Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 21 November 2019 at 10.00 am

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

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Sean Gaul

Councillors:	Mark Cherry	Hilary Hibbert-Biles	Laura Price
	Mike Fox-Davies	Jeannette Matelot	Alison Rooke
District Councillors:	Paul Barrow		David Bretherton
	Nadine Bely-Summers		Neil Owen
Co-optees:	Dr Alan Cohen	Barbara Shaw	

Notes: ***Date of next meeting:*** *6 February 2020*

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	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *Email: colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

November 2019

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 19 September 2019 and to receive information arising from them.

For ease of reference when considering the Matters Arising from the minutes, a list of actions is attached at the end of the minutes.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 19 - 22)

10.15

The Committee's Forward Plan is attached for consideration.

6. Oxfordshire Clinical Commissioning Group Update (Pages 23 - 26)

10.20

This item will provide a report on the key issues for the CCG and outline current and upcoming areas of work. Including an update on Chipping Norton First Aid Unit and the CCG Annual Reports.

7. Future arrangements for NHS commissioning (Pages 27 - 38)

10.50

This paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an overview of future commissioning arrangements across Buckinghamshire, Oxfordshire and Berkshire West (BOB) and seeks feedback on the proposals.

8. **Health Inequalities Commission Implementation Group Update report** (Pages 39 - 46)

11.35

This report will focus on furthering the prevention agenda and reporting on good practice in some new projects funded through the Innovation Fund which was set up in response to recommendation from the Health Inequalities Commission.

This report also includes information on the strategic direction being proposed by Ansaf Azhar, the Director of Public Health for Oxfordshire.

9. **CAMHS** (Pages 47 - 50)

12.20

This paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with a progress report on implementing Mental Health Support Teams (MHSTs) in Oxfordshire schools. It will also explain how the new MHSTs fit within the overall Children and Adolescent Mental Health Service (CAMHS) provided by Oxford health NHS Foundation Trust.

The paper also updates on progress with the Oxfordshire four week wait pilot, funded by NHS England.

10. **Healthwatch Oxfordshire** (Pages 51 - 56)

13.00

A report on the views of health care gathered by Healthwatch.

11. **Chairman's Report** (Pages 57 - 84)

13.10

The Chairman's report for November 2019 is attached.

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.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 September 2019 commencing at 10.00 am and finishing at 3.20 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair District Councillor Neil Owen (Deputy Chairman) Councillor Mark Cherry Councillor Hilary Hibbert-Biles Councillor Laura Price District Councillor Paul Barrow City Councillor Nadine Bely-Summers Councillor Mrs Anda Fitzgerald-O'Connor (In place of Councillor Mike Fox-Davies) Councillor Jane Hanna OBE (In place of Councillor Alison Rooke) Councillor Kieron Mallon (In place of Councillor Jeannette Matelot)
Co-opted Members:	Dr Alan Cohen Anita Higham OBE Barbara Shaw

Officers:

Whole of meeting	Sam Shepherd, Senior Policy Officer; Colm Ó Caomhánaigh, Committee Officer

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

46/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from:

District Councillor David Bretherton
Councillor Mike Fox-Davies (Councillor Anda Fitzgerald-O'Connor substituting)
District Councillor Sean Gaul
Councillor Jeannette Matelot (Councillor Kieron Mallon substituting)
Councillor Alison Rooke (Councillor Jane Hanna substituting).

The Chairman welcomed Anita Higham to her first meeting.

47/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Anita Higham declared a personal interest in that she will remain a Governor of Oxford University Hospitals until the end of September 2019.

Dr Alan Cohen declared a personal interest as a Trustee of Oxfordshire Mind.

Councillors Arash Fatemian and Kieron Mallon stated their local surgeries were involved in the Banbury merger referred to under Item 7.

48/19 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

The Chairman had agreed to the following requests to speak at this meeting:

Agenda Item 7 Oxfordshire Clinical Commissioning Group Update
Bill MacKeith - Oxfordshire Keep Our NHS Public

Agenda Item 8 PET CT Scanning
Bill MacKeith - Oxfordshire Keep Our NHS Public

Brexit Planning
Councillor Jane Hanna – Oxfordshire County Council

Councillor Hanna asked the Committee to consider planning for Brexit – in particular when discussing Agenda Item 10 Winter Plan. Operation Yellowhammer was only published in the last few days and too late for inclusion on the agenda for this meeting in the usual way.

There are risks across the whole system – long term and short term. A university study predicted that up to 12,000 extra deaths could occur between 2021 and 2030 as a result of increased food prices following a no-deal Brexit. The system for medicines is already creaking.

Councillor Hanna called for the publication of risk assessments for Oxfordshire. This Committee is the only democratic body in Oxfordshire where this issue can be discussed before 31 October 2019 – the proposed date for Brexit. Consideration should be given to having an extra meeting. Professionals on the frontline need support in this matter.

49/19 MINUTES
(Agenda No. 3)

The minutes of the meeting of 20 June 2019 were approved and signed with corrections to the list of Voting Members, correction of typos and, in item 38/19 on Agenda Page 4, first full paragraph, the insertion of “Banbury” before “Community Partnership Networks”.

50/19 FORWARD PLAN
(Agenda No. 5)

It was **AGREED** that the Integrated Care System will be a substantive item at the November meeting.

51/19 HOSC RECOMMENDATION TO THE BOARD OF OXFORD HEALTH FT
(Agenda No. 6)

David Walker, Chairman of Oxford Health, summarised the letter containing the OH Board's response to the Committee's resolution of 31 May 2019. He emphasised that OH and HOSC share the same common purpose to deliver excellent health services for the people of Oxfordshire.

At the Oxford Health AGM, later the same day, the main issues of work-related stress, inadequate staffing levels and heavy workloads will be discussed. These problems are experienced by all public bodies. He hoped that District Councils could particularly help in the provision of more social housing.

Councillor Laura Price asked if the emerging plans of the Integrated Care System (ICS) could help resolve these problems. She also asked if representations have been made to central government. City Councillor Nadine Bely-Summers noted that Oxford City Council had voted to support Oxford weighting in salaries and asked how that would be achieved. District Councillor Neil Owen stated that some people had expressed concern to him that increasing salaries would result in reduced resources for patients.

David Walker responded that the same problems of recruitment were seen across the Thames Valley area covered by the ICS. The first meeting of ICS addressed that and messages have been sent to central government. Oxford Health is a strong advocate of pay justice and wants to be able to pay competitively in order to recruit but the budget needs to be there to do that sustainably. His personal view was that the country needs to put more resource into the NHS especially given the aging population profile.

Anita Higham asked if Brexit was leading to a loss of staff. David Walker responded that it remains a threat rather than a measurable reality. Some staff fear that they will not be able to stay in the UK and this creates a debilitating insecurity.

Dr Alan Cohen asked how the type of misunderstanding that led to the Committee's resolution in May could be avoided in future. David Walker stated that he was very happy to attend meetings of the Committee and suggested that there should be a mutual attendance at Oxford Health's public meetings. He saw the Winter Plan as an opportunity to recalibrate.

The Chairman welcomed the suggestion and stated that attendance at partner meetings was being arranged. He asked for a commitment to flag issues earlier to the Committee.

David Walker **AGREED** to a "no surprises" approach but noted that OH would have to be trusted when it needed to make decisions in the interest of safety and practicability.

52/19 OXFORDSHIRE CLINICAL COMMISSIONING GROUP UPDATE
(Agenda No. 7)

Prior to consideration of this item, the Committee was addressed by the following member of the public:

Bill MacKeith of Oxfordshire Keep Our NHS Public expressed his group's concern at the proposal to merge the Clinical Commissioning Groups of Oxfordshire, Buckinghamshire and Berkshire West. He asked how the larger CCG could be effectively scrutinised. He urged the Committee to seek a full public consultation before any application to merge is made.

Louise Patten, Chief Executive Officer, summarised the CCG's update report. General Practices in Banbury continue to merge with the running of Horsefair surgery taken over by PML. It is not anticipated that there will be any change to services for patients.

On Gynaecology services, as a temporary measure to alleviate the waiting times for Oxford University Hospital (OUH), patients were given a list of alternative hospitals if they wished to be seen sooner. However, if they wanted OUH then they could still go there. There were no patients waiting 52 weeks in April 2019 and by June 2019, 66% were referred within 18 weeks for benign gynaecology. There is still more work to do. Patients with chronic pelvic pain are continuing to be offered referrals elsewhere due to the 39-week waiting time.

Professor Meghana Pandit, Chief Medical Officer OUH, updated the Committee on Gynaecology Oncology. The Royal College of Obstetricians and Gynaecologists were invited to review the service in January and delivered a final report in July.

All are agreed that Oxford needs to be a centre for tertiary services and that time was needed to reorganise. Diversions to Imperial Health will continue until a new clinical leader has developed a new team to deliver the service. That position has been filled to start this week.

Barbara Shaw asked if patients are still being referred out-of-county for gynaecology services, how long they have to wait and if Oxfordshire patients are receiving a poorer service. Louise Patten responded that hospitals work well together anyway. Other hospitals have shorter waits but people tend to prefer their local hospital if they are given a choice. Chronic pain is where they are asking GPs to encourage patients to go elsewhere but now for other services people are just informed of the longer wait in local services.

Councillor Hilary Hibbert-Biles asked that the Committee be kept involved in any possible changes to pathways. Louise Patten **AGREED** to do this.

Dr Alan Cohen welcomed the reports showing that everything was being done to reopen the City Community Hospital but asked if there was any progress on a wider county-wide strategy for community hospitals.

Louise Patten said that all providers are reporting workforce challenges. It needs to be tackled along with social care and she has already had discussions with the new Director for Public Health about it. It will need to start with workforce modelling. Louise Patten **AGREED** to scope the work to look at how the workforce challenges in health and social care locally limit the provision of community services.

The Chairman asked if it would not have made more sense in Banbury to merge Horsefair and West Bar surgeries as they operated in the same building. Louise Patten responded that the previous provider for Horsefair had a number of practices outside Oxfordshire and did not have much interest but the solution arrived at keeps the providers local.

With regard to Brexit, there are seven key areas for regional and national preparations and they are working to provide a readiness plan for the potential impacts. This is all part of emergency preparedness which the CCG does all the time. Each organisation has to have a Senior Responsible Officer. They work with the Local Resilience Forum. The A&E Delivery Board is cited on plans. Mitigation plans are being worked through. The CCG says no significant risks have been identified.

It will all depend on behaviours which may change as we get closer. There are regular regional and national events to share information. The three main areas are continuity of supply, reciprocal care (charging those not eligible for free services from 1 November) and communications.

Anita Higham asked if the departure of the Director of OUH would have any implication for continuity. Meghana Pandit responded that the Chief Operating Officer, Sarah Randall, was the officer with responsibility.

Members of the Committee asked about

- reported shortages of anti-depressants and HRT drugs;
- potential difficulties relating to drugs for epilepsy which cannot be stockpiled;
- who will have to pay for their care?;
- the number of staff who are EU nationals;
- publishing risk assessments.

Louise Patten responded as follows:

- It is difficult to know if medicine shortages are due to stockpiling in advance of Brexit or not. She will raise the issue of epilepsy at the next regional meeting. Drug issues are handled at a national level.
- Who will have to pay for services will depend on the outcome of the Brexit negotiations.
- The risk assessments are subject to Freedom of Information requests anyway so she was happy to **AGREE** to make them available. She **AGREED** to find out if they include issues raised in Operation Yellowhammer.

Matt Akid, Head of Communications at OUH, added that they had 1500 EU staff and they were working hard to retain them.

It was **AGREED** that national and local risk assessments be shared with the Committee who can then collate a set of questions for the CCG to be answered in their next report.

53/19 PET CT SCANNING
(Agenda No. 8)

Prior to consideration of this item, the Committee was addressed by the following member of the public:

Bill MacKeith of Oxfordshire Keep Our NHS Public stated that his group was concerned that the provision of mobile scanners in the other areas of the Thames Valley region could have knock-on effects for Oxfordshire. He understood that many clinicians believed that the mobile scanners were inferior and that scans would have to be redone at the Churchill Hospital in Oxford.

He asked the Committee to contact other local authorities in the region to coordinate support for public provision of services and to require a six-month report from NHS England to measure performance of the services in the different centres.

Janet Meek, Director of Commissioning South East, NHSE, described the collaborative approach that has been agreed. The OUH service based at Churchill Hospital will be retained on a separate contract directly with NHSE. New services in Milton Keynes, Reading and Swindon will be run by InHealth. The agreement increases access and will reduce waiting lists.

Dr Bruno Holthof, Chief Executive OUH, stated that the new contract met their requirements and would allow them to invest in new scanners. They were keen that pathways be maintained especially those involving multi-disciplinary teams. Any changes will be clinically-led.

Nicola McCulloch, Head of the Cancer Programme of Care, Specialised Commissioning NHSE, confirmed that this was NHSE's view. Clinical consensus would include cancer groups.

Louise Patten, Chief Executive OCCG, added that there was a lot to be learned from the process in terms of how to engage locally in national procurement. This will set a precedent for others. There will be a local specialist commissioning board for the Oxfordshire services moving forward.

Councillor Laura Price asked what NHSE had learned from this. The feeling was that they presented a blank wall to those expressing concerns. She also asked if there was a danger of duplication if mobile scanners produced inferior quality scans, that then had to be redone at Oxford. She was also concerned that waiting times might be used to nudge Oxfordshire residents towards the services outside the county.

Janet Meek and Nicola McCulloch confirmed that there would be much earlier and greater engagement. All parties recognise their responsibilities. Changes suggested by clinicians were taken on board. They would have to make sure that they heard directly from HOSC.

Dr Bruno Holthof stated that the feedback on their original bid was that it focussed mostly on clinical quality whereas access was a key issue too, which the trust had not prioritised in its bid. Increased capacity in Thames Valley will help cope with expected increases in demand. If scans need to be redone this will be registered as a serious incident as it increases the patient's exposure to radiation.

Janet Meek confirmed that the contract is for seven years with an option for three more. The Long Term Plan envisages earlier diagnosis and the increase in capacity will help deal with this.

City Councillor Nadine Bely-Summers asked if there would be more investment in the Churchill Hospital or if this was really about privatisation.

Janet Meek responded that only the new services were being supplied by InHealth. Investment in OUH will continue. All providers go through a rigorous process and must work closely with the NHS and clinicians. Nicola McCullough added that there had been a procurement process for the extra services and InHealth was the only bid offering services on the wider geography.

Dr Alan Cohen asked if the situation had not been inflamed by threats of legal action by NHSE. The Chairman stated that he understood there were threats made from lawyers to lawyers regarding staff speaking out. He asked for assurances that this would not happen again.

Janet Meek stated that she would not support that, never instructed it and would not ever do so.

Councillor Jane Hanna asked if the procurement arrangements took account of research networks and if there was any difference in terms of accountability and grievance processes between public and private contracts.

Janet Meek responded that all contracts are managed and evaluated the same way with the same grievance procedures including the Ombudsman. Research is outside of core NHSE services. A question about this is included in the bidding process. In this case, both providers are able to do research.

The Chairman thanked Members of the Committee for their robust scrutiny and welcomed the outcome as being in the best interests of the residents of Oxfordshire. He asked for confirmation that no consultation was needed since there was no change of service. He also asked when would be the best time to receive a follow-up report – including pathways, number of patients and patient flows – and if the contracts had actually been signed at this stage.

Nicola McCulloch said that the contracts were still being finalised and confirmed that no consultation would be required. She **AGREED** to provide a follow-up report as

requested. It would need to be a joint report and will include notifications of any serious incidents. She suggested early in the new year.

54/19 INTEGRATED CARE SYSTEM

(Agenda No. 9)

Louise Patten, CEO OCCG, gave a presentation on progress and plans with the Integrated Care System. This is a way of working regionally. It is not creating new organisations. For planning and commissioning the level of population makes sense. The counties share the characteristics of additional population growth and an aging population.

Integrated Care Partnerships, involving health and social care, are certainly at the best level of population for commissioning and provision. For example, with discharge from hospital we need to look at the cost of everything and then see is there a way of working differently to change the provision at a cost that works. A budget would be delegated to Oxfordshire and local accountability would remain.

With ICS the partnership at this scale makes sense for dealing with workforce, digital and prevention issues. It is all a bit empirical at this stage but she can provide examples of how it is working elsewhere.

There is a certain inevitability of the CCGs merging. It will free up money for services. The process includes consultation – an engagement document has been drawn up with the initial thoughts. The timescale is being worked on.

From April 2020 it will shadow the ICS but will have more form at that stage and it will be clearer how it relates to HOSCs and the Health and Wellbeing Boards.

At the request of the Chairman, Louise Patten **AGREED** to share the maturity assessments.

Anita Higham asked where the patient voice would be in this. Louise Patten responded that Patient Participation Groups are the patient voice in primary care. They can vary greatly in how they operate. There will be a contracting group for a PCN rather than for individual practices. The commissioning process will set expectations for PCNs and will need to state that they are expected to have the patient voice represented.

Councillor Laura Price asked to what extent the ICS is a Sustainability and Transformation Partnership (STP) rebranded. The language is the same: it's a way of working not a body. She also asked how the different financial positions are being managed and what the relationship will be with Adult Social Care.

Louise Patten said that the STP is a difficult concept to communicate. They will only work together where it adds value and makes efficient use of NHS resources. There are many overlaps and much learning that can be shared. At this higher level the scale is enough to have our own Special Commissioning Board. People locally can sit on that and influence it. There is more form on ICS than before, but the statutory

organisations still exist. Different providers such as OUH and Royal Berkshire Hospital are starting to work together on common issues to support choice and outcomes for people. With regard to different financial positions, all have got challenges and they can be better tackled by working together. There is an aspiration to bring together health and social care. This will be developed further with outcomes-based work.

The Chairman suggested and it was **AGREED** that ICS be a more substantive item on the Committee's agenda for the November meeting with adult social care represented.

Dr Alan Cohen said that the difference between purchaser and commissioner was not clear. There appeared to be more movement towards commissioning. He asked, if there is going to be closer working between health and social care, what the role of the CCG will be and could it be a case of getting rid of the CCGs?

Louise Patten responded that what CCGs did was to engage clinicians and that engagement must not be lost. Historically commissioning described what we want and they bid. Now it works on describing the outcomes, setting up frameworks so patients get a better experience as they go through the system. Some commissioning functions are not needed anymore. What is needed is analysis, planning and making sure the outcomes are being achieved. Some commissioning needs to happen at scale, in particular special commissioning such as Mental Health. It's not about CCGs getting bigger. The role is changing.

District Councillor Paul Barrow asked what the estimated savings would be over five years and how they will be distributed. Louise Patten stated that each CCG has to achieve a 20% reduction in running costs - including the cost of clinicians and services bought from Commissioning Service Units. The money is expected to be recycled into clinical services. There may be a single management team with more money put back into the front line.

Anita Higham asked what the governance arrangements will be in a CCG merger. Louise Patten noted that no decision has been made to merge but where they have, there is a single board with the same representation as currently. There will be an engagement exercise to go through.

55/19 WINTER PLAN 2018/19
(Agenda No. 10)

Diane Hedges, CEO OCCG, gave a presentation. She described the learning from last winter. A number of aspects showed improvement: shortened hospital stays and reduced waiting. Schemes that need new staff struggle. The 'home first' approach is important - avoiding someone going into hospital in the first place. They are integrating mental health into the planning.

Sam Foster, Chief Nursing Officer OUH, said that a key aim is to reable more quickly and release capacity. She emphasised that health was not just about hospital beds and that there was no "Winter Ward".

The Chairman noted that last year a commitment was made to send weekly updates but none were received. He asked for a commitment again and that it be followed through. He also asked for clarification on the target for the Home Assessment Reablement Team (HART).

Benedict Leigh, Deputy Director Commissioning OCC, responded that the target for HART Contingency Hours was 600 and the actual outcome was 447. These are hours that HART can use to support people to leave hospital quickly while a longer term solution is found. So a reduction in the hours needed is a positive indicator.

Diane Hedges apologised for the absence of weekly briefings last year and **AGREED** to provide them this year. They will need to discuss what is most useful to include.

Councillor Mark Cherry asked how they were set up to cope with any heavy snow fall, for example how will patients be transferred?

Ross Cornett, Head of Operations Oxfordshire, South Central Ambulance Service, responded that they have a 4x4 but could not have a whole fleet of them based on the need for a few days of the year. They would get assistance from the local resilience forums and through the County Council prioritising roads around hospitals for gritting.

Councillor Laura Price asked with the trusted assessor model if private providers are being asked to do an assessment and if their assessments can be believed? She also asked if the £1.4m fund included the Better Care Fund and Improved Better Care Fund.

Benedict Leigh said that short-term beds would be sourced from private and voluntary sectors. They have brought together the various schemes to create a more coherent offer. It was a much clearer way of buying short-term beds and being supported by multi-disciplinary teams. They are asking all to trust the assessments of other people and developing relationships between those in the system. He **AGREED** to circulate more detail through a briefing around this next week. He confirmed that the BCF and iBCF are not included in the £1.4m.

Dr Alan Cohen said that the Section 136 figures looked extraordinary. He asked if the planning on beds was with or without the Fulbrook Centre and if there would be an impact on the strategy for community beds.

Diane Hedges **AGREED** to come back on the section 136 numbers to explain them. On Community Hospital beds, they have made the same assumptions as last year. With short term beds, throughput will be different to acute beds.

Pete McGrane, Clinical Director OH, said that there would be recommendations next week on the City Community Hospital. They gave a commitment to reopen it through recruitment. Winter planning excluding CCH is for 140 beds and he thought they will open more beds than that.

Barbara Shaw noted that families often underestimate the amount of unpaid care needed. She asked what they are doing to ensure right levels of care and not over-reliance on unpaid care and for the number of readmissions.

Sara Randall, Chief Operating Officer OUH **AGREED** to provide readmissions numbers. Sam Foster added that they use a clinical assessment in the home with the family to determine how much support people need. Readmissions are not always a bad thing.

Councillor Jane Hanna raised a number of issues:

- She asked to see a list of all the acuities to see where the pressures are coming from.
- Does the £1.4 million include Brexit?
- When will the Emergency Medical Unit will be live?
- What is the latest on the temporary closure of Wantage Community Hospital?

Diane Hedges **AGREED** to provide a list of acuities and an update on the EMU. It has been agreed to have an Urgent Care Leader. Sam Foster is writing the scope to ensure there are structures in place.

With regard to Wantage CH, patients are moved to where the bed is most appropriate, irrespective of where they live, in order to get the best outcome. They are looking at the blend of services and beds needed. Workforce problems make it difficult to keep beds open.

The Chairman noted the commitments to provide information on trusted advisors, winter weekly updates, section 136 growth, readmissions data, EMU and risk assessments. He asked for them all to be circulated within two weeks of the meeting.

56/19 TRANSITION OF LEARNING DISABILITY SERVICES

(Agenda No. 12)

Helen Ward, Deputy Director of Quality, OCCG, introduced the report. There have been significant improvements since Oxford Health NHSFT took over provision of services. Mainstream services have become more accessible for those with Learning Disabilities and autism. There is a self-assessment toolkit available. Before 2017 there was no local inpatient provision but now nearly half are being treated within Oxfordshire. They are reliant on independent providers for specialised services. The Oxford Health contract is monitored through a range of information including serious incidents and complaints.

The LeDer programme involves reviewing the deaths of people with a learning disability and helps identify proactive work to address any factors that may have contributed.

Kirsten Prance, Associate Clinical Director of Learning Disability Services at OH, added that the aim is to support all those with LD where there is ability to have life expectancy the same as the rest of the population. They work in partnership with

Adult Social Care and provide supported living placements where there are changes to family support.

Benedict Leigh stated that Oxfordshire Family Support Network have targeted support specifically for parents supporting an older adult to ensure they have a sustainable home available.

Dr Alan Cohen asked if health outcomes are being measured. Helen Ward responded that people with LD have an annual health check. The LeDer programme nationally has data on this. People with LD have the same issues as the general population but do not access health care services as much. For example, annual health checks found two previously undiagnosed conditions when first rolled out.

Kirsten Prance added that the priorities in terms of physical health are diabetes, respiratory health and bowel management.

Councillor Jane Hanna asked about epilepsy given that, in some areas, 25% of people with LD have epilepsy.

Kirsten Prance responded that the LD team have a comprehensive toolkit. There are usually a range of other health needs associated with epilepsy. There is a special clinic for complicated cases. Every death is reviewed but none has been found to be directly from epilepsy.

The Chairman noted that it was rare for a service to receive 43 compliments and seven complaints, but it was clear that they were not resting on their laurels.

57/19 DENTAL SERVICES AND DENTAL HEALTH IN OXFORDSHIRE

(Agenda No. 13)

Anna Ireland, Consultant in Dental Public Health (Thames Valley), Public Health England South East, stated that dental health in Oxfordshire is good compared to the national average but, as with general health, there are more problems in some groups, especially the young, the old and the poor.

Hugh O'Keefe, Contract Manager for Dental Services, NHS England South Central, added that in the Thames Valley there has been a 30% increase in people accessing NHS dentists in the last ten years which is a higher rate of growth than for other areas.

There are about 280 NHS practices in the Thames Valley and 150 private providers. Work focuses on deprived areas with "Starting Well" pilots. They are also looking at how to provide dental services in care homes.

Dr Eunan O'Neill, Consultant in Public Health OCC, described the oral health promotion service which is trying to improve knowledge and behaviours. They have trained people to work with children and adults as well training care home workers in older adult oral care. A report by the Care Quality Commission helped in shaping the response. Care plans should include oral health.

The Chairman noted that he had seen nursery school children being encouraged to brush their teeth after lunch and asked if this was common.

Anna Ireland said that it was becoming more commonplace but was not universal. Eunan O'Neill added that they had piloted toothbrushing in primary schools but it was difficult to get schools to keep it up.

Barbara Shaw noted a couple of references in the report to data to be released shortly but one of these referred to data from 2016. She also asked about variations in the numbers of UDAs Commissioned.

Anna Ireland described two types of survey. A national survey was delayed due to confusion over who should pay. A survey commissioned locally in 2016 on 'mildly dependent' was carried out locally but the data is "cleaned" nationally. Both are due but there are no timelines.

Hugh O'Keefe said that the number of UDAs is dependent upon the new contracts and how much NHS dentistry is involved. Cash limiting was introduced in 2006 in areas where there is pressure on contracts and so reflects where demand is and explains the variation.

Councillor Kieron Mallon asked if there was a connection between bad oral health and heart disease. Anna Ireland said that there were links with aspiration problems and pneumonia but any association with heart disease was not understood.

Anita Higham asked if there were differences between ethnic groups and if more attention should be paid to 11 to 14-year-olds. Anna Ireland responded that there were different decay rates in different ethnicities but there was no data on brushing. 11 to 14-year-olds in the UK had quite good oral hygiene. They are most likely to attend a dentist and so would not be a group they would target.

District Councillor Paul Barrow asked what were the high risk groups. Dr Eunan O'Neill said that they target high levels of deprivation where they provide an offer with schools. They are moving towards an accreditation programme with primary schools with policies on sugary food, water etc. Some look to use the pupil premium to invest.

Barbara Shaw asked how they are linking with community dental services and care homes. Dr Eunan O'Neill responded that they went to a workshop with Healthwatch Oxfordshire and looked at aspects of the care plan. They want to establish an accreditation where staff can do online training that will be free and quick. Face-to-face training is also available.

58/19 MUSCULOSKELETAL (MSK) SERVICES

(Agenda No. 14)

Diane Hedges, CEO OCCG introduced Rob Walker, Senior Operations Manager, Healthshare and invited questions on the report.

Dr Alan Cohen noted that the last meeting of the Committee asked for EQ5D data but has not received any. There is debate about which measure and then how you measure. He asked for a demonstration on how patient feedback is being used to improve care.

Rob Walker stated that EQ5D is used to benchmark for the CCG. The information is independently gathered. He **AGREED** they can share the data and members are welcome to visit and see for themselves. Dr Cohen asked for one example of a PDSA cycle.

The Chairman asked if physiotherapists employed by Healthshare are getting their uplift according to Agenda for Change. Robert Walker responded that all staff “tupe’d” across came with their terms and conditions. There are band increases every year and Healthshare gave a 1% rise. The Agenda for Change uplift is unprecedented so they are discussing with the CCG what they can do. It was **AGREED** to receive a report back on this when discussions are complete.

Anita Higham gave the example of where a patient is referred to a physiotherapist, all of their notes are given to them. How are patients’ GDPR rights managed in such a situation.

Rob Walker said that referrals us a pro forma. He was only aware of two incidents where extra information was given. It is incumbent on GPs to do this correctly. Diane Hedges added that clear advice has been given to GPs following investigations into the cases and they were particularly advised to be aware of the issues around auto-population of data.

Councillor Hilary Hibbert-Biles asked why provision in Chipping Norton is not in Chipping Norton Hospital. Rob Walker said that they engaged with the hospital at the time but there was no space so they took space in the health centre that is just next door.

Barbara Shaw asked if they identify and support patients who have suffered from delay in referral. City Councillor Nadine Bely-Summer said that she had been told there is a six month wait. Rob Walker stated that times are always within the KPI. They need to engage with GPs more.

The Chairman commented that 56 days was still not great. Rob Walker responded that 8% of the population is referred every year. They have new staff coming in.

The Chairman stated that if the EQ5D data, up to date data on waiting times and an update on Agenda for Change are delivered in good time, then this does not need to be on the agenda next time.

59/19 HEALTHWATCH OXFORDSHIRE

(Agenda No. 15)

Rosalind Pearce presented the update report and will share it with the Task and Finish Group.

Healthwatch meets with the Chief Executives on the Buckingham, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) - formerly the Sustainability Transformation Partnership (STP). They are concerned that there is no stakeholder involvement at BOB level but only at county level and
that strategies and decisions are taken without local involvement.

She wished to make it clear that Healthwatch is a patient voice and is not signing things off. They have been asked to do more at BOB level but that is outside of their remit and they are negotiating for resources to deliver this.

Healthwatch has no input into the Integrated Care Partnerships either. There is a reporting process to the Health and Wellbeing Board. Healthwatch wants Patient Participation Groups to be strong in their Primary Care Networks.

A problem Healthwatch has identified is with access to dentistry in care homes. A visit can cost £150 for patients to access (with taxis and paid time for carers to accompany care home residents) and clinics are often upstairs. They stressed the need for commissioners not to commission dentists who have not addressed access issues.

BOB does not meet in public. Their argument is that this happens at county level where the decisions are made.

Dr Alan Cohen asked if it is difficult for Healthwatch to represent all of the voices on HWB and BOB - voluntary sector, patients – while looking to them for finance.

Rosalind Pearce responded that Healthwatch will not compromise its independence and she is happy to be challenged on that point. They get funding from the County Council but that does not stop them being critical.

60/19 CHAIRMAN'S REPORT

(Agenda No. 16)

Councillor Hilary Hibbert-Biles noted that the Health and Wellbeing Board (HWB) and the Integrated Care System (ICS) are supporting each other and asked who will be scrutinising their decisions. The Chairman stated that this Committee scrutinises the HWB regularly. Where scrutiny of ICS sits will need to come out at the November meeting.

.... in the Chair

Date of signing ....

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HOSC Actions from 19th September 2019

Item no	Item	Action	Lead	Progress update
	Forward Plan	Amend forward plan to include: • Integrated Care System, to include information on maturity assessments and the involvement of patients and the public in ICS roll out. • Two follow-up items on PET scanning to include information on patient numbers and flows and any serious incidents.	Sam Shepherd	Completed Link to maturity assessment guidance: https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
	CCG Update	1. Scope the work to look at how the workforce challenges in health and social care locally limit the provision of community services. This will include workforce modelling. 2. Provide risk assessments in relation to the national and local preparations for Brexit. Confirming whether issues raised by the Yellow Hammer report had been incorporated. 3. Ensure the committee is kept updated on whether and when gynaecological pathways change.	Lou Patten (CCG)	1. Workforce challenges in health and social care is on-going. 2. EU Exit risk information provided to HOSC- in the Chairman's report (21/11/19) 3. No further updates
	Winter Plan	Provide within two weeks of the meeting: • Briefing on the trusted assessor model (Benedict Leigh to provide) • Confirmation of how communications will take place with the committee over winter. • Information to be provided on: - section 136 growth in incidents - readmissions data - the situation regarding the EMU - list of acuity.	Diane Hedges (OCC)	Trusted Assessor briefing provided 25th Sept 2019 (appendix 4 to Chairman's report) Information provided on communication with the committee, section 136 incidents, readmissions, EMU and acuity on 15th Oct 2019. Information in the Chairman's report.

HOSC Actions from 19th September 2019

Item no	Item	Action	Lead	Progress update
	MSK Services	Provide feedback on the discussions and decision on: • Agenda for change uplifts for staff previously TUPE'd across • EQ5D analysis requested- showing a full cycle • Up to date information on the average wait for an appointment	Diane Hedges (OCC)	• This is still in negotiation with CCG finance – a further meeting took place in October. The CCG is awaiting feedback from Healthshare before this can be progressed. • The CCG has we had reviewed The EQ5D data and have requested clarification. • See below table

Average waiting time for appointment

Jul-19		Aug-19	
Patients on list10	Week wait time (average)11	Patients on list11	Week wait time (average)12
1645	5 Weeks	1800	6 weeks
4085	9 Weeks	4415	9 weeks
34	2 Weeks	58	3 weeks
1	0 weeks	3	0 weeks
30	3 Weeks	4	2 weeks
1009	8 Weeks	1418	9 weeks
6985	7 Weeks	7698	8 weeks

HOSC Forward Plan – November 2019

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

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

Meeting Date	Item Title	Details and Purpose	Organisation
Feb 2019	Mental health	To follow an item at a Performance Scrutiny meeting (planned for new year) which will scrutinise Oxfordshire County Council mental health activity and spend. Including: a) Section 75 partnership agreement between OHFT and OCC covering the delivery of social work - Acre Act compliant assessments, care planning, and reviews.	CCG/OH/OCC

Meeting Date	Item Title	Details and Purpose	Organisation
		b) Mental Health Outcomes Based Contract between OHFT and OCCG (OCC contribute funding to this contract) covering the delivery of all mental health support to people with particular conditions, including inpatient care, community support, wellbeing and employment support, housing, and Care Act assessed social care needs. • How are mental contracts being fulfilled and delivered? • How is money being channelled to deliver on outcomes for the people of Oxfordshire?	
Feb 2019 (extra meeting)	Options for OX12	• To scrutinise options for health and care services in the OX12 locality, following the implementation of the Local Health Needs Assessment Framework	CCG
February 2020	Director of Public Health Annual report	• An Annual Report is a statutory duty of Director's of Public Health and it is a duty of the County Council to publish the report. • The Director of Public Health for Oxfordshire will present his Annual Report for 2018/19	Director of Public Health (OCC)
February 2020	HWB Voluntary Sector Network	• Healthwatch Oxfordshire to review and present to HOSC how effective they feel the HWB voluntary sector network is at feeding in views to the board	Healthwatch
Future Items			
TBC- twice within the twelve months to September 2020	PET Scanning	• This item will provide follow-up information following the change of provider of PET scanning services for patients outside of Oxfordshire (but within the Thames Valley region). This item will report to the committee on the clinical pathways followed as a result of the change, the numbers of patients and patient flows.	

Meeting Date	Item Title	Details and Purpose	Organisation
		• It will also include any information on serious incidents which are reported.	
	Adult Social Care Green Paper	• The potential implications of the ASC Green paper on the local health and social care system	System-wide
	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns. • Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities	
	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell) • How District Councils and other partners link with and support social prescribing	
	Health support for children and young people with SEND	• How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care? • Linked to outcomes of SEND Local Area Inspection	OH, OUH
	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
	Optometry	• Provision of optometry in Oxfordshire.	CCG

Meeting Date	Item Title	Details and Purpose	Organisation
		• Trends and issues in the provision of optometry services. • How best practice and innovation from elsewhere are used within the services in the county. • To include a summary of the pathway and waiting times for NHS cataract surgery.	
June 2020	HWBB Annual Report	• Annual Report from the HWBB	HWBB

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21 November 2019

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

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

1. Chipping Norton First Aid Unit
2. Winter
3. OCCG Annual reports

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

Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. Chipping Norton

The Chipping Norton First Aid Unit (FAU) operates from Chipping Norton Community Hospital. The service will be moving to the Chipping Norton Health Centre GP practice, which is on the same site, opposite the hospital building in January 2020.

Although this change comes from NHSE national guidance,[1] it is also in line with the strategic intention to integrate clinical services. There will be clear benefits for patients when the FAU is located together with the multi -disciplinary teams of clinicians working in the Chipping Norton Health Centre and the on-site pharmacy. The clinicians working in the FAU, local GPs and pharmacists are all supportive of this move and are keen to see the FAU continue to provide a service to local people and to explore what further benefits can be achieved.

The service itself will not change and will continue to be provided by the same highly skilled clinicians, with the same opening hours. It will continue to be open to anyone, regardless of where the patient is registered.

The service will continue to be monitored to ensure it delivers a nationally compliant way of securing local first aid/injury services. OCCG will oversee the transition and will continue to measure patient satisfaction with the service.

Two public meetings have been held, to engage with local people about the move to the adjacent building; one through the North Oxfordshire Public Locality Forum on 24 September and another on 23 October so that patients from the local area can see where the FAU will be based and how it will integrate with other services. The meeting at the health centre was highly publicised and gave people the opportunity to talk to the clinicians involved and to ask questions.

2. Winter update 2019

Oxfordshire Clinical Commissioning Group (CCG), Oxfordshire County Council (OCC), Oxford Health NHS Foundation Trust (OHFT), Oxford University Hospitals NHS Foundation Trust (OUHFT), South Central Ambulance NHS Foundation Service (SCAS) and partners are working together to ensure the Oxfordshire health and care system is resilient throughout the winter period - providing safe, effective and sustainable care for the local population, ensuring there is sufficient capacity available, and providing care in the most appropriate setting. The winter plan and has already been shared with HOSC and discussed at their 19 September 2019 meeting.

This update focuses on the delivery of the winter campaign in Oxfordshire which is based on the national campaign ‘Help us Help You’. The aim is to support people to

[1] Urgent Treatment Centres – Principles and Standards July 2017

avoid becoming unwell and if they do need care, help them know how to get the right care at the right time.

Oxfordshire launched the winter communications campaign on 7 October, ahead of the national launch. A major part of the campaign focuses on encouraging all those people in the 'at risk' groups to ensure they are vaccinated against flu. Raising awareness with patients has involved direct communications from GP practices, advertising in local media, providing stories for local media and social media and providing posters and leaflets across local communities. OCCG have also attended student fresher fairs and other community events to share information, answer questions and encourage uptake of the vaccination.

The Oxfordshire Winter Communications Plan sets out themed weeks to help coordinate communications activity over winter. As we progress through winter themes will include raising awareness about the phone app, encouraging people to think about their own winter plan, getting ready for holidays with the '12 days of Christmas' health messages and ensuring repeat prescriptions are organised in good time, promoting the role of NHS 111 for getting to the right service and the additional appointments being made available in primary care and raising awareness of mental health issues.

3. Annual Reports

OCCG have published their full annual report and annual accounts for 2018/19 and a separate annual report for patient and public involvement 2018/19. These were presented at the OCCG Annual Public meeting and are available on the OCCG website www.oxfordshireccg.nhs.uk/get-involved/how-we-are-doing.htm.

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21 November 2019

Title of Paper: The future arrangements for NHS commissioning

Purpose: Over the past year, we have been exploring how our organisations can work more effectively to meet our shared ambitions. This work, together with the publication of the NHS Long Term Plan (LTP), has helped to shape our thinking about how future arrangements could look.

The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an overview of future commissioning arrangements across Buckinghamshire, Oxfordshire and Berkshire West (BOB) and seeks feedback on the proposals.

Each clinical commissioning group in the BOB area is engaging with local people and key stakeholders. In Oxfordshire information about future commissioning arrangements and an online questionnaire have been shared with local NHS staff and GP practices, and with more than 3,500 people through Talking Health, the CCG's online engagement tool. It has been shared via provider trusts with their patient networks and a wider range of stakeholders. Including Healthwatch Oxfordshire, the Local Medical Committee and Oxfordshire councillors. The proposals have also been discussed at various meetings including the Health and Wellbeing Board workshop in November. All information is available on the CCG's website: https://www.oxfordshireccg.nhs.uk/about-us/buckinghamshire-oxfordshire-and-berkshire-west-integrated-care-system.htm

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The future arrangements for NHS commissioning in your area

October 2019

Engagement Document

About this document

This is the first stage of seeking feedback on the future of commissioning within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). We would like to hear your views on two new ways of working:

- local working in each of the three counties (the 'integrated care partnerships')- **See page 5**
- wider, at-scale working across the three areas (the 'integrated care system') - **See page 6**

The way in which the NHS Clinical Commissioning Groups (CCGs) in your area work together is changing. For some time, the three CCGs have been working more closely together, most notably including commissioning services such as 999 and 111. Since 2016, there has been even closer working with an agreed intention to establish joint committees and take single joint decisions on behalf of the whole population, where this is appropriate.

As these new ways of working become more established, this document aims to describe why the management and structure of the existing organisations needs to change and how it could help support all partners to work in a more efficient way which will benefit the local population.

When it was published earlier this year, the NHS Long Term Plan set an expectation that each Integrated Care System will "typically" be covered by a single CCG. By delivering this, the organisations which are part of the BOB ICS would be better able to achieve their vision of a joined up health and care system where everyone can live their best life, get high quality treatment, care, and support now and into the future.

For the BOB ICS, this would mean making sure we get the balance right to keep our focus local wherever possible, while making sure we maximise the opportunities to deliver benefits to our patients. We recognise the opportunity that exists to be more efficient by pooling our expertise and resources across the whole of the ICS and this document sets out some of these.

This engagement is aimed at key stakeholders who would be impacted by the proposed new structure and governance arrangements. However, the engagement document is a public document and we would welcome feedback from anyone with an interest in the proposals.

During this engagement period we would like to hear initial views from:

- GP Practices which are members of the CCGs
- Members of staff from the three CCGs
- Healthwatch and other patient representative bodies

We would also welcome responses from the following stakeholders:

- Members of the public
- Local authorities
- Elected representatives
- Other NHS organisations
- Voluntary and community services

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Introduction

Dear Colleague,

We are asking for views on proposals about the future of commissioning arrangements in Buckinghamshire, Oxfordshire and Berkshire West.

First and foremost, our main focus will be to ensure that everyone living in our geography has the best health and wellbeing they can. To this end, each county based partnership will continue to develop its own local plans, based on local needs, for local people.

Whatever commissioning arrangements are put in place in the future, our priority is making sure local needs are addressed , that we provide people with access to quality healthcare and that we reduce the health inequalities that exist today.

We have a responsibility to make sure valuable resources are used wisely and in the best way to support people in living longer, happier, healthier and more independently into their old age.

We would like to seek your views and opinions about proposals for any new working arrangements that would help to enable this ambition.

You may be aware that health and care partners have been working more closely since 2016, culminating in our designation earlier this year as a ‘wave three’ integrated care system for Buckinghamshire Oxfordshire and Berkshire West.

Over the past year, we have been exploring how our organisations can work more effectively to meet our shared ambition. This work, along with the publication of the NHS Long Term Plan (LTP), has helped to shape our thinking about what any future arrangements could look like.

Our intention is to engage with you on the proposals contained within this document as a first step in a longer process, leading to a CCG member vote. We want to hear your views on our proposals and how future arrangements could be designed for the greatest benefit of local people.

We ask that you please take the time to consider the proposals set out in this document and respond to us with your views by 1st December 2019.

We look forward to hearing from you.

David Clayton-Smith
Independent Chair
BOB ICS

Dr Raj Bajwa
Clinical Chair
Buckinghamshire CCG

Dr Kiren Collison
Clinical Chair
Oxfordshire CCG

Dr Abid Irfan
Clinical Chair
Berkshire West CCG

Fiona Wise
Executive Lead
BOB ICS

Lou Patten
Accountable Officer
Buckinghamshire CCG
Oxfordshire CCG

Dr Cathy Winfield
Accountable Officer
Berkshire West CCG

Existing Commissioning Arrangements

Our three CCGs are:

How we are structured now

There are three Clinical Commissioning Groups (CCGs) within the BOB Integrated Care System.

Over the past six years, the number of CCGs has changed from seven to three. Each is a separate statutory organisations with the same healthcare responsibilities and the need to meet legal and NHS duties.

When CCGs were formed in 2013, the four CCGs established in the Berkshire West area - North and West Reading, South Reading, Newbury and District and Wokingham – operated as a federated group, with one Accountable Officer and a shared management team. They merged in April 2018 to become Berkshire West CCG in order to more effectively support the work towards greater integration and the development of their Wave One ICS.

Similarly, in Buckinghamshire, 2013 saw the establishment of Aylesbury Vale and Chiltern CCGs. In July 2016, the CCGs federated and went onto merge to become Buckinghamshire CCG in April 2018. Since 2017, Oxfordshire and Buckinghamshire CCGs have been led by the same named Accountable Officer.

Most recently, each of the CCGs has been working on the design of joint committees which can take single joint decisions on behalf of the whole population. This is an important step which will begin the process of taking joint decisions where it is most appropriate to do so.

Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care System (ICS) will have three Integrated Care Partnerships (ICPs) delivering improved services to patients

The future development of each Integrated Care Partnership

What is an Integrated Care Partnership?

Integrated Care Partnerships (ICPs) are alliances of NHS and Local Government organisations that work together to plan and deliver care through a joint approach. These providers include hospitals, community services, social care, mental health services and GPs.

Each of our three ICPs in Buckinghamshire, Oