHS for some time before they go to private practice?  
• Sharing back office functions - couldn't support more. Council has saved £9m a year in avoiding duplication - small pool of very well trained admin staff.  
• Length of time to get an appointment an issue  
• Waiting times for appointments need to go down  
• A lack of GPs in the Eynsham GP practice so there is pressure on GPs; need to recruit more GPs at the surgery  
• Why can't practices list conditions that other staff can deal with - signposting  
• Physios could take a huge load off GPs - muscular skeletal etc  
• Community based teams - ideal to spot emergencies before they happen |
| DTOC | • On the whole the NHS is a v good service. It's aftercare - 'bed blocking' and time it takes from knowing the person is fit to go home, to the time it takes to get a plan in place.  
• Used to be intermediate care - maybe nursing homes are taking their place? But they are full.  
• Recognise that high level full on provision isn't there. It's the convalescent stage during that transition that is needed at a local level.  
• Out of hospital discharge |
| Social Care | • Poor sharing of discharge information from OUH.  
|            | • Overnight stay - discharged and notes transferred to GP. Patient had notes. |
| Technology/Communication | • If I go to Swindon - the letters don't go back to your GP/the right place - e.g. Cancer treatment in Swindon. Results don't get referred back? Technology to save time and communicate/share information.  
|            | • Had test at Witney hospital but they didn't know about it at the JR.  
|            | • Better communications between OUH, GP Surgery, patients at pharmacist without discharge summary.  
|            | • Language about the elderly - it's not our fault  
|            | • Hospital admin not good, duplicate letters - bad service. Staff frustrated at the hospital with it - problems.  
|            | • Website improvement and communication. |
| Pharmacy | • NHS cuts to pharmacist - cuts income by 15%.  
|            | • Independent pharmacies.  
|            | • Pharmacist availability also a problem. GP employ pharmacist to do medicine reviews - new idea.  
|            | • Pharmacist skill mix  
|            | • Need more pharmacists to save GP time |
| Future services | • Walk-in services in town centres, shopping areas (i.e. where people are during the day or can get too easily) - for advice, and minor conditions. A good way to promote self-care. |
| Receptionists | • Don't want to see receptionists triaging patients  
|              | • Using receptionists to triage is cost effective for the NHS  
|              | • Receptionists are rude |
| Mental Health | • A mental health nurse should be attached to each practice  
|              | • Need to look at self-harm rate in south Witney which is above average  
|              | • People with mental health issues need more support |
Appendix 4: Feedback and themes from Meeting with Deer Park Patients

Eight previous patients of Deer Park Medical Practice met with a Director and two senior managers from OCCG on 29 November 2017.

The themes raised at this meeting included:

<table>
<thead>
<tr>
<th>Themes</th>
<th>Content</th>
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</table>
| Concern about the IRP advice which did not preclude having a GP practice in Deer Park or another practice in Witney | • The CCG haven’t taken on board the recommendation of the IRP?  
• The IRP response was focussed but the CCG plans address wider issues.  
• IRP states that patients should be involved in the process.  
• Lack of engagement by CCG |
| Waiting times | • When looking at Deer Park closure waiting time for appointment was 2 working days. Windrush was 3-4 weeks for a non-urgent appointment. Now, its 6-8 weeks for non-urgent. No online appointments available for the last 3 months. More doctors have been taken on and the waiting times are still bad.  
• Data – analysis of Drs to patients in Witney – 1,200-1,300 patients per GP. This hasn’t changed but waiting times have doubled/trebled. |
| Access | • Transport from outside Witney comes in to the Deer Park side but not the other side of Witney.  
• Concern about people not being able to |
| **Population increasing** | People are making appointments in case they need an appointment and cancelling if they don’t need it.  
- Need to recognise the new developments along the A40. |
|--------------------------|-------------------------------------------------|
| **Alternative suggestions** | Suggested there are 2 GPs who worked at Deer Park would be willing to come back.  
- Have you considered the idea of using the Deer Park as an option.  
- The land at Deer Park belongs to the council and a new building could be built or expanded there.  
- Our proposal is that services at Deer Park or somewhere in West Oxfordshire should be re-convened. Need more doctors to allow more appointments available. Hub appointments not sufficient for population.  
- Deer Park walk-in clinics worked very well and would like to see something similar available.  
- Open it on a community-led social enterprise. |
| **Financial Impact** | Not yet had a cost analysis of closing Deer Park. What would have been the cost of keeping it open? Ploughed money |
- We need to have a better understanding of the costs and of the benefits/value of the new model. What are the clinical outcomes? How much has the whole process cost and what would it have cost to stay where we were until the new developments produced more patients.
- Concern that commercial element might lead business managers in other practices to be keen to take on new patients to get the extra money without being able to deliver clinical services needed.

### Patient outcomes

- Comparing outcomes? Look at walk-ins, waiting times for appointments? KPIs used? Has the T/F of patients made things better, the same or worse?

### Communication

- Messages displayed in waiting room suggests because more patients being absorbed, more notice is needed for prescriptions.

### A new practice in Witney

- Could bigger practices have worse waiting times? Are the practices being managed properly?
- Wanting to have another practice in Witney suggests you have come to the same conclusion?
- What are the benefits and disadvantages of opening a new practice in the Deer Park area?
- Talked to west Oxon practices about growth.
<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Question whether small practices can be sustainable?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APMS contracts are different and challenges of recruiting GPs are not as big.</td>
</tr>
<tr>
<td></td>
<td>Many new GPs are reluctant to be partners, so would we not need to move to more APMS contracts?</td>
</tr>
<tr>
<td>Shared resources</td>
<td>How much time spent doing the paperwork? Should the other surgeries take on board the model of Virgin and have a hub to take on the back room work.</td>
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Third Party Review of primary care plans in West Oxfordshire

A third party independent review of Oxfordshire Clinical Commissioning Group’s (OCCG) plans for primary care and related services in Witney and the surrounding areas has concluded with a report published on the NHS England website and shared with key members of the public and partners.

Background

The review follows recommendations made by the Independent Reconfiguration Panel (IRP) after the Secretary of State, Rt Hon Jeremy Hunt MP, asked the panel to look at the OCCG decision not to re-procure general practice medical services at Deer Park Medical Centre following a referral from Oxfordshire Joint Health Overview and Scrutiny Committee under regulation 23(9) of the Local Authority Regulations.

The IRP considered the referral and concluded that it was ‘not suitable for full review because further local action by the NHS with the Committee (OJHOSC) can address the issues raised’. The third party review report is the completion of one of the IRP recommendations which relates to NHS England.

Independent review

Following a procurement process, involving a patient leader from the NHS England South East Patient Leader programme, NHS England commissioned North East London Commissioning Support Unit (NEL CSU) to conduct the independent third party review. The review covers the period since the IRP recommendations were received until the first version of the CCG plan was produced (April to December, 2017). The review was conducted throughout November 2017 to January 2018. It should be noted that OCCG’s work to develop a plan for primary care services in Witney and the surrounding area, known as the West Locality, was underway prior to the publication of the IRP recommendations, as part of the development of place-based plans for all parts of Oxfordshire. Patient and stakeholder engagement and involvement was in progress as part of this process. Further development of these plans and engagement in them will continue beyond January 2018.

Review findings

The report sets out the findings of the independent reviewers’ assessment of OCCG’s activity to develop its plan for primary care in Witney and the surrounding area. The primary care and engagement findings are:

- There is evidence of patient and public engagement in developing the primary care plan, although evidence of how needs were identified and options and solutions developed could be strengthened
• A single vision for the West Locality with links to the OCCG and national aims should be included.
• There are links to wider plans developed by OCCG and the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership (BOB STP), although detail on the alignment and integration of these plans and the affordability of solutions needs to be added.
• The solutions identified for meeting the current and future needs of people in Witney and the surrounding areas needs more detail e.g. definitions of new roles and services and the impact they will have in meeting the population’s needs.
• The plan would benefit from the inclusion of a definition of co-production that can be articulated to all stakeholders, and aligned to wider co-production approaches undertaken across OCCG and BOB STP. Evidence was found that the plan was developed with key stakeholders, but solutions were not found to have been co-produced to date using the NHS England definition of co-production.
• A governance structure to describe how the patient and public voice informs, influences and shapes strategic decisions was not evidenced in the current version of the West Oxfordshire Locality plan, although there is evidence the engagement process was signed off by locality clinical leads and Healthwatch Oxfordshire.
• Further detail should be included in the communications and engagement plan to represent the breadth of work undertaken to develop the primary care plan e.g. partnership work undertaken with the West Locality Forum.
• It is clear that OCCG has listened to patients and the public during the development of their primary care plans.

Recommendations

The report follows these findings with a number of associated recommendations for OCCG to take forward as they continue to develop their plans and carry out further engagement activities. NHS England will monitor the development of these plans and has offered to support OCCG through the development process.

Recommendations include:

• Improve documentation, provide greater clarity and increase active stakeholder management.
• OCCG’s engagement needs to ensure that it includes all groups likely to be affected by any proposed changes, as identified through an equalities impact assessment.
• Develop a vision owned by the locality that is easily articulated and aligned to the vision for the wider Oxfordshire Primary Care Framework and the STP.
• The plan should be co-produced with patients. OCCG needs to be clear about their local definition of co-production and how this would work.
• As the plan develops, more detailed definitions of the changes patients and the public may see and the benefits these would bring should be included.

Next steps

Following publication of the third party review report, the below actions are being undertaken:
The report has been sent to the Secretary of State for Health, Rt Hon Jeremy Hunt MP and copied to Lord Ribeiro, Chairman of the Independent Reconfiguration Panel to note that the recommended third party review of OCCG’s primary care plans for Witney and the surrounding area has been conducted and published, with recommendations shared with OCCG and a full update provided to Oxfordshire JHOSC on 8 February.

- NHS England will seek an action plan from OCCG to address the recommendations of the report, which will be monitored and assured by NHS England
- NHS England will support OCCG as it progresses further iterations of the West Oxfordshire Locality plan, which it will co-produce with patients and the public.
- Findings and recommendations of the review report will be subject to discussions between OCCG, NHS England and Oxfordshire JHOSC at its committee meeting in public on 8 February 2018.

Further information

The independent third party review can be found on the NHS England website [here](#).

For further information please contact Annie Tysom, Senior Communications and Engagement Manager, NHS England South East – [annie.tysom@nhs.net](mailto:annie.tysom@nhs.net)

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Review of NHS Oxfordshire Clinical Commissioning Group Locality Place-Based Primary care plan: West Oxfordshire Locality and public and patient engagement into the development of the plan August – December 2017

Prepared for NHS England

January 2018
Document assurance process

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<td>16.01.18</td>
<td>Annie Tysom, Senior Communications and Engagement Manager, NHS England South East</td>
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<td>16.01.18</td>
<td>Ginny Hope, Head of Primary Care, NHS England South East</td>
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<td>16.01.18</td>
<td>Douglas Findlay, Patient leader, NHS England South East Patient Leader programme</td>
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<tr>
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<td>17.01.18</td>
<td>NHS England South East Director Commissioning Operations Senior Management Team, Hampshire, IOW, Buckinghamshire, Berkshire, Oxfordshire and Frimley</td>
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<td>Ginny Hope, Head of Primary Care, NHS England South East</td>
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<td>Felicity Bull, Head of Communications, NEL CSU</td>
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<td>draft5</td>
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<td>Annie Tysom, Senior Communications and Engagement Manager, NHS England South East</td>
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1. Context and purpose of the review

1.1 Background

The re-procurement for Deer Park Medical Centre (DPMC) was initiated during 2015/16 by NHS England during the period of joint commissioning with NHS Oxfordshire Clinical Commissioning Group (OCCG). From 1 April 2016, OCCG took on delegated responsibility from NHS England for the commissioning of primary medical services across Oxfordshire. The re-procurement process resulted in no new provider being awarded the contract and alternative provision identified in the three remaining Witney GP practices. This enabled a managed dispersal of the Deer Park patient list.

The decision not to re-procure the Deer Park Medical Centre contract following the failure to award the contract was referred to the Secretary of State for Health by the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) in February 2017, who in turn referred the decision to the Independent Reconfiguration Panel. The Independent Reconfiguration Panel concluded that ‘this referral was not suitable for full review because further local action by the NHS with the committee can address the issues raised’ and made a number of recommendations.

On 25 July 2017, NHS England wrote to OCCG confirming expectations that OCCG would address the recommendations from the Independent Reconfiguration Panel, and in particular:

'OCCG should commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. Engagement with the public and patients is required in assessing current and future health needs, understanding options and co-producing the solutions. This should not preclude the possibility of providing services from DPMC in the future. To be completed in six months and reviewed by a third party identified by NHS England so that residents can see a credible plan for delivering the services they need.’

OCCG planning for primary care services in and around Witney was underway prior to the publication of the Independent Reconfiguration Panel recommendations in July 2017, as part of the development of place-based plans for all parts of Oxfordshire. Patient and stakeholder engagement and involvement was also underway as part of this process. Development of these plans and engagement will continue beyond January 2018.

1.2 Scope of the review

In November 2017, NEL Commissioning Support Unit (NEL CSU) was appointed by NHS England to conduct a third party review into the development of a comprehensive plan for primary care and related services in Witney and its surrounds – known as the West Oxfordshire locality. The review covers the period since the Independent Reconfiguration Panel recommendations were received, August to December 2017.

This review was conducted from November 2017 to January 2018. Experts in communications and engagement and primary care were asked to:

- Consider what OCCG has done in order to develop the locality place-based primary care plan in the West Oxfordshire locality and the communications and engagement plan to support this
- Interview stakeholders to gather further insight into the development process
- Produce a written review of the locality place-based primary care plan: West Oxfordshire locality (4 December 2017 iteration) to give an expert view on whether it delivers what it is required to in respect to the Independent Reconfiguration Panel recommendations, setting out any gaps and future recommendations
- Provide an assessment of how far OCCG has engaged with patients and key stakeholders to co-produce solutions.

When talking about co-production, it is important to define this process. NEL CSU has used the definition: ‘a way of working that involves people who use health and care services, carers and communities in equal partnership and which engages people at the earliest stages of service design, development and evaluation’. It also includes ‘a commitment to sharing power and decisions with citizens.’ This has been taken from NHS England’s co-production model: https://www.england.nhs.uk/participation/resources/co-production-resources/.

NEL CSU has examined the plans in the context of development work for the plan for primary care in the West Oxfordshire locality, which has been undertaken and will continue to be undertaken outside the timeframe of this review. It is also important to acknowledge that this review is not looking at the decision about Deer Park Medical Centre or the previous engagement undertaken around this decision.

### 1.3 Statutory requirements

There is a legal duty on clinical commissioning groups (CCGs) to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- Section 242, of the NHS Act 2006, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions that affect how those services operate.
- Section 244 requires NHS bodies to consult relevant health overview and scrutiny committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to health overview and scrutiny committees).
- The NHS Act 2012, Section 14Z2, updated for clinical commissioning groups, places a duty on CCGs to make arrangements to secure that individuals, to whom the services are being or may be provided, are involved (whether by being consulted or provided with information or in other ways) in the:
  o planning of the commissioning arrangements by the group
  o development and consideration of proposals by the group for changes
  o commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals, or the range of health services available to them, or in decisions of the group (CCG) affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Current guidance includes:

1.4 NEL CSU background and role

NEL CSU is the largest commissioning support unit (CSU) in the country. Our collaborative and innovative approach drives high standards in the consistency, reliability and quality of our work. We provide services to over 160 customers, including clinical commissioning groups across England, in London, Northamptonshire, Essex, Hertfordshire, Bedford, Luton, East Anglia, Kent, Surrey and Sussex, representing more than 10 million people. We also deliver a range of services and bespoke solutions to healthcare organisations across England, including hospital trusts, GP practices, mental health trusts, NHS England (nationally and regionally) and local authorities.

The review of the West Oxfordshire locality place-based primary care plan is led by NEL Healthcare Consulting, the transformation directorate at NEL CSU. We are an external, independent organisation with in-depth experience of primary care, communications, and engagement within the NHS.

Our skilled and experienced multi-disciplinary consultants are experienced in designing and delivering portfolio, programme and project management solutions and end-to-end transformation, in areas including out-of-hospital transformation, analytics, provider support, primary and secondary care, organisational development, whole system redesign and finance. Our team of communications and engagement specialists have delivered wide-ranging support including patient and public engagement and consultations for NHS clients with complex and varied needs, often in relation to contentious or unpopular service change proposals.

NEL CSU is a member of The Consultation Institute.

2. Methodology and approach

This review has been undertaken using NEL CSU’s established consultative approach. This includes desktop research of key documents followed by stakeholder interviews with representatives of: OCCG, clinicians, patients, representatives of patients and the public including Healthwatch, local councillors and the local MP.

The research has been undertaken by consultants who are subject matter experts in primary care and in consultation and engagement. The report has been written independently with assurance provided by NHS England.

We have tested our stakeholder interview questions, report structure and final report with an independent patient leader from the NHS England South East Patient Leader Programme to give assurance from a patient perspective.

2.1 Primary care review methodology

To ensure the findings of the primary care review of the locality place-based plan were aligned to the specific recommendations made by the Independent Reconfiguration Panel, six criteria were developed and agreed by NHS England to be used to assess OCCG plans and the process of developing these plans. A desktop assessment of the documents in scope of this review has aimed to ascertain whether these criteria have been fully evidenced, partially evidenced or not evidenced, based on the evidence identified within the locality place-based plan document (4 December 2017 iteration).
Assessment criteria

1. There is evidence that patients and the public have been engaged in assessment of their health needs
2. There is a strategic vision for Witney primary care in line with national and regional aims
3. The vision and solutions proposed are linked to and integrated with the wider OCCG and STP plans
4. OCCG has developed options for meeting their health needs
5. The solutions identified have been co-produced with public, patients and stakeholders
6. There is a clear and transparent primary care programme governance structure describing how strategic decisions are made, and how these are informed by patient and public voice.

This approach and the benefits it intended to achieve are outlined below.

2.2 Engagement review methodology

NEL CSU has reviewed the engagement plans, activities, and outputs and outcome of engagement report against national best practice guidelines and standards such as those outlined by The Consultation Institute, as well as legal requirements and NHS guidance for CCG engagement outlined in section 1.3 of this report. The review consisted of desktop research and stakeholder interviews conducted by phone, email and in person.
2.2.1 Desktop research

NEL CSU consultants read a number of key documents relating to the development of the West Oxfordshire locality place-based plan. These have been grouped into four categories listed below:

A) Documents in scope for third-party review
   - Engagement plan (part of the OCCG primary care commissioning papers – November 2017)
   - Locality place-based primary care plan: West Oxfordshire locality – 4 December 2017 iteration

B) Documents developed by OCCG to provide relevant context in relation to the development of the West Oxfordshire locality place-based and engagement plans
   - OCCG primary care framework
   - Developing GP services and a locality plan for the West Oxfordshire locality (PowerPoint – November 2017)
   - Developing GP services and locality place-based plan across Oxfordshire – engagement report

C) Independent Reconfiguration Panel documentation for background and context:
   - Letter from OJHOSC to the Secretary of State
   - OJHOSC minutes (containing the decision to refer)
   - NHS England letter to OCCG – July 2017
   - Letter from Independent Reconfiguration Panel to the Secretary of State – April 2017

D) NHS England guidance documents
   - NHS England General Practice Forward View
   - Patient and public engagement guidance as referenced in statutory requirements section 1.3 of this report.

Current editions of locality plans are on the OCCG website.

2.2.2 Stakeholder interviews

A number of stakeholders were identified by NHS England, OCCG and NEL CSU to provide further detail, expertise and experience of OCCG engagement.

Stakeholders were chosen based on their involvement with the project within West Oxfordshire and knowledge of the issues and challenges, including from a public and a clinical perspective. Some were chosen as representatives of the wider population to provide insight and personal reflections on the development of the plan. Interviews were based on questions (listed in appendix A) that were assured by NHS England and an independent patient expert with additional freeform conversations and were captured in writing by NEL CSU consultants.

Table A: stakeholder interviews

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Method</th>
<th>Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ally Green and Sarah Adair, OCCG Heads of Communications and Engagement</td>
<td>Email/ telephone call</td>
<td>A</td>
</tr>
<tr>
<td>Julie Dandridge, Deputy Director of Delivery and Localities/Head of Primary care, OCCG</td>
<td>Telephone call with interview questions A; a follow-up telephone call</td>
<td>A</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Method</td>
<td>Interview questions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Catherine Mountford, Director of Integrated Governance, OCCG</td>
<td>was agreed for OCCG to outline locality plan context to NEL CSU primary care subject matter expert</td>
<td></td>
</tr>
<tr>
<td>Ginny Hope, Head of Primary Care, NHS England South East</td>
<td>Email/ telephone call</td>
<td>B</td>
</tr>
<tr>
<td>Andrea Collins, Head of Communications and Engagement, NHS England South East</td>
<td>Telephone call</td>
<td>C</td>
</tr>
<tr>
<td>Graham Shelton, Locality Forum Chair (Patient) and Public and Patient Partnership for West Oxfordshire</td>
<td>Telephone call</td>
<td>D</td>
</tr>
<tr>
<td>Rosalind Pearce, Chief Executive, Healthwatch Oxfordshire</td>
<td>Telephone call</td>
<td></td>
</tr>
<tr>
<td>Brenda Churchill, Witney Town Councillor and Mayor of Witney, Previous patient of Deer Park and previous Chair of the Deer Park Patient Participation Group and one of the spokespeople of the campaign group</td>
<td>The pre-arranged telephone call was declined due to the context of the review not being as the participant anticipated.</td>
<td>C</td>
</tr>
<tr>
<td>Councillor Arash Fatemian, Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) Chair</td>
<td>Telephone call</td>
<td>E</td>
</tr>
<tr>
<td>Dr Kiren Collison, Deputy Locality GP Chair and incoming OCCG Clinical Chair</td>
<td>Telephone call</td>
<td>F</td>
</tr>
<tr>
<td>Robert Courts, MP</td>
<td>Face-to-face meeting</td>
<td>E</td>
</tr>
<tr>
<td>Peter Emery, West Oxfordshire District Council</td>
<td>No response was received from this stakeholder</td>
<td>E</td>
</tr>
</tbody>
</table>

### 2.3 Patient leader input

NHS England nominated a patient leader to give assurance from a patient perspective that:

- the report structure and scope of the report was adequate and would be easy to understand
- interview questions were suitable and would be able to identify the information required for the review
- an opportunity was given to recommend further actions and raise issues which may not have been included.

The patient leader is an independent expert patient with no affiliation to Oxfordshire.
3. Key findings

Key findings are detailed in this section using data gathered from the desktop review of documents and feedback from stakeholders.

This provides a narrative overview of the evidence that reviewers have found within the key documents in scope of this review. Further specific recommendations on how OCCG can strengthen the West Oxfordshire locality place-based plan and their engagement into it are included in section 4 of this report.

3.1 Primary care review

The West Oxfordshire locality place-based and engagement plans were assessed against the criteria as agreed with NHS England. The table below shares details for each criterion as ‘fully evidenced’, ‘partially evidenced’ or ‘not evidenced.’ The evidence identified within the plan to support this has also been provided to ensure transparency in respect to how the reviewer’s conclusions have been reached.

Table B: Findings from primary care review and evidence identified

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Fully evidenced/partially evidenced/not evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
</table>
| 1 There is evidence in the plan that there has been engagement of the public and patients in assessing future health needs | Partially evidenced                                | The review identified that there has been engagement of patients and the public in assessing future health needs and includes the following information identified within the 4 December 2017 iteration of the locality place-based primary care plan: West Oxfordshire locality. The approach for wider engagement was agreed by the West Oxfordshire Locality Forum Chair and by Healthwatch Oxfordshire. There were two patient and public events held on 1 and 8 November 2017. At these events the following needs were identified by people who attended:  
  - Continuity of care for the elderly and people with long term conditions  
  - Transport  
  - Improved access to pharmacy and GP practices to see both GP and nurses – people waiting too long for appointments  
  - Keeping older people active  
  - Provision of gerontology expertise closer to their homes  
  - Given levels of self-harm – mental health support for young people. |
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Fully evidenced/partially evidenced/not evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evidence of the needs identified could be strengthened with a section on need in Part B or the Part D – Priority 1 sections of this iteration of the plan. Whilst the summary and health of population are described, it would be useful to conclude with the list of specific needs this information identifies, linking back to the patient and public engagement report and how this has informed the identification of needs. This criteria was found to be partially evidenced. There was no specific evidence that showed a link between the needs, options and solutions outlined in the plan with public and patient engagement into the assessment of future health needs, as outlined in the Independent Reconfiguration Panel recommendations.</td>
<td></td>
</tr>
</tbody>
</table>

2 There is a strategic vision for primary care and related services in Witney in line with national and regional aims

<table>
<thead>
<tr>
<th>Fully evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially evidenced</td>
<td>Evidence of the needs identified could be strengthened with a section on need in Part B or the Part D – Priority 1 sections of this iteration of the plan. Whilst the summary and health of population are described, it would be useful to conclude with the list of specific needs this information identifies, linking back to the patient and public engagement report and how this has informed the identification of needs. This criteria was found to be partially evidenced. There was no specific evidence that showed a link between the needs, options and solutions outlined in the plan with public and patient engagement into the assessment of future health needs, as outlined in the Independent Reconfiguration Panel recommendations.</td>
</tr>
</tbody>
</table>

3 There is evidence that the vision for Witney and solutions proposed are linked to and integrated with the wider OCCG and STP plans

<table>
<thead>
<tr>
<th>Fully evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially evidenced</td>
<td>Evidence of the needs identified could be strengthened with a section on need in Part B or the Part D – Priority 1 sections of this iteration of the plan. Whilst the summary and health of population are described, it would be useful to conclude with the list of specific needs this information identifies, linking back to the patient and public engagement report and how this has informed the identification of needs. This criteria was found to be partially evidenced. There was no specific evidence that showed a link between the needs, options and solutions outlined in the plan with public and patient engagement into the assessment of future health needs, as outlined in the Independent Reconfiguration Panel recommendations.</td>
</tr>
</tbody>
</table>

1 Page 33-38 - Locality place-based primary care plan: West Oxfordshire locality – 4 December 2017 iteration

2 Page 2 – as above
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Fully evidenced/ partially evidenced/ not evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
</table>
| A more efficient system with more health and social services working together providing services closer to home | • A more efficient system with more health and social services working together providing services closer to home  
• Better access to mental health services and the introduction of digital solutions (such as virtual consultations) and self-management tools, making it easier for people to access advice and care 24/7  
• A focus on prevention. Offering bespoke packages to support people to adopt healthier lifestyles and reduce preventable ill health and long-term conditions. | This criteria could not be shown to be fully evidenced because there was not enough information in the locality plan showing the alignment with and relationship between plans. In particular to how GP practices would integrate to meet greater levels of need in an ageing population at greater scale or how affordable the proposed solutions are.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Priority 1: Meeting the needs of the ageing population3                  | Priority 1: Meeting the needs of the ageing population3  | The review identified that OCCG has developed solutions within the locality place-based plan for meeting the population’s current and future needs and that they are aligned to the CCG’s four key priorities. However, these are not comprehensive and require more detail, as outlined below, and the review therefore judged them to be partially evidenced.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Options for meeting current and future demand are listed4 in the locality place-based plan. Equity of access to (option d) care/nursing homes – access to a gerontologist or an interface being developed with an opt-in approach for general practice: the plan would benefit from understanding how this approach has been received by patients and the public. Increased access to gerontology and nursing home services has been expressed as a need by patients and the public, therefore options could be strengthened by being |  | |
### Priority 1: Increased access to primary care and urgent care

Evidence of criteria identified within the document:

- There is potential for inequity of access if a care home’s general practice does not opt into this service.
- Increasing the capacity of primary care visiting services (option e) – emergency practitioners: the plan could be strengthened by including the numbers of practitioners that would be needed and by when.
- There are conflicting statements in respect to meeting needs in this priority area. Page 21 of the locality place-based plan describes that there is good access to primary and urgent care in West Oxfordshire. However, feedback from patients and the public at events held on 1 and 8 November 2017 included that access could be improved to both GP and nurse appointments. Therefore, the December version of the plan is saying two different things in regards to current levels of access and whether this is meeting the needs of the population.

### Priority 2: Safe and sustainable care

Addition of an urgent access hub – it would be useful to understand more about the positive impact of this hub for people who have used it, in order to strengthen the reasoning for developing a second hub in the future.

Increasing numbers of allied health care practitioners with particular skill-sets. The plan could be strengthened by understanding how many more staff are required and at what point they would be required.

Patient involvement – usefully contains examples of how signposting will be delivered through stronger patient involvement in signposting.

The detailed plans conclude that most options would require funding sources to be approved before implementation. Further iterations of the plan would benefit from further

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5 Page 24 – as above
6 Page 25 – as above
7 Page 25, option d – as above
8 Page 30-33 – as above
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Fully evidenced/partially evidenced/not evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>There is evidence that the solutions identified for meeting these needs have been co-produced with public, patients and stakeholders</td>
<td>Not evidenced</td>
</tr>
<tr>
<td></td>
<td>Draft priorities were discussed with the public and patient partnership forum. However, this criteria was found not to be evidenced. This is because:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- There was no definition of what is meant by the term 'co-production'.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reviewer was unable to identify evidence that the solutions identified were co-produced with patients and the public. The West Oxfordshire locality place-based primary care plan may have been produced with key stakeholders who may be involved with implementing the changes in the future. However, there is no evidence in the plan that enables the review to conclude that these solutions have been co-produced.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Note the definition of co-production used in OCCG primary care framework described patients 'co-producing' their own care plan with clinicians rather than co-producing solutions to meet population needs. A consistent definition would be of</td>
<td></td>
</tr>
</tbody>
</table>

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9 Page 27 – as above
10 Page 28 – as above
11 Page 7/8 – as above
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Fully evidenced/partially evidenced/not evidenced</th>
<th>Evidence of criteria identified within the document</th>
</tr>
</thead>
<tbody>
<tr>
<td>benefit and provide evidence that solutions are being co-produced to align with NHS England’s definition. NEL CSU notes that co-production is a lengthy process and it would be difficult to undertake true co-production in the six month timescale set to develop this plan. However, by identifying what it means locally co-production with patients and the public can be more readily undertaken in future and more easily demonstrated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a clear and transparent primary care programme governance structure describing how strategic decisions are made and how these are informed by patient and public voice</td>
<td>Partially evidenced</td>
<td>Whilst unable to identify a governance structure that described how decisions are made or how they are informed by the patient and public voice, the place-based locality plan does mention a number of patient events and patient and public participation forums where the plans have been discussed. Whilst unsure how the outputs of the patient and public participation work inform/influence/shape strategic board-level decisions, the engagement process has been signed off by Healthwatch Oxfordshire and locality leads. The governance framework may exist in other documentation outside of the scope of this review. However, because it was not included in the documents this criteria can only be seen to have been partially evidenced. Further iterations of the report would benefit from greater transparency in how decisions about local transformational change are being made, who is involved in these decisions, providing further credibility of the leadership and strengthening relationships across the system. The detailed planning for the future could also be strengthened by assigning responsible owners to individual work streams.</td>
</tr>
</tbody>
</table>

12 Pages 30-32 – as above
3.2 Patient and public engagement review

Engagement findings have fed into the primary care criteria review. Further feedback, below, is a narrative reflection following desktop research of engagement documents and stakeholder interviews.

3.2.1 Engagement plan

Between August and December 2017, Oxfordshire CCG conducted patient and public engagement to support the development of the West Oxfordshire primary care locality plan. OCCG produced a communications and engagement plan which outlined how they planned to undertake patient and public engagement to develop the first version of the West Oxfordshire locality plan. This plan was published and assured at the Oxfordshire primary care commissioning committee on 7 November 2017, of which NHS England is an attendee.

This engagement plan was developed following discussions about engagement with: key stakeholders at a stakeholder workshop hosted by Healthwatch Oxfordshire; the West Oxfordshire Locality Forum; members of the previous patient participation group at Deer Park Medical Centre; and at a meeting in public of the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC). Most of these meetings were held in September 2017. The plan was also informed by previous intelligence and feedback from Healthwatch Oxfordshire and was then shared with Healthwatch Oxfordshire, the West Oxfordshire Locality Forum Chair and a local council representative. Additional feedback given about the public events was taken into consideration and the format of those events included a question-and-answer session allowing people to make their views and feelings known.

Although the engagement plan was shared, feedback received and plans amended, from our review there is no evidence that the engagement plan was co-produced with patients and the public. Reviewers have not found that patients have developed the engagement plan in equal partnership with the CCG nor have there been opportunities for shared decision-making with patients and the public.

The communications and engagement plan lacks detail in a number of areas, which means it does not adequately reflect the breadth of work undertaken by OCCG both during this period and during previous engagement informing the plan.

3.2.2 Engagement activities

Below is a narrative overview and description of engagement activities. This has emerged from the desktop review of the engagement plan, the engagement feedback report produced by OCCG and feedback from stakeholders gathered via interviews.

- Informal stakeholder workshop, September 2017
  Healthwatch facilitated a workshop with stakeholders (including councillors, the local MP, GPs and the former Chair of Deer Park patient participation group) to discuss the development of the locality primary care plan and to give stakeholders the opportunity to input. This meeting was well received by stakeholders who felt it was a useful session.
However, there was some confusion from members of OJHOSC as to who was invited and the purpose of the meeting.

- **Three public meetings, held during November and December 2017**
  Two meetings were round-table events with a presentation from OCCG to discuss draft locality priorities including future health needs. The third meeting reported back public responses, OCCG plans and offered opportunity for further open discussion.

  Members of the public and stakeholders were given one month’s notice about these meetings. Some interviewees suggested this was not long enough, in particular, for key political stakeholders. Some also suggested this provided insufficient time to consider properly the issues and to respond.

  People were asked to pre-register their attendance so OCCG could estimate how many people would attend. This caused confusion as to whether the events were open to all or only to people who had registered. All those who wished to attend could, although there was a perception that some people would physically be turned away if they had not registered. Last-minute venue changes to accommodate a larger-than-expected audience also caused confusion. OCCG ensured that staff were at both venues to signpost and mitigate any issues. Key stakeholders, such as the Chair and members of OJHOSC, were not formally invited.

  Feedback from each event was incorporated into the next one. For example, an OCCG presentation was updated to reflect what OCCG had been told during previous events. The final event, which was intended to feedback responses, still offered members of the public an opportunity to give their views with OCCG taking comments at this stage.

- **Two public surveys**
  OCCG ran an initial survey to gather people’s responses to the locality plan. A second survey was made available online alongside the draft primary care plan. This invited further comments on the draft document before publication at the end of January 2018 and included information on the feedback received on the plan to date.

  People were asked whether or not they agreed with a set of priorities put forward by OCCG, to discuss what they felt works well currently in primary care and offer solutions as to how services could be improved.

  The initial survey was hosted on OCCG’s consultation hub for practical reasons. An early version of the document contained the word ‘consultation’. This caused some confusion as to whether this period of engagement was a formal consultation or not. This confusion was acknowledged by OCCG, text was updated and the survey was moved to a different area of the CCG’s website.

- **Ongoing engagement with the Locality Patient Forum (Public and Patient Partnership for West Oxfordshire)**
  OCCG attended and spoke at the monthly meetings of the group to keep members updated on the engagement process.

- **Attending meetings by invitation**
  OCCG has responded to requests from groups (such as patient participation groups, campaign groups and other political stakeholders) for meetings to discuss the plans.

- **Communication was conducted** via social media, newsletters, the media, posters in GP surgeries and the OCCG website to encourage residents to attend meetings and respond to
the survey. Much of the communication was to Oxfordshire residents as part of wider geographic engagement to develop six locality place-based primary care plans. One of these was for West Oxfordshire (Witney and the surrounding area). Stakeholders felt that there was an overreliance on digital communication.

- **Stakeholder management**
  Although stakeholder management was referenced in the OCCG communications and engagement plan feedback from interviewees suggested that key stakeholders were not all updated adequately or to the extent they wanted. For instance OJHOSC was not updated with information on reporting dates and the Chair was not formally invited to attend any events. The local West Oxfordshire MP was not consulted on dates of any public meetings and was given four weeks’ notice of events making it difficult for him to attend.

  There was a desire from all stakeholders to work more closely and effectively with OCCG to improve communications and engagement and develop workable solutions for the future. However most felt that this was hindered by poor communication from OCCG, limited briefings and a lack of links in some key areas (such as the planning committee to consider the impact of growth).

  Overall, stakeholders felt that engagement during this time was adequate, given the timing restrictions of the Independent Reconfiguration Panel recommendations. Some stakeholders noted that the public was uneasy about the length of time given for this phase of engagement.

  It is important to recognise that this phase of engagement is part of on-going engagement during 2017 around primary care. It is unclear how earlier engagement (pre August 2017) has influenced the early thinking about primary care in West Oxfordshire.

OCCG has indicated that it expects to undertake further engagement following the publication of the locality plan at the end of January 2018. This future engagement is likely to focus on gathering feedback from groups that OCCG has heard less from during previous engagement phases and may include young people and those with mental health issues. Future plans for engagement work have not been published.

### 3.2.3 Considering equalities and reach into the community

An equalities analysis has been undertaken on the place-based plan. This information has not directly informed OCCG’s engagement approach, i.e. which groups or communities to engage and prioritise. Although a number of seldom-heard groups are listed within the communications and engagement plan, other than through email communication it does not appear that specific efforts have been made through this phase of engagement to target them and hear their views.

Anecdotal feedback suggests that the majority of those engaged throughout this phase are already well engaged with OCCG and have broadly been from the older white demographic, as detailed in OCCG’s engagement report published in December 2017.

Engagement also has tended to be through groups who represent patients. Key channels for OCCG and the reach and representativeness of engagement mechanisms (such as the Locality Patient Forum and PPGs) should be examined as they are heavily relied on.

### 3.2.4 Impact of patient and public feedback

From OCCG’s engagement report and from stakeholder feedback it is clear that, throughout this phase of engagement, OCCG has listened to patient and public feedback. There is evidence within the engagement report that feedback has already influenced the West Oxfordshire locality primary
care plan. Feedback received was reflected back to the community at the final event. Presentations were updated for meetings with various stakeholders and the final engagement report sets out indicative CCG responses to all of the feedback received.
4. Recommendations

After conducting this third-party review, we have set out our recommendations below to support the further development of the West Oxfordshire locality place-based plan and OCCG engagement.

NEL CSU believes these would strengthen OCCG’s engagement approach and improve the relationship with patients, the public, and other key stakeholders and ultimately demonstrate the value that commissioners place on co-producing the next iteration of their plans with their populations.

The recommendations refer to a number of general principles for strengthening future engagement and transformation plans. There are also a number of more specific recommendations aligned to the criteria outlined in section 3.1 of this document that require actions to be taken to strengthen content of the plan in these areas.

Table C: Recommendations identified

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Increase confidence in patients and public of OCCG’s commitment to engage through more detailed and active communication | Improve documentation and provide greater clarity and more active stakeholder management:  
  - Documentation needs to be clearer in purpose, scope and include a greater depth of information. This would give transparency to plans, decision making and reassure stakeholders. Specifically:  
    o Explain the purpose of the document  
    o Outline how it has been developed, including historic activity  
    o Detail who has supported the development of the document and how it would be assured  
    o Explain decision making processes and feedback loops.  
  - Greater clarity in documents and in language:  
    o Be explicit around whether processes are engagement or formal consultation, what these mean for the public and their ability to influence plans  
    o Ensure that the purpose of documents, meetings and events is clearly explained.  
  - Engagement planning should be more detailed and plans should set out:  
    o That the process of engagement is ongoing  
    o How earlier engagement has impacted on where OCCG is now  
    o Future plans for engagement and how this particular phase relates to it  
    o What areas OCCG is seeking feedback on and what areas patients and the public can genuinely influence, e.g. assessment of population need. Individual patient and public events aimed at the key needs identified would... |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| **Enable more detailed discussions and provide opportunities to co-produce future solutions to address these needs.** | enable more detailed discussions and provide opportunities to co-produce future solutions to address these needs. (Relates specifically to meeting evidence in respect to criteria 1, 4, and 5 in Section 3.1)  
- More information on planned activities, how they would be undertaken and a breakdown of how stakeholder groups would be targeted  
- How stakeholders would be prioritised  
- How non-digital channels would be used to reach the population  
- Who is being asked to cascade and promote engagement  
- How responses would be monitored and what efforts would be made to reach out to groups who have not responded  
- How feedback from engagement activity would be responded to and reported. |
| **The inclusion of a clear governance structure aligned to the outline mobilisation plan (page 37 of the place-based plan) would also increase confidence in OCCG’s commitment to engage.** | The inclusion of a clear governance structure aligned to the outline mobilisation plan (page 37 of the place-based plan) would also increase confidence in OCCG’s commitment to engage. (Relates specifically to meeting evidence in respect to criterion 6, Section 3.1) |
| **More emphasis on stakeholder management and communication is needed, by providing more timely and regular updates to all stakeholders regarding progress and process, closer liaison with political stakeholders when planning engagement events, and ensuring clarity around the purpose of events and meetings.** | More emphasis on stakeholder management and communication is needed, by providing more timely and regular updates to all stakeholders regarding progress and process, closer liaison with political stakeholders when planning engagement events, and ensuring clarity around the purpose of events and meetings. |
| **Planning of engagement activities needs to ensure an appropriate period of engagement in order for all stakeholders to engage effectively and respond. Key stakeholders and groups likely to be affected by changes need appropriate notice of events and activities.** | Planning of engagement activities needs to ensure an appropriate period of engagement in order for all stakeholders to engage effectively and respond. Key stakeholders and groups likely to be affected by changes need appropriate notice of events and activities. |
| **Consider equalities and seldom-heard groups in all engagement activities** | - OCCG’s engagement needs to ensure that it includes all groups likely to be affected by any proposed changes, as identified through an equalities impact assessment, with emphasis on characteristics that are protected by the Equality Act 2010. Plans should outline how groups likely to be impacted by changes would be engaged.  
- OCCG should take a proactive approach to out-reach engagement with patients, members of the public and groups from whom OCCG has not heard. This might include people who are not linked to formal groups (e.g. individual members of the public) or who are not currently using health and care services. |
| **Develop a vision to strengthen appetite and enthusiasm for change** | Develop a vision owned by the locality, easily articulated and aligned to the vision for wider Sustainability and Transformation Partnership and the Oxfordshire Primary Care Framework  
- The next iteration of the place-based plan should include the development of a vision for the West Oxfordshire locality that is aligned to that of OCCG and the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership. (Relates specifically to meeting evidence in respect to criteria 2 and 3 in Section 3.1) |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Relating to criteria 2 and 3 | • All documents across the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership and Accountable Care System, Oxfordshire CCG primary care framework and the Locality place-based plan would benefit from a ‘road map’ of how they all fit together.  
• The existence of a clear vision that has been developed and owned by West Oxfordshire Locality could make it easier to share what the programme is aiming to achieve.  
• A key national strategic aim detailed within the GP Forward View is for primary care to transform so that it is sustainable and meets the population’s needs now and in the future. Including further detail on the resource required in West Oxfordshire locality, and specific benefits this would achieve could engage patients and public more effectively. |
| Co-production Relating to criterion 5 | • The plan should be co-produced with patients. OCCG needs to be clear about their local definition of co-production and how this would work. This might include patients being empowered to work with OCCG to write future iterations of the plan, e.g. assessment of population need. Individual patient and public events aimed at the key needs identified would enable more detailed discussions and provide opportunities to co-produce future solutions to address these needs. (Relates specifically to meeting evidence in respect to criterion 5 in Section 3.1). |
| More detailed definition of change to increase understanding | |
## Theme | Recommendation
--- | ---
| | o Capacity: aiming for an additional 30 to 45 minutes consultation capacity per 1,000 population.
| | o Models of care: the OCCG primary care framework contains more detail on new models of care than is currently expressed in the locality place-based plan. More visible alignment between these two documents would enable people to understand potential impact and how realistic these ambitions are – for instance: neighbourhood services, locality services and services people would see that are different to what they have already at their primary care/GP surgeries.
| | o Workforce: tables have been included to indicate the increase in specific roles that will be required. It would be helpful for patients and public to understand how the increases proposed meet the increased need for them to comment/engage meaningfully with the process. Where new roles are being proposed, role descriptions, the benefits they are intended to bring and how these relate to Five Year Forward View ambitions would be helpful information.
| | o Estates: further detail on what physical changes people could expect to see and when e.g. number of primary care centres/estate. This would improve transparency in respect to future plans and reduce anxiety when changes are proposed, subject to further planning and consultation where appropriate. Where estates could be reduced in number, future solutions for maintaining equal access for those more frail and/or less mobile may need to consider transport solutions as expressed by the patient and public voice.
| | o Digital: how ambitious these plans are would be more easily understood where further detail on the current state could be provided. For example defining shared records and services that could be accessed 24/7 would help stakeholders, patients and the public understand the benefits this would bring and the potential impact.
5. Next steps

- The third party review document will be published by NHS England on 30 January 2018 on its website within the publications section and shared direct with key partners and members of the public.

- The review document has also been sent to the Secretary of State for Health, Rt Hon Jeremy Hunt MP and copied to Lord Ribeiro, Chairman of the Independent Reconfiguration Panel to note that the recommended third party review of Oxfordshire Clinical Commissioning Group’s (OCCG) primary care plans for Witney and the surrounding area has been conducted and published with recommendations shared with OCCG and a full update provided to Oxfordshire Joint Health Overview and Scrutiny Committee on 8 February 2018.

- The review document will inform further discussion between NHS England and Oxfordshire Clinical Commissioning Group (OCCG) with a view to supporting OCCG to evolve further iterations of the West Oxfordshire locality plan as they co-produce their plan with patients and the public.

- The review document and subsequent activities will also form part of discussions between OCCG, NHS England and Oxfordshire Joint Health Overview and Scrutiny Committee at its committee meeting in public on 8 February 2018.

- OCCG, NHS England and Oxfordshire Joint Health Overview and Scrutiny Committee, together with other health organisations in Oxfordshire participated in an independently facilitated workshop on 18 January 2018 to develop working principles for the future.

To discuss receiving this information in an easy read or another format please ring 01865 963 896 or email england.southcomms@nhs.net
Appendix A – Stakeholder questions

A – Oxfordshire CCG

Developing the engagement plan
1. Can you explain the process for developing the engagement plan?
2. How and at what stage (i.e. how early in the process) were PPGs, patients and the public and stakeholders involved in developing the engagement plan?
3. How did their feedback incorporate into the plan?
4. Was an equalities analysis undertaken on the project?
5. What outreach approaches were considered for those who could not attend the two public engagement meetings, given the demographics in the area?
6. How did your equalities analysis shape the stakeholder list outlined in the engagement plan?
7. The plan references attending meetings/events by invitation. How were these promoted and what was the uptake?

Developing the primary care plan
8. Please describe the engagement activities undertaken in order to develop the primary care plan.
9. How have PPGs, patients and the public been involved in developing the primary care plan?
10. How have Healthwatch, voluntary and community groups and other interested patient groups been involved in developing the primary care plan?
11. What have patients been able to influence throughout this engagement process? What areas of the plan were people asked to respond to (either at the public events or through the survey)?
12. Was a stocktake undertaken during the engagement period to ensure OCCG was reaching and receiving responses from the right audiences?
13. How representative of the population do you feel the engagement to date has been?
14. The engagement plan refers to Public and Patient Partnership for West Oxfordshire (PPPWO) continued engagement. What did this include?
15. How did you work with the voluntary and community sector and other stakeholders to promote/cascade engagement opportunities?
16. What part has Healthwatch played in planning, running and reporting the two public events?
17. How continuous was the engagement?
18. How did the feedback you received influence the development of the primary care plan?
19. What plans are there to close the feedback loop and communicate next steps?
20. Are there any plans for further engagement on the plan?
21. Did those you engaged with have the opportunity to comment on the final version of the primary care plan? If so, what was their feedback?
22. Reflecting on the engagement work you have undertaken to date, is there anything you would have done differently?

B – NHS England
1. What feedback has NHS England given around the engagement plan?
2. Did NHS England attend either of the public engagement events? If you did, what were your impressions?
3. Do you feel OCCG has been successful in engaging patients and the public in assessing current and future health needs?
4. Do you feel OCCG has been successful in engaging patients and the public in understanding the options for the future of primary care services?
5. Do you feel OCCG has been successful in co-producing solutions for the future of primary care with patients and the public?
6. Reflecting on the engagement work OCCG has undertaken to date, is there anything you feel could have been done differently?
C – Patient stakeholders
1. How were you involved in developing the engagement plan? If yes, at what stage were you brought into the process?
2. How have you been involved in developing the primary care plan? If yes, at what stage were you brought into the process?
3. What opportunities did you have to comment on the final version of the primary care plan? What was your feedback?
4. How well do you feel the engagement period has been publicised?
5. How have you personally been encouraged to respond during this period of engagement?
6. Were you able to attend either of the public events? If you were, what was your experience of engaging on this topic?
7. Throughout the process of developing this plan and the engagement activities themselves, how have you been listened to and your comments taken on board?
8. How do you feel you have been able to influence the future of primary care services?
9. How do you feel the engagement activities went (events/survey)?

D – Healthwatch Oxfordshire
1. How have you been involved in developing the engagement plan? If yes, at what stage were you brought into the process?
2. How have you been involved in developing the primary care plan? If yes, at what stage were you brought into the process?
3. What opportunities did you have to comment on the final version of the primary care plan (including the list of stakeholders)? What was your feedback?
4. How have you been involved in planning, running and reporting on the two public engagement events?
5. How far do you feel you have been able to advise on best practice approaches to engagement throughout this project?
6. How adequate do you feel the engagement has been in developing plans for the future of primary care services?
7. How representative of the population do you feel engagement activities have been?
8. How do you feel the engagement activities went (events/survey)?
9. Are there any areas of the engagement plan which you feel could have been improved upon?

E – Political stakeholders
1. How have you been encouraged to respond during this period of engagement?
2. From your perspective, how well do you feel patients, residents and stakeholders have been engaged in developing solutions for the future of primary care?
3. From your own experience and/or the experience of your constituents, how do you feel the engagement activities went (events/survey)?
4. Is there other engagement activity you would have liked to have seen?

F – Clinical stakeholders
1. How have you been involved in developing the engagement plan, and what was your feedback?
2. How have you been involved in developing the primary care plan, and what was your feedback?
3. How has the feedback from patients, the public and other stakeholders been incorporated into the development of the engagement plan?
4. From your perspective, how well do you feel patients, residents and stakeholders have been engaged in developing solutions for the future of primary care?
5. How do you feel the engagement activities went (events/survey)?
6. Is there other engagement activity you would have liked to have seen?
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HOSC and Health ‘Ways of Working’ Workshop Report

Joint Health Overview and Scrutiny Committee
8th February 2018

1.0 Purpose

1.1 The Independent Reconfiguration Panel (IRP) made recommendations to Oxfordshire following a referral by the Oxfordshire Joint Health Overview and Scrutiny Panel (HOSC) on Deer Park Medical Centre in 2017. JHOSC and health partners were advised to consider how they can “work together differently to command public confidence and maintain an open relationship”. The purpose of this report is to outline the process, outcomes and next steps for a workshop that was held to respond to this IRP recommendation.

2.0 Introduction

2.1 In response to advice from the IRP, a ‘Ways of Working’ workshop was held on the 18th of January 2018 at the Kings Centre, Oxford with HOSC members and health representatives. The objectives, structure and agenda of the workshop was jointly agreed between HOSC and health partners and aimed to achieve the following objectives:

- Committee members and health partners are certain about the objectives and intended outcomes of scrutiny activity.
- Best practice and learning from other local areas is used to inform jointly agreed working principles.
- Mechanisms are developed that help HOSC and Health partners identify when a topic needs to be brought to the committee, including being clear about the appropriate use of the substantial change toolkit.
- There is a clear understanding of when joint committees will/should be established with neighbouring areas to scrutiny issues/proposals.
- The Committee has the tools available to better understand the financial context that Health partners operate in.

2.2 The workshop was well attended by representatives from JHOSC, Oxfordshire Clinical Commissioning Group, Oxford University Hospitals, Oxford Health and NHS England South (South Central). The session was independently facilitated by a representative of the Consultation Institute who had specific knowledge and understanding of the IRP and health landscape.

3.0 Outcomes

3.1 Lessons from the toolkit
A session was held with participants to consider the lessons learned from recent applications of the Oxfordshire Substantial Change Toolkit. Participants identified the following points:
a) Having a toolkit and assessment process is helpful in initiating debate and encouraging openness and transparency. If completed well, the toolkit can offer useful evidence for change and the process. There was recognition that what constitutes ‘substantial change’ will always be through the lens of the individual or organisation e.g. change for specific people, specific communities or in an Oxfordshire (or wider) population.

b) However, there is little flexibility in the existing process to allow early dialogue and discussion. Alternative ways of working would be helpful to tackle this (for example forming reference groups, task and finish groups, workshops, seminars or briefings).

c) The existing toolkit requires proposals to be well progressed and significant detail to be available. This does not work well for small-scale change or temporary change and makes the timing and process of a toolkit ineffective for scrutiny. Introducing a high-level step earlier in the assessment process would be helpful.

d) There is ambiguity and confusion regarding what is ‘substantial’ change. Clarity on what thresholds should trigger an assessment should be introduced- and be able to be applied in circumstances where change is small-scale and/or temporary as well as more significant change.

e) The toolkit does not currently include a section on the outcome of HOSC discussions/judgements or the outcome of changes that were implemented. Recording the outcome of the assessments by HOSC and the outcome of the change itself would assist clarity and evaluation of change.

3.2 Developing working principles for Oxfordshire

Using learning from local experience, other IRP recommendations and examples of working principles that have been developed elsewhere in the country (from Cheshire East, Lincolnshire and Hampshire) participants discussed working principles that may be important for HOSC and health in Oxfordshire. The following were determined to be important to include in a documented and agreed set of ‘ways of working’ principles/code of conduct/protocol for Oxfordshire:

a) The goal for all working in HOSC and health in Oxfordshire is common; to delivery high quality and sustainable health and care services that meet the needs of the local population. This includes addressing inequalities and focuses on improving outcomes for patients.

b) It is important to recognise the different frames of reference that occur so what is described and seen as best outcome is likely to be seen differently (e.g. for an individual, local community or population-wide).

c) Whilst HOSC and health may work to different constitutions, codes of conduct and behavioural frameworks; respect is a cornerstone of relations between HOSC and health.

d) Evidence presented to HOSC should be appropriate, credible and clearly presented. The view of clinicians should be clearly demonstrated as part of the evidence for proposals, discussions and evaluations.

e) Feedback from HOSC should be documented and communicated.

f) There should be a ‘no surprises approach’ so engagement with HOSC should be early to allow scrutiny to be a critical friend and be proactive not reactive.

g) Working together to reduce ambiguity around the toolkit and the change process.
4.0 Next steps

4.1 Participants discussed actions needed to take forward the learning from the toolkit and the development of working principles for Oxfordshire. The following steps are therefore recommended in the following timeframes:

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>1</td>
<td>Develop working principles that can be signed up to by HOSC and health colleagues.</td>
<td>April 2018</td>
</tr>
<tr>
<td>2</td>
<td>Amend the change process to introduce a staged approach with different thresholds of change (i.e. minor/temporary/moderate/significant).</td>
<td>June 2018</td>
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<td>3</td>
<td>Introduce more flexible and different ways of working to allow for early engagement, dialogue, feedback, evaluation (for example, briefings, task and finish groups, reference groups, debriefs, visits, annual planning event and training).</td>
<td>April 2018</td>
</tr>
<tr>
<td>4</td>
<td>Change the layout of meetings/presentations so health representatives sit ‘with’ and not ‘in front’ of HOSC.</td>
<td>February 2018</td>
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<tr>
<td>5</td>
<td>Robust feedback and communications (e.g. ensure HOSC feedback is recorded and communicated).</td>
<td>February 2018</td>
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<tr>
<td>6</td>
<td>Set an evaluation and reporting back framework.</td>
<td>June 2018</td>
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5.0 Recommendations

5.1 This report is provided to HOSC by way of feedback on an IRP recommendation. It is recommended that HOSC:

1. **NOTE** the report and progress made against the IRP recommendation.
2. **AGREE** the 'next steps' outlined in section 4 of this report.
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Chemotherapy services at Oxford University Hospitals NHS Foundation Trust

Increasing demand for chemotherapy treatment

Over the past 5 years, the number of patients receiving chemotherapy locally has increased by 10-12% each year. This increase in demand has been driven by:

- Increasing incidence of cancer, particularly within an ageing population.
- Improved survival of cancer patients (both as a result of treatment improvements and of screening and symptoms awareness), resulting in the disease becoming a chronic condition for some, with a corresponding requirement for ongoing treatment and an increased number of cycles per patient.
- The introduction of new treatments – this can happen quickly with significant implications, particularly if a tumour site with a large number of patients is involved, eg breast cancer.
- An increase in novel immunotherapy treatments licensed for use for treatment.
- A significant amount of work which has been undertaken so that more patients previously treated as inpatients are now treated as day cases.

The table below outlines the growth in both patient and treatment numbers for chemotherapy

![Chemotherapy - Patient and prescriptions trend, 2009 to 2016](image)

Performance against national performance standards for chemotherapy treatment

Oxford University Hospitals has consistently met the national performance standard that at least 98% of patients will start administration of chemotherapy within 31 days of a clinician making the decision that chemotherapy is the appropriate course of treatment.

The table at the top of page 2 summarises performance against the 31-day target since 2015.
Chemotherapy services in Oxford and Banbury

The OUH Chemotherapy service is currently provided from:

- The Day Treatment Unit (DTU) at the Churchill Hospital in Oxford which has 30 chemotherapy treatment chairs and 12 chemotherapy treatment beds. Treatment beds enable patients to receive treatment lying down. They are not inpatient beds to which patients are admitted.
- The Brodey Cancer Centre at the Horton General Hospital in Banbury which has 8 chemotherapy treatment chairs.

The Day Treatment Unit at the Churchill Hospital is open 6 days a week, from 8am to 7pm Monday – Friday and from 8am to 4pm on Saturday. The Brodey Cancer Centre is open from 8am to 6pm Monday – Friday.

In addition to intravenous and subcutaneous chemotherapy treatments, the two hospital units also provide other treatments including blood transfusion, line insertion and venesection. This includes treatment for some patients with benign disorders.

In 2017, on average, the two unit combined saw 90-95 patients per day, approximately 60 with chemotherapy and 30 receiving blood transfusion or other supportive treatments.

In addition, some patients receive chemotherapy at home through a contract with an external provider. These patients remain under the care of the NHS and their treatment is free at the point of delivery.

Clinical leadership of chemotherapy services

The Trust has a Chemotherapy Operational Group (COG) which includes key staff involved with the delivery of chemotherapy services at OUH.

This group:

- Meets monthly to discuss operational issues – it also has a monthly sub-committee which discusses strategy for chemotherapy delivery.
- Leads discussions and implements changes in order to ensure the provision of an efficient and safe chemotherapy service.
- Is responsible for ensuring that cancer drugs within OUH are being delivered and monitored utilising consistent, evidence based and appropriate clinical protocols and guidance.
- Reports to the Trust’s Medicines Management Therapies Committee (MMTC) and feeds into directorate management meetings.
The group is well established. It has been in existence since 2007 with the same chemotherapy lead clinician, nurse and pharmacist. There is representation across the different staff groups within both Oncology and Haematology.

**Nursing vacancy rates in the Day Treatment Unit**

The chemotherapy service proactively sought additional funding to resource the level of chemotherapy staff required to meet the increasing demand for treatment.

The Trust provided additional investment in the service in October 2017 to support the growth in chemotherapy activity. The Day Treatment Unit received just over £200,000 to support the development of the acute chemotherapy team, who work between the wards and the Day Treatment Unit. The team consists of a Band 7 senior specialist nurse and 4 Band 6 specialist nurses.

This has resulted in an increased nurse staffing establishment and a vacancy rate of 29% as of 11 January 2018. The vacancy rate in September 2017, before the nurse staffing establishment was increased, was 21.9%.

The high overall nursing vacancy rate in the Oncology & Haematology directorate (including the chemotherapy service) is on the directorate risk register and has been escalated to both the Surgery & Oncology division risk register and the overall Trust risk register.

**Ongoing initiatives to increase the capacity of the chemotherapy service**

A number of initiatives have been undertaken to increase capacity – these include the following:

1. **Providing chemotherapy in people’s homes**
   Where suitable, chemotherapy is provided in patients’ homes so they don’t have to come to the Day Treatment Unit at the Churchill Hospital. We work in partnership with a private provider, which has its own chemotherapy trained nurses who can administer chemotherapy, in order to provide this service. Treatment remains free at the point of delivery and patients remain under the care of the NHS.

2. **Dedicated focus on nursing recruitment**
   There is a dedicated national recruitment campaign for Oncology & Haematology nursing, including a Facebook advert and regular open days. The service runs weekly adverts and shortlisting to proactively recruit staff.

3. **Better access to training**
   For new nurse starters at OUH, there is rapid access to chemotherapy education and training. In 2015, a new initiative with the Royal Marsden Hospital collaborating with the OUH resulted in an in-house chemotherapy course, in addition to the established course run by Oxford Brookes University. This has resulted in an additional cohort of 4 nurses twice per year receiving chemotherapy training.

4. **Increased recruitment of support staff**
   The directorate has reviewed the workforce plan and proactively recruited nursing assistants in the Day Treatment Unit and in Outpatients so nurses can focus on nursing responsibilities. In addition, administrative and clerical staff support is being reviewed so that, if suitable, further tasks can be delegated to this staff group.

5. **Expansion of the Brodey Cancer Centre at the Horton General**
   There are a number of patients currently receiving chemotherapy treatment in the Day Treatment Unit at the Churchill Hospital in Oxford who could be treated closer to home in
the Brodey Cancer Centre at the Horton Cancer Centre in Banbury. Historically, recruitment of chemotherapy trained nurses has been easier in Banbury than in Oxford. Therefore the Trust plans to increase the number of chemotherapy treatment chairs in the Brodey Cancer Centre in 2018 to accommodate more patients. This will result in 3 additional chairs and approximately 7-8 extra patients a day receiving chemotherapy treatment.

Recent media coverage – background

The Chemotherapy Operational Group was provided with a report on 3 January 2018 reiterating the ongoing nursing recruitment challenges and increased demands for chemotherapy in the Day Treatment Unit at the Churchill Hospital – the report aimed to generate discussion among clinicians and proactive plans to manage this demand in order to maintain high quality services to patients.

The report was discussed on 3 January 2018 with consultants and registrars at both the Oncology Mortality and Morbidity meeting and the Oncology Clinical Leads meeting.

Following the discussion at the Oncology Clinical Leads meeting, Dr Andrew Weaver (Clinical Lead for Chemotherapy) was tasked with sending an email to oncology and haematology clinicians to ask for clinical teams to review practice in their own specialty groups.

The aim of Dr Weaver’s email was to generate ideas from staff and for these to be presented at February’s Oncology Clinical Leads meeting.

Dr Weaver’s email was leaked by one of its recipients to The Times newspaper. The Trust press office issued a media statement to The Times on 8 January which stressed that no decisions about delaying chemotherapy treatment or reducing the number of cycles of chemotherapy treatment had been made. The statement categorically stated that changes to treatment had not been made.

The Times published a front page story on 10 January under the headline ‘Top hospital cuts cancer care due to lack of staff’ which inaccurately suggested that OUH had reduced treatment for cancer patients.

This story was followed up by a wide range of national and local media outlets on 10 January. Also on this date the Prime Minister answered a question about the issue in the House of Commons.

Reassuring cancer patients – communications to patients, the public and staff

Following the misleading headline in The Times on 10 January, our priority was to reassure cancer patients that their treatment was not affected – a number of patients called the Day Treatment Unit at the Churchill Hospital that morning to ask if they should still come in for their chemotherapy.

The following operational actions were taken on 10 January:

- All leads in the directorate were briefed and staff informed of the headline so they could support patients and answer any questions or queries
- All senior nurses in the directorate ensured they were visible in the clinical areas
- Phone lines were managed by these senior nurses, with support and guidance provided to concerned patients and relatives
- Email enquiries from patients were monitored and responses promptly provided
- Information was put on digital screens in patient waiting areas
- Information was also provided to switchboard operators, our PALS service and the Maggie’s Centre on the Churchill Hospital site in case they had contact with concerned patients

Since 10 January, the following operational actions have been taken:
- Patients who have a definitive start date for chemotherapy treatment have been reassured that this date will not be cancelled or deferred, unless there are clinical reasons to do so or a patient indicates they would like their treatment start date to be delayed.
- All Day Treatment Unit referrals received up to 10 January were scheduled with start dates between 17 and 29 days from the referral date – patients were informed.

The Communications team undertook the following activity on 10 January to reassure patients and the public, and also to brief key local stakeholders:

- Supported Dr Claire Hobbs (Clinical Director for Oncology & Haematology) who did a series of national and local media interviews – including 7 TV and 2 radio interviews – to reassure patients that their treatment would not be cut, as The Times headline had suggested.
- Proactively contacted local journalists (TV, radio and newspapers) to issue our media statement to ensure that follow-up coverage was accurate.
- Linked to this on our social media accounts (Twitter and Facebook).
- Sent briefings to key stakeholders including:
  - Oxfordshire MPs
  - Elected representatives of patients, members of the public, and staff on our Foundation Trust Council of Governors
  - Healthwatch
- Sent briefings to the Communications teams of key NHS organisations including:
  - Oxfordshire CCG
  - NHS Improvement
  - NHS England

The result of the media relations activity was that by the end of the day on 10 January the media coverage was much more balanced and accurate, with almost all reports stressing that no decision to delay or reduce chemotherapy treatment at OUH had been made.

Most importantly for us, this message was strongest in local and regional media – radio, TV and online/print – because our key audience was current patients who may have been concerned to read The Times headline.

The result of the stakeholder engagement activity was that these briefings ensured that the Prime Minister had accurate information with which to answer a question about the issue in the House of Commons on 10 January.

A week after the initial flurry of media coverage, a personal message from the Chief Executive was sent to all staff at OUH to remind them of the various channels available to staff who wish to raise concerns about issues of patient safety and quality.
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Chairman’s Report

1. Reporting back from HOSC on 16th November 2017

1.0 At the HOSC meeting on the 16th of November 2017, HOSC members requested answers to a number of questions relating to item 6 on the agenda ‘Health Inequalities: Update on the response by the Health and Wellbeing Board’ and item 8: ‘Managing the impact of winter on Oxfordshire’s Healthcare System’. The following reports back to the Committee on the questions raised.

1.1 Report back on item 6: Health Inequalities: Update on the Response by the Health & Wellbeing Board.

1.2 Question: How does the STP pick up on the recommendations of the Inequalities Commission – in particular with reference to recommendation 7 about resource allocation?

1.3 The BOB STP covers West Berkshire and Buckinghamshire as well as Oxfordshire. It is a compilation of plans for addressing some of the significant challenges that we all share. Some of the STP relates to coordinated work across the whole patch, other parts are specific to the individual areas. Oxfordshire CCG has a strong commitment to addressing health inequalities and the Inequalities Commission Report has been received formally by the CCG and its recommendations have been accepted.

1.4 In relation to Recommendation 7 (relating to resource allocation), there are several strands to this recommendation and the work needed will be in different areas. For example:

- The Locality Place based Plans for primary care currently being developed specifically refer to health inequalities – in particular for North Oxfordshire and Oxford City Localities, but all address this.
- OCCG have agreed to match the financial contributions made by local authorities to establish an Innovation Fund that will sustainable community based projects and social prescribing.
- OCCG introduced an “inequalities” locally commissioned service to target investment to support practices address this

1.5 Question: Why has the mental health review taken so long (recommendations 39-41)

1.6 OCCG and partners agreed to a review of mental health across the system to inform ongoing priorities; after an extended period agreeing the terms of reference for the review it was agreed it would concentrate on Oxfordshire rather than the original intention to include Buckinghamshire and Berkshire. Work is in progress to be completed during Q4 to:
• Produce a comprehensive mental health needs assessment for Oxfordshire, to include current and future prevalence data and trends, and consider social and physical determinants of health and include those with protected characteristics.

• Report on the effectiveness of current resources and practice, and consider further opportunities arising from improved coverage of a range of interventions to treat mental disorder, prevent associated impacts, prevent mental disorder from arising and promote mental wellbeing.

1.7 A multiagency Oxfordshire Mental Health Five Year Forward View (FYFV) Delivery Group was established in December. This group will consider and agree a list of local priorities for partner Management Boards that will inform ongoing service design and delivery, and monitor progress against agreed work streams.

1.8 **Question: How are we ensuring inequalities are reflected and addressed in all areas of work (recommendation 48)?**

1.9 Addressing health inequalities is a key commitment of OCCG and this is evidenced in a number of other ways. For example:

• Equality Analyses are completed for all pieces of work that could lead to changes in services or service re-design. These are published and are recognised as an important and integral part of the way OCCG works. For major pieces of work, additional expertise may be commissioned to support this assessment.

• The draft Locality Place based Plans for primary care will all include a key feature relating to addressing health inequalities reflecting the local differences across Oxfordshire’s communities whether the inequalities relate to urban deprivation or social isolation in rural parts of the county.

• A specialist team is employed in OCCG to support work reaching into communities that might otherwise be missed. Their work focuses on Banbury and Oxford where the highest density of health inequalities exist but their work stretches to other parts of the county as needed.

• There are multi-agency Health Partnerships in the Oxford city regeneration areas and in Banbury, which have action plans to address the local health inequalities.

• There are joint workshops with Public Health to review data sets and ensure that anomalies in data for areas of inequality are highlighted and acted on.

1.10 As part of its public sector Equality duty, OCCG is required to conduct a Workforce Race Equality Standard survey annually and to publish the results. This is to ensure that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

1.11 Additionally, OCCG is required to undertake the Equality Delivery System (EDS2) annually, to review and improve performance for people with characteristics protected by the Equality Act 2010 and ensure that those patients receive equitable access to services. This is conducted in partnership with the patient/public Equality Reference Group.

1.12 **Report back on Item 9: Managing the impact of winter on Oxfordshire’s Healthcare System**
1.13 **Question:** What are the staff sickness levels in the Oxfordshire Provider Trusts?

1.14 **OUHFT:** Oxford University Hospitals NHS Foundation Trust staff sickness and absence was 3.2% for the year to date to October and the figure for the rest of the Shelford group (other leading teaching hospitals) is 3.9%.

1.15 **OHFT:** Oxford Health takes the issue of staff wellbeing seriously and recognises the importance of this issue. We have worked with clinical and operational leads in association with staff-side representatives across our trust to better understand the nature of work-related stressors over the last year. Some points worth considering are:

- Overall sickness absence levels in Oxfordshire Health Foundation Trust remain quite constant at around 4% over the last 3 years.
- There is some seasonality in the figures, e.g. sickness absence peaks typically in winter months.
- The main regular causes of sickness absence are stress (both work related stress and other causes) and musculoskeletal issues.
- We have a 'Stress Group' jointly established involving senior clinical and operational leaders and staff representatives. This is examining a number of causes and potential solutions to staff stress including additional staffing, flexible working, providing best available equipment, providing more training and support, "back to the floor" initiatives by senior managers and examining situations where demand has grown rapidly.
- The HSE's Management Standards are the standards we are working to achieve in terms of work related stress.
- We also have an active wellbeing programme for staff which promotes exercise, cycle to work schemes, healthy diet, good mental health, resilience, mindfulness and ad hoc health awareness campaigns.
- We also have a professional Occupational Health team with services including counselling available to all staff.

1.16 **Question:** What are the numbers of beds currently available compared to the same period last year?

<table>
<thead>
<tr>
<th>Oxford Health NHS Foundation Trust Data for beds available:</th>
<th>Oxford University Hospitals NHS Foundation Trust Data for beds available:</th>
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<tbody>
<tr>
<td>Available Beds across the community hospitals</td>
<td>Available Beds across OUHFT sites</td>
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<tr>
<td>10th Jan 2017</td>
<td>7th Jan 2017</td>
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<td>151</td>
<td>1,071</td>
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2. **Banbury Health Centre: update**
2.0 At the Committee’s meeting on the 16th of November 2017, information was sought from Oxfordshire CCG on its plans for future changes and consultation for Banbury Health Centre. The following provides a briefing on the current situation regarding Banbury Health Centre.

2.1 The contract for providing GP primary care services at Banbury Health Centre was due to end on 31 March 2018. In preparation for this, OCCG held several meetings with patients of the practice to consider the options and propose a way forward. A formal public consultation on options had been proposed as one possible outcome as the practice location could close and patients would need to travel to a different location to see their GP.

2.2 JOHOSC discussed consultation plans in November. Patients and members of JOHOSC recognised and understood the challenges being faced by primary care, and the importance of finding solutions that improved sustainability and resilience. Concerns were raised from patients and members of JOHOSC to continue to provide from the same location. Registered patients of Banbury Health Centre value the town centre location, proximity to other services, and ease of access using public transport.

2.3 OCCG have listened to the patients of the practice and to the views of other stakeholders including JOHOSC, Cherwell District Council, the local Community Partnership Network and the local MP. Further discussions will agree the details but OCCG have determined that whilst they wish to continue with forming a new larger practice, it will continue to provide services from Banbury Health Centre building. OCCG have agreed a contract extension with PML1 the current holders of the contract to allow new arrangements to be put in place. This means the consultation is no longer needed as it is anticipated there being no significant changes for patients. OCCG have written to PPG members and others who have been involved so far.

2.4 OCCG have now published a Prior Information Notice (PIN) seeking a provider arising from expiry of contract. This PIN states OCCG wishes to identify a provider specifically for a GP Practice at Banbury Health Centre. The provider will be expected to actively collaborate with local Primary Care Providers. There are identified Practices who are keen to collaborate with a provider to deliver more resilient services and offer a wide range of care through working at scale. The PIN further states OCCG’s vision for the GP patients in Banbury is to provide a locally led service which works collaboratively across the Banbury neighbourhood and is GP led and supported by nurses and other clinical professionals as appropriate.

2.5 This information updates the JOHOSC on the future proposals for the primary care element of the contract. The extended hours part of the current contract (weekends, evenings and bank holidays) are subject to further review and we will wish to discuss this in full with the JOHOSC in future.

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1 PML (Principal Medical Ltd) is a not-for-profit organisation. It is owned and run by GPs in Oxfordshire and Northamptonshire.
3. **Health and Social Care Liaison**

3.0 The following meeting was held with the Chairman and HOSC members since the last meeting of the Committee:

- **9 January 2018 – Interview for independent review of engagement**
  *In response to advice from the IRP, NHS England South appointed an independent expert to review the CCG engagement in relation to the West Oxfordshire Plan. The Chairman was interviewed as part of this review; the outcomes of which will be considered by the Committee on the 8th of February 2018.*

- **18 January 2018 – Ways of Working Workshop**
  *In response to advice from the IRP, a ‘Ways of Working’ workshop was held on the 18th of January 2018 at the Kings Centre, Oxford with HOSC members and health representatives. A full report on the process, outcome and next steps from the workshop will be considered by the Committee on the 8th of February 2018.*

4. **Outcome of the Judicial Review of Phase One of the Transformation Programme**

4.0 A Judicial Review was heard on the 6th and 7th of December 2017 in response to a legal challenge on Oxfordshire Clinical Commissioning Group’s (CCG) consultation for Phase One of the Transformation Programme. The challenge was launched by Cherwell District Council, with support from South Northamptonshire Council, Stratford-on-Avon District Council, Banbury Town Council and interested party Keep the Horton General. Following the hearing at the High Court Judge, Mr Justice Mostyn announced his decision on the 21st of December to dismiss the judicial review. Cherwell District Council and partners, had appealed six points relating the consultation process. All six of the following were dismissed:
  - The interdependencies of clinical disciplines and the split consultation
  - Misleading maternity information
  - Insufficient information
  - Not meeting the new Government test for hospital bed closures
  - Legitimate expectation
  - Inadequate ambulance service effect.

4.1 A full copy of the judgement can be found in Appendix A of this report.

5. **Secretary of State’s Referral to IRP on permanent closure of obstetrics at the Horton**

5.0 In response to the Committee’s referral of the CCG’s decision to permanently close consultant-led maternity services at the Horton General Hospital, the Secretary of State has passed the matter to the Independent Reconfiguration Panel (IRP) for initial assessment. The Secretary of State’s letter is printed below and the Independent Reconfiguration Panel, has been requested to report to the Secretary of State by the 9th of February.
POC_1097166

Councillor Arash Fatemian
Oxfordshire Joint Health Overview and Scrutiny Committee,
County Hall,
New Road,
Oxford,
OX1 1ND

10 JAN 2018

Dear Cllr Fatemian,

Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital Formal referral under Regulation 23(9) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Thank you for your letter of 30 August referring to me the permanent closure of consultant-led maternity services at Horton General Hospital. I am today writing to the Independent Reconfiguration Panel (IRP) asking them to undertake an initial assessment of your referral.

Should the IRP advise me that a full review is necessary, you will have the chance to present your case to them in full.

I have asked the Panel to report to me no later than Friday 9th February.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to the Oxfordshire Clinical Commissioning Group.

Yours sincerely,

Jeremy Hunt

[Signature]
6. **Musculoskeletal services**

6.0 Following queries raised by HOSC members to the CCG regarding the recommissioning of musculoskeletal (MSK) services and the new provider, a briefing was provided to HOSC in November 2017. The CCG also provided answers to a number of queries the briefing raised. The following provides further answers and clarification on issues raised by HOSC members.

6.1 **Question:** Can the CCG help us to understand what the new pathway/model of care is and what was its intended process and measurable benefits/indicators?

6.2 See below for the pathway. Note: self-referral will start once waiting times have met the relevant key performance indicator (KPI).

6.3 **Question:** The Business case - approved in April 2015 - was clear about what was intended to be commissioned / purchased. Since then, have there been any changes in the business case proposed model? What has been omitted, what extra has been included?

6.4 For example, the business case made reference to commissioning a specific care package for “mental health” - was this included in the final agreement? Was it included? Were any elements of the final business case not included in the final contract arrangements?
6.5 Pain management/rehabilitation has been included and yes mental health was included and the service staffing included psychology but the service will mainly use the IAPT service to ensure services are joined up. Nothing was removed.

6.6 **Question:** The evidence base for the referral management centre have described the criteria required for a RMC to be effective. Which of those criteria have been included in the final agreed contract with the provider?

6.7 All MSK conditions.

6.8 **Question:** The contract that has been agreed for MSK is unusual in that the referral management centre and the provision of services are delivered by the same provider. Whilst this is an innovation that is very interesting, and based on the successful programme in the Pennines, there could be concerns about the quality of care delivered, or how the RMC works so that there are not perverse incentives (does the provider earn more money depending on the number of people entering treatment?). So, can the CCG please:

a. Explain how the quality of care will be independently evaluated.
   There are a set of quality outcomes that the service are working towards. The majority of these types of services are delivered in the community by the provider of the community elements of the service e.g. Brighton, Bedford, Camden, Hammersmith and Fulham.

b. **What other measures of evaluation are planned?** The contract has a range of Key Performance Indicators within it to evaluate the service. Phase 2 of the data collection will be patient level data to assess patient pathways. See outcomes in the section below for the ‘outcomes to be measured’.

c. **Is the commissioning “outcome” based?** If so, how will the CCG prevent the provider from “cherry picking” the easy to improve patients, at the expense of those with more complex and difficult conditions?
   It is outcome based block contract so there are no additional payments for seeing more patients.

d. **If the commissioning structure will prevent any possibility of perverse incentives.**
   All of those that we have thought of.

6.9 **Transition/implementation issues:**

6.10 **Question:** What was the average waiting time for MSK services for the six months before the end of the previous-providers contract?

6.11 Average waits were around 16 weeks as far as we know. OH waits were around 20 weeks and OUH waits around 8-10 weeks.
6.12 Question: What has been the average waiting time for MSK services for the period following the introduction of the new service?

6.13 10-12 weeks for physiotherapy aiming to get to 6 weeks or less by May 2018. Podiatry is 12 weeks aiming to reduce waits to circa 6 weeks or less in 18/19 by 2nd quarter.

6.14 Question: Can the CCG please share any data they hold about how the new services is performing against the measures it agreed with the provider? Not yet as we have only held one contract meeting so far and the service has only completed 3 months of working. We are happy to provide a report in another 3 months.

6.15 Outcomes to be monitored:

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Outcome</th>
<th>Outcome description</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Outcome 1</td>
<td>People will improve with treatment/intervention in 1 or more areas measured by EQ5D</td>
<td>% Improvement measured using EQ5D</td>
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<tr>
<td>2.1</td>
<td>Outcome 2</td>
<td>People have a good experience of their care</td>
<td>% of people rating the service good or excellent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People are asked about their experience of the service</td>
<td>% of people asked to rate the service</td>
</tr>
<tr>
<td>2.2</td>
<td>Outcome 2</td>
<td>People are asked about their experience of the service</td>
<td>% of people returning the survey</td>
</tr>
<tr>
<td>3.1</td>
<td>Outcome 3</td>
<td>People are involved in decisions about their care</td>
<td>% of people with an MSK long term condition have a patient centred care and support plan</td>
</tr>
<tr>
<td>3.2</td>
<td>Outcome 3</td>
<td>People are involved in decisions about their care</td>
<td>% of people referred to secondary care having taken part in shared decision making</td>
</tr>
<tr>
<td>4.1</td>
<td>Outcome 4</td>
<td>People are aware of opportunities to improve their health</td>
<td>% of people that have received a prevention plan following a conversation regarding stop smoking, BMI and exercise.</td>
</tr>
<tr>
<td>4.2</td>
<td>Outcome 4</td>
<td>People are aware of opportunities to improve their health</td>
<td>% of people that following a conversation are suitable to be referred for Mental Health Support and/or to the falls service in addition to their MSK treatment</td>
</tr>
</tbody>
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Neutral Citation Number: [2017] EWHC 3349 (Admin)

Case No: CO/1587/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/12/2017

Before:

MR JUSTICE MOSTYN

Between:

CHERWELL DISTRICT COUNCIL & OTHERS  Claimant
- and -
OXFORDSHIRE CCG  Defendant
- and -
KEEP THE HORTON GENERAL  Interested Party

Jonathan Auburn (instructed by Cherwell DC Solicitors) for the Claimant
Fenella Morris QC and Rory Dunlop (instructed by Capsticks) for the Defendant
Samantha Broadfoot QC and Leon Glenister (instructed by Leigh Day) for the Interested Party

Hearing dates: 6 & 7 December 2017

Approved Judgment
Mr Justice Mostyn:

1. On 16 January 2017, the defendant launched a consultation, pursuant to section 14Z2(2) of the National Health Act 2006, entitled “The Big Consultation: Best Care, Best Outcomes and Best Value for Everyone in Oxfordshire”. This was the first of a two-phased exercise. It stated:

   **“Phase 1 consultation”**

   **We would like your views on proposed changes to the following:**

   Acute hospital services (acute hospitals provide a wide range of specialist care and treatment including surgery, medical care, emergency care and tests):

   - changing the way we use our hospital beds and increasing care closer to home in Oxfordshire

   - planned care at the Horton General Hospital (planned care includes tests and treatment planned in advance and not urgent or emergency care)

   - acute stroke services in Oxfordshire

   - critical care (critical care helps people with life-threatening or very serious injuries and illnesses) at the Horton General Hospital

   - maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit."

2. The consultation document proposed the following changes to the existing arrangements:

   i) More care would be provided **out of** inpatient hospital beds. The need for hospital beds had reduced and 146 acute beds had been closed already on a temporary basis. This temporary closure should be made permanent.

   ii) More **planned** diagnostic, outpatient and elective surgery services would be provided at the Horton General Hospital.

   iii) All patients diagnosed with acute stroke would be taken immediately by ambulance to the hyper acute stroke unit (HASU) at the John Radcliffe Hospital in Oxford.

   iv) While the Horton General Hospital would continue to have a Critical Care Unit, the sickest critical care patients from North Oxfordshire would in the future be treated at the Oxford Intensive Care Units at the John Radcliffe Hospital.
v) The existing temporary closure (made in October 2016) of the obstetric unit at the Horton General Hospital would be made permanent. Obstetric services, and emergency gynaecology inpatient services, would be provided in the future at the John Radcliffe Hospital. However, a Midwife Led Unit (MLU) would be established and maintained at the Horton General Hospital.

3. The consultation document had a dedicated section on the Horton General Hospital. It stated, in bold:

“Our vision is that the Horton General Hospital will stay open and develop to become a hospital fit for the 21st century. OUHFT is planning to invest significantly in the hospital so it can continue to develop and change as healthcare evolves and meet the needs of local people.”

This section of the document set out in greater detail the proposed changes which I have set out above. Specifically, it confirmed that all patients in North Oxfordshire diagnosed with an acute stroke would be taken immediately by ambulance to the nearest HASU at the John Radcliffe hospital. Similarly, the sickest critical care patients would be treated at the John Radcliffe hospital. Treatment of these patients would no longer be provided at the Horton General Hospital. It explained in some detail, setting out the arguments for and against, its proposal to make permanent the temporary closure of the obstetric unit and the discontinuance of emergency gynaecological services.


5. The consultation document also set out the scope of the second phase. It stated:

“Phase 2 consultation

During the next phase of consultation we are expecting to invite your views on proposed changes to the following services in Oxfordshire:

Acute hospital services:

- A&Es in Oxfordshire
- Children’s services

Community hospitals including MLUs

During this second phase we will also be looking in more detail at plans to develop primary care, which will underpin all our other changes (primary care services include GPs, nurses, healthcare assistants, community nurses and other clinicians).

…”
These proposals set out in phase 1 would involve investment in some areas and would not be a cost of other proposals we will be discussing in the consultation for phase 2.”

6. The consultation document did not state when phase 2 would be undertaken.

7. The claimants (which are the district and town councils in which the Horton General Hospital is situated, and two neighbouring councils), and the interested party (a campaign group called “Keep the Horton General”), say in these judicial review proceedings that this consultation was unfair and, therefore, unlawful. They also say that irrespective of the question of fairness the consultation, inasmuch as it concerned bed closures, is defective and thus unlawful as it failed to refer to a newly arrived test on that subject. And they say that in consequence the decision reached following the consultation on 10 August 2017 implementing the proposals is unlawful. They seek that the consultation be re-run and that phases 1 and 2 be merged. They say that will hardly be a problem given that phase 2 has not yet happened. That is their objective, but it is agreed that if I find the primary or threshold case proved, I should not in this judgment deal with the question of remedy, as we ran out of time in the hearing to deal with that. I agree with this approach. A split hearing plainly has merit. If I find that the primary or threshold case is not made out then debates about discretion and remedies just fall away. If I find that it is made out I can see that there will be lively argument about whether there should be any positive relief actually granted, for reasons which I will set out in that event.

8. The grounds relied on by the claimants and the interested party are as follows:

**Ground 1: two phase consultation**

A The manner in which the consultation is split into two phases is unlawful as decisions are to be made at phase 1 which will have a great influence on matters to then be consulted upon such that the phase 2 consultation will not be conducted when proposals are still at a formative stage.

B During the phase 1 consultation period, consultees did not know what would be proposed regarding A&E, paediatrics, primary care, community hospitals & MLUs, and what those future services would look like. Yet it was important for consultees to understand the nature of services in those areas in order to give an informed view on the phase 1 proposals.

**Ground 2: misleading consultation**

A The consultation gives the impression that women will be able to give birth locally unless they are “high risk” pregnancy, when in reality almost all (i.e. 94%) will now not be giving birth locally, and will have to contend with the highly congested traffic into Oxford City. The treatment of MLUs, without distinguishing “alongside” from “freestanding” MLUs, obscures this.

B The consultation presented the “need” for beds as a foregone conclusion, rather than one which was very much a live issue which was clear from the JHOSC minutes which stated “…there were concerns around pressures on GPs…together with pressures on community hospitals”
C The CCG’s constitution does not fulfil statutory requirements for involvement arrangements.

Ground 3: new bed closure test

The CCG was under a duty to consult on the bed closure test announced on 3 March 2017 by Simon Stevens, Chief Executive of NHS England, given this represented a change of criteria, but it failed to do so.

Ground 4: insufficient consultation information

A The interrelationships between the different services considered, and the impact which phase 1 decisions may have on phase 2 matters, were very important matters for consultees to be informed of. This is related to, but arises independently of, ground 1.

B Consultees were not told about an important and obvious alternative option for the maintenance of an obstetric unit at the Horton General Hospital.

C Consultees were not given information about the effects of the proposal on people living beyond North Oxfordshire.

Ground 5: legitimate expectation

The Secretary of State made a promise in 1998. Mr Smith, on behalf of the defendant stated that the CCG will take this into account in Phase 2 because that is when emergency services are to be decided on. However, if Ground 1A is correct and Phase 1 impacts on Phase 2, then the promise should be taken into account in Phase 1. In addition, emergency gynaecology and emergency critical care is dealt with in Phase 1. Therefore, it should have been put to consultees.

Ground 6: challenge to decision on 10 August 2017

The decision following consultation on 10 August 2017 was unlawful because the decision was contingent on a safe and viable method of transport for patients. As the CCG accepts the temporary ambulance “may not be clinically or financially justifiable”, yet the modelling is based on the temporary ambulance data and does not test what will happen in its absence. Therefore, the Board unlawfully failed to consider whether there was a safe and viable transport mechanism in order to implement the permanent changes decided upon on 10 August 2017.

9. Primarily, I have to decide whether this consultation was “fair”. In R (on the application of Moseley) v London Borough of Haringey [2014] UKSC 56 [2014] 1 WLR 3947, a consultation case, Lord Wilson at para 24 stated that:

“Fairness is a protean concept, not susceptible of much generalised enlargement. But its requirements in this context must be linked to the purposes of consultation.”

10. This reflects observations about the nature and content of the concept of fairness in other spheres. For example, in R v Secretary of State for the Home Department, ex parte Doody [1993] UKHL 8, [1994] 1 AC 531 Lord Mustill stated:
"What does fairness require in the present case? My Lords, I think it unnecessary to refer by name or to quote from, any of the often-cited authorities in which the courts have explained what is essentially an intuitive judgment. They are far too well known. From them, I derive that: … (2) The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type. (3) The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision, and this is to be taken into account in all its aspects. …"

11. Similarly, in the field of family law, Lord Nicholls stated in White v White [2001] 1 AC 596, [2000] 2 FLR 981 at para 1:

"Features which are important when assessing fairness differ in each case. And, sometimes, different minds can reach different conclusions on what fairness requires. Then fairness, like beauty, lies in the eye of the beholder."

And in Miller v Miller; McFarlane v McFarlane [2006] UKHL 24, [2006] 2 AC 618, [2006] 2 WLR 1283, [2006] 1 FLR 1186 at para 4 he stated:

"Fairness is an elusive concept. It is an instinctive response to a given set of facts. Ultimately it is grounded in social and moral values. These values, or attitudes, can be stated. But they cannot be justified, or refuted, by any objective process of logical reasoning. Moreover, they change from one generation to the next. It is not surprising therefore that in the present context there can be different views on the requirements of fairness in any particular case."

12. Therefore, at its heart a judgment about what is fair is intensely fact-specific and is instinctive and intuitive. Ultimately, I think it is likely to be determined by the "I know it when I see it" legal technique. That received its most famous expression from Justice Potter Stewart in the US Supreme Court in Jacobellis v Ohio (1964) 378 U.S. 184, an obscenity case, where he stated "I shall not today attempt further to define the kinds of material I understand to be embraced within that shorthand description [of hard-core pornography]; and perhaps I could never succeed in intelligibly doing so. But I know it when I see it, and the motion picture involved in this case is not that."

However, in order, perhaps, to rein in excessive judicial individualism and subjectivity the courts have given in a number of cases, and over many pages, broad guidance about the nature and content of fairness in cases such as this. Cutting through the foliage I think that the guidelines (all of which are, in my respectful judgment, statements of the obvious) can be summarised thus:

i) The consultation must be at a time when the proposals are still at a formative stage. Obviously, it is not likely to be fair if the proposals have been worked up to a final conclusion and are presented to the audience as a fait accompli. Consultees should not be presented with a false or empty choice akin to “you can have any colour you like as long as it is black.”

Page 196
ii) To split a consultation into two phases (as here) is not *eo ipso* unfair, but if that route is followed great care will have to be taken to ensure that decisions made following phase 1 do not pre-determine or heavily influence decisions to be made following phase 2. Splitting a consultation obviously runs the risk that the second phase is not at a formative stage.

iii) Sufficient reasons must be given for the proposals to permit intelligent consideration and response. Thus, the audience must be told in full, clear and accurate terms what the proposal is and exactly why it is under positive consideration. The degree of detail may depend on the supposed degree of expertise of the audience. If the audience comprises specialist bodies then perhaps lesser detail needs to be given than if the audience is the general public.

iv) Where a proposal is advanced it should set out both pros and cons. This is not to say that an extensive case arguing the merits of maintenance of the status quo needs to be advanced, or that it is mandatory to set out, and then argue against, all plausible alternatives. Indeed, the proposer may, and, I would have thought, almost invariably would, set out his or her reasons why the proposals should be adopted in preference to the status quo or other alternatives.

v) Where the proposal is to remove an existing benefit then the demands of fairness are likely to be higher than where the proposal is to grant a new one.

vi) Not all findings of flaws in the process will inevitably lead to a finding of unfairness of such a degree that the process was unlawful. Put another way, it is possible for the court as the guardian of fairness to find that while the process was somewhat unfair it was not so unfair as to be unlawful. In one case, it was said it had to be shown that something had “clearly and radically” gone wrong but the courts have rowed away from that acid test. The test is now stated to be that the court must be satisfied that the process was “so unfair” as to be unlawful. The use of the adverb “so” shows that there is a threshold to be surmounted. In my judgment, the court will only be satisfied that the unfairness renders the process unlawful if the unfairness is significant. In this regard, the court will look with especial care at the materiality of the alleged flaws.

13. **Ground 1** (which was in terms of pages of evidence and argument, and time taken in court, by far the biggest ground) complains about the splitting of the consultation into two phases. The ground has two limbs. Limb A is the argument that if the changes proposed in phase 1 are approved then this will heavily influence the outcome of the matters which are subsequently to be consulted upon in phase 2. Limb B is the argument that by splitting the process at no point do consultees have the opportunity to make meaningful representations on the proposal as a whole. In truth, these two limbs are opposite sides of the same coin, as was accepted by parties before me.

14. **Ground 4A** complains that consultees needed to be told about the interrelationships between the different services considered, and the impact which phase 1 decisions may have on phase 2 matters.
15. **Ground 5** complains that a promise made by the Secretary of State as long ago as 1998 about emergency services should be taken into account in phase 1 as well as phase 2.

16. In my judgment, these latter three grounds (1B, 4A and 5) stand or fall on a determination whether as a matter of fact there is a *material interdependency*.

17. I observed during the hearing that the arguments and evidence for and against these “splitting” grounds seemed to me to be strong on rhetoric and short on hard data or numbers. As a result of questions asked by me a witness statement by David Smith was produced on the second day on behalf of the defendant which gave key numerical evidence. This provoked a heated response from the claimants and the interested party who pointed out, with some justification, that this very material had been sought for a long time from the defendant, not only by them but also by the local MP, to no avail. However, as I had asked for this material I obviously was going to look at it. I did however allow the claimants and the interested party to file evidence or arguments in response which they did on 11 December 2017 in the shape of further witness statements by Ian Davies, on behalf of the claimants, and Peter Fisher on behalf of the interested party. Nobody had sought an adjournment of the proceedings.

18. The statement of facts and grounds asserts that the removal of obstetrics from the general hospital will mean the loss of both the Special Care Baby Unit (SCBU) and the emergency gynaecological service. This is true. This will mean the loss of paediatricians and children’s nurses as well as anaesthetists. This is also true. These losses will surely, it is argued, significantly influence the phase 2 consultation on A&E and paediatric services at the hospital. This might be true, but it would all depend on the numbers. How many paediatric cases are neonates? Out of all emergencies how many are gynaecological? How many of those cases where anaesthesia is administered are obstetric?

19. The witness statement of Mr Smith demonstrates that in the year 2014 – 2015 the SCBU had 219 “spells”. In contrast for the same year there were 2,699 non-elective paediatric admissions; 242 paediatric day cases; 11,062 paediatric outpatient appointments; and 8,500 paediatric attendances at A&E. Ian Davies argues that this is not to compare like with like. A spell in the SCBU will be for a very sick baby who may need high dependency care for up to 10 days, while an outpatient appointment might last just 15 minutes. Mr Fisher makes the same point (at some length). This is true, but that qualitative difference cannot mask the quantitative one. On any view, the SCBU spells are a vanishingly tiny proportion of the overall paediatric activity, and it is impossible to conclude from this data that a decision to confirm the temporary closure of the obstetric unit has any material relevance to the decisions that have to be made about the maintenance of paediatric services at the hospital. The fears, eloquently expressed by Mr Fisher, are not, in my judgment, borne out by the hard data.

20. Mr Smith’s statement does not tell me how many of the overall emergency cases treated in that year were gynaecological cases but there appears to be a consensus that it would have been very small. I do not believe that the loss of emergency gynaecological cases has any material bearing on a future assessment of the A&E department.
21. Similarly, I am not satisfied that the loss of the obstetric unit has any bearing on the question of what anaesthesia services are needed at the hospital in the future. This is because when the obstetric unit was there, a dedicated anaesthetist for that unit was in place, to administer, almost invariably, epidurals, which are given in 60% of births. That dedicated anaesthetist was not on the general rota which covers critical care, advice for the management of general patients, support to A&E, supervision of trainees, elective surgery and some out of hours work. In my judgment, the loss of the dedicated obstetric anaesthetist does not have material relevance to decisions that have to be made about paediatric and A&E anaesthesia. Given that there were just under 1,500 births in the unit in 2014/15 it can be seen that the dedicated anaesthetist would have been very busy administering 900 epidurals (almost 3 each day). Ian Davies does not appear to dispute any of this.

22. It is said that if Level 3 critical care patients are no longer treated at the hospital then there will be even less anaesthetic expertise there. But as Mr Smith’s witness statement demonstrates there were only 41 such admissions in the year in question. Even if all of them required anaesthetic services that would only represent 6% of the total critical care workload, and a mere 1% of the overall workload of the anaesthetists. Ian Davies argues that the true percentage is 12%. If that is right it is still a very small proportion. Both Ian Davies and Peter Fisher argue that the removal of these patients may give rise to a risk that accreditation for Year 2 anaesthesia training will be stopped, with a possible knock-on in the future for the training of Years 3 and 4 anaesthetists. Peter Fisher points out that the loss of these patients will mean that junior anaesthetists will have no opportunity to treat ventilated patients. That risk has not been quantified in probability terms to me. In my judgment, and taking that risk fully into account, I nonetheless conclude that the loss of the Level 3 critical care patient cannot be said to have any material bearing on decisions to be made about anaesthetic services overall at the hospital.

23. Quite apart from the question of anaesthesia the figure of 41 admissions is to be compared to 37,816 A&E attendances and 8,948 emergency admissions. Those 41 admissions cannot sensibly have any bearing on decisions that need to be made about the future of the A&E department.

24. It is said that if acute stroke victims are always taken to the John Radcliffe Hospital then the ability of the A&E department of the Horton General Hospital to treat unselected emergencies will be limited. I am not sure that I understand the logic of this argument but in any event Mr Smith’s witness statement shows that it is anticipated that around one hundred people each year from North Oxfordshire will be diagnosed with an acute stroke requiring care at the John Radcliffe and that a further hundred patients might present with stroke like symptoms requiring investigation at the John Radcliffe. 200 such cases are to be compared to the figures in the preceding paragraph. For the same reasons, it cannot be said that such a small number of cases has any bearing on decisions that have to be made about the future of the A&E department.

25. The conclusions I have reached thus far should not be taken to signify that I personally approve of the decision to split this consultation. It was said that the reason it was done in this way was because of the urgency of the matters covered by phase 1. But they were not urgent. The obstetric unit had already been closed, albeit temporarily. The number of Level 3 critical care and stroke victims was tiny
compared to overall activity. And in any event, it proposed that phase 2 should follow very shortly after phase 1 – the papers mention the consultation for phase 2 beginning in April 2017. Miss Morris QC argued that to leave the obstetric unit temporarily closed without a definitive decision was bad for morale, but that was mere assertion and did not, in my opinion, justify taking the risks in splitting which I have mentioned above.

26. I can well see why in the absence of hard data the claimants and the interested party would assert that as a matter of principle decisions made following phase 1 would queer the pitch when the phase 2 consultation came around. However, as I have demonstrated, the hard data shows quite clearly that the decisions on the very small number of cases involved will have no material effect on the scope of the phase 2 consultation. It is a mystery to me why that data was not supplied sooner.

27. In my judgment there was no material, significant, unfairness. For these reasons, the challenge under both limbs of Ground 1 is dismissed. That deals with the controversy about splitting. It is not necessary for me to consider whether the consultation with, and the actions by, the JHOSC has any impact on the splitting of the consultation process, although I will have something to say about this in my concluding remarks.

28. Having decided that the splitting was not unfair it follows that Grounds 4A and 5 fall away.

29. I now turn to the remaining grounds. These assert, for various reasons, that the phase 1 consultation was unfair and therefore unlawful (and indeed independently unlawful irrespective of the question of fairness) even if there was never to be a phase 2.

30. **Ground 2** concerns alleged inadequacy of consultation information. It has three limbs. Limb A alleges that the consultation information contained misleading or wrong information about obstetric services. Limb B alleges that there was misleading or wrong information about bed closures. Limb C alleges that the defendant was in breach of statutory requirements for consultation arrangements.

31. The claimants refer to the consultation document which states that “most women have a low risk pregnancy and are cared for by the midwifery teams during the antenatal, labour and postnatal period” and that “higher risk pregnancies” will be going to the John Radcliffe. This implies, they argue that most births will continue under midwife care, which is still available at the Horton General Hospital and so women will not have to travel into central Oxford city to give birth. If people are not of borderline child-bearing age, of normal health, and do not have a relevant medical condition, then they would have no reason to expect themselves to be “high risk”, and would presume themselves not to be. Thus, women who have no reason to expect themselves to be “high risk” would, upon reading the consultation document, expect that they would be unlikely to be travelling an appreciable distance to the John Radcliffe.

32. This is said to be thoroughly misleading. It is said that statistics show that only 6% of women elect to give birth in a free-standing MLU, that is to say a MLU with no obstetricians close at hand. 94% elect to give birth in obstetric unit or in a MLU with an obstetric unit close at hand such as the Spires MLU at the John Radcliffe. Therefore, contrary to the misleading impression conveyed by the consultation document, the overwhelming proportion of pregnant women will have to make the
trek from North Oxfordshire to the John Radcliffe, just as they have had to since the temporary closure of the obstetric unit at the Horton General Hospital.

33. The defendant says that the information provided in relation to the obstetrics proposals was neither misleading, nor wrong. Page 16 of the document explains that the proposal is to provide obstetric services at the John Radcliffe and a MLU at Horton General Hospital. Page 40 of the document makes clear that this means that anyone wanting an obstetric unit, either because of clinical need or because they want obstetricians nearby, will have to travel to the John Radcliffe. Page 36 of the document shows that in 2015/2016 there were 1,466 births at Horton General Hospital. Page 40 of the consultation document shows that it was anticipated that the proposal would lead to a reduction to between 200 and 500 births per year at Horton General Hospital.

34. It was extremely clear that the proposal would involve obstetrics being removed from Horton General Hospital, and that the proposal would thus have an impact not just on those who have a high risk birth and a clinical need to be in an obstetric unit but also on those who wish to have obstetricians in the same location when they gave birth. Therefore, the proposal would likely lead to a significant drop in the number of women wishing to give birth at Horton General Hospital.

35. I do not believe that anyone reading the document could have been in the slightest doubt as to the scope and impact of the proposals. In my judgment, all relevant information was set out. It is clear, as Miss Morris QC says, from the responses to the consultation that the information provided about obstetrics did not mislead the public or prevent them being involved in decision-making. There were ‘significant levels of opposition’ to the proposal to change Horton General Hospital’s maternity services permanently into a MLU because of the impact on mothers who either present as low risk and problems escalate, or who want to have pain relief.

36. I agree with Miss Morris QC. Ground 2A is therefore dismissed.

37. Ground 2C alleges that there has been a breach of section 14Z2(3) of the 2006 Act which requires the CCGs must include in their constitution a description of the arrangements made by them to secure the necessary involvement of public under subsection (2) together with a statement of the principles it will follow in implementing those arrangements. Apparently, the defendant’s constitution does not contain such a description or such a statement. The claimants accept that by itself this complaint cannot lead to a finding that the consultation was unfair; and, indeed, Miss Morris QC rightly points out that this has nothing to do with the fairness or otherwise of the consultation. This ground was not seriously pursued and I regard it as an arid technical irrelevance.

38. Grounds 3 and 2B both complain about the consultation on bed closures. Ground 3 complains that the defendant was under a duty to consult on the bed closure test announced on 3 March 2017 by Simon Stevens, Chief Executive of NHS England, given this represented a change of criteria, but it failed to do so. Ground 2B complains that misleading or wrong information was provided in the consultation document about bed closures.
39. It is certainly true that on 3 March 2017 Mr Stevens announced an additional test or criterion where bed closures were proposed to the existing four general tests. This additional bed-closure-specific test was to take effect on 1 April 2017. It is not disputed that the original four tests were explicitly addressed in the consultation document. The additional test announced on 3 March was that the proposer must (a) demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or (b) show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or (c) where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

40. It can be seen that this new test arose in the middle the phase 1 consultation. The defendant’s initial stance was that this new test did not apply retrospectively to a consultation already underway. Plainly, the new test would be operative at the time that any decision following the consultation was made. It seems to me that if it was considered apt to consult on the original test then it was equally apt to amend or supplement the consultation document to consult on the new additional test. It is agreed that the public were not consulted on this new additional test. I do not accept the arguments of Miss Morris at paras 71–73 of her skeleton. I cannot see why the later acceptance that the test was met by NHS England or the Clinical Senate has any bearing on the question whether the public should have been asked about it.

41. Therefore, the consultation was flawed but the question is whether the flaw is sufficiently serious to justify a finding either that the consultation was unfair, or quite apart from the question of fairness, was vitiating by this omission.

42. It seems to me that if the consultation document had been amended to set out this new test in terms it would have done so on page 19. I cannot see that any of the text that followed would have needed to have been the subject of any serious redrafting. Indeed, the explanation of the measures taken to reduce the need for beds with the result that 146 had been temporarily closed went directly to addressing, albeit unwittingly, limb (a), and possibly limb (b), of the new test.

43. I therefore consider that the public was de facto substantively consulted about the new test. I cannot see that had it been mentioned the responses, or the decision, would have been any different.

44. In my judgment the omission, while regrettable, and somewhat troubling, was not sufficiently material to lead to a finding that the consultation was unfair, let alone that it is vitiated.

45. Ground 2B says that the consultation presented the “need” for beds as a foregone conclusion, or as an incontrovertible fact. I have to say that this is a very weak argument. The statement is plainly one of opinion or belief, an opinion or belief based on the evidence and reasoning set out in some detail on pages 19 – 22 of the consultation document. The analysis of the responses shows that the consultees treated it in exactly that way: many responded saying that in their view too many acute hospital beds had already been lost. It is not illegitimate for a proposer, such as
the defendant, to express its opinion; indeed, I would have thought it was bound to do so.

46. **Ground 4B** complains that consultees were not told about important and obvious alternative options for the maintenance of an obstetric unit at the Horton General Hospital, namely either a “full integration” of the obstetric services at the John Radcliffe and the Horton General, or the creation of a MLU at the Horton which is alongside the obstetric unit (like the Spires unit at the John Radcliffe). I have explained above that there is no mandatory duty explicitly to consult on all plausible alternatives. This is especially so if the thrust of what is proposed implicitly captures a rejection of such alternatives. The consultation proposal was very clear: the existing temporary closure, since October 2016, of the obstetric unit should be made permanent. It was saying that no reasonable way could be found to keep it open. The alternatives which the claimant say should have been explicitly mentioned both involve keeping the unit, or something like it, open. They were variations on a theme of non-closure. The defendant explicitly consulted on the general option of keeping obstetric services open. Obviously, consultees would have been at liberty to have responded urging adoption of either of these options, and indeed a number did. In my judgment, this ground has no merit.

47. **Ground 4C** complains that consultees were not given information about the effects of the proposal on people living beyond North Oxfordshire. In my judgment, this is a very weak ground, which should be dismissed. It is clear from the evidence that the defendant took steps to ensure that patients and stakeholders outside North Oxfordshire were aware of the proposals and its potential impact. The consultation document was available online and anyone who lived in neighbouring areas who read it would have been perfectly well aware of what was being proposed and how it would affect them.

48. In **Ground 6** the interested party complains that the decision of 10 August 2017 was unlawful because the decision was contingent on a safe and viable method of transport for patients, which on the evidence, it is said, was not proven. This ground does not go to the alleged unfairness of the consultation. Rather, it challenges on Wednesbury principles the actual decision. Thus, the high standard of that test must be met. The interested party must show that the decision was irrational or perverse. I agree with Miss Morris QC that it is unarguable that the defendant misrepresented the letter of the Southern Central Ambulance Service of 31 July 2017, let alone that its conduct in dealing with that evidence reached the levels of irrationality or perversity.

49. I am baffled by the suggestion that the decision not to trial additional ambulance services, was flawed. Following the temporary closure of the obstetric unit and the establishment of a MLU at the Horton General a dedicated static ambulance was provided to take obstetric patients from the MLU to the John Radcliffe where necessary. A contract is in place to provide this static ambulance for a year. During that year, the number of ambulance journeys will be counted and the experiences reviewed. I agree with Miss Morris QC that this is, in effect, a trial. No decision was taken on 10 August 2017 as to what to do when this contract expires. At the end of the year a decision will be taken, in the light of the data, whether to extend the contract for the static ambulance, or whether to revert to using SCAS for obstetrics patients, or whether to conduct a further trial. Thus, the complaint is meritless as well as being premature. I note from the recent witness statement of Ian Davies that in its first year
of operation the Horton MLU transferred 98 cases to the John Radcliffe, a rate of nearly two each week.

50. I am not satisfied that the other aspects of Ground 6 which were advanced have any merit, let alone come close to meeting the Wednesbury test.

51. For all these reasons, the claim will be dismissed. I will not, therefore, have to consider the question of discretion or remedy. I can therefore keep my concluding remarks brief.

52. Under Regulation 23(1) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013 No. 218), the defendant was obliged to consult the relevant local authority (county council) where it has under consideration any proposal for a substantial development of the health service in the area of the local authority. This it does by consulting a committee known as the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). If the committee is not satisfied that consultation on any such proposal has been adequate, or that the reasons given by the CCG are adequate, or that the proposal would not be in the interests of the health service in its area, it may make a report to the Secretary of State. In that event, then pursuant to regulation 25, the Secretary of State has wide-ranging powers which include, relevantly for the purposes of this case, a direction that the public consultation be re-run, or that the decision to make permanent the closure of the obstetric unit be reversed. The time taken for the Secretary of State to make a decision, including taking advice from an advisory panel, should be, according to the material put before me, no more than six months.

53. On a 7 August 2017, the JHOSC held a meeting at which it was resolved to support the proposals for critical care, for acute stroke services, and for the closure of the beds that had already taken place. However, it strongly opposed the proposals in respect of maternity services and decided to refer the matter to the Secretary of State on the grounds that the committee had not been adequately consulted and that the proposal was not in the best interests of the residents of Oxfordshire. Nothing has since been heard from the Secretary of State. However, as I have explained, given the terms of the reference, it is within the power of the Secretary of State to reverse the decision to shut permanently the obstetric unit.

54. Given that judicial review is meant to be a remedy of last resort it can be seen that had I decided that the consultation was unfair, or that the decision of 10 August 2017 was unlawful, then I would almost inevitably have deferred any question of exercise of discretion or remedy until after the Secretary of State had rendered a decision.

55. Moreover, it seems to me that in exercising his powers the Secretary of State is far more able to make a broad merits-based decision that am I exercising the very stringent powers of judicial review.

56. Finally, I record two concessions made by the defendant during the course of the hearing. First, it was made crystal clear that it was not the intention of the defendant to close the Horton General Hospital. Second, it was stated that decisions made following Phase 1 of the consultation would not affect decisions to be taken on Phase 2.
57. That concludes this judgment.
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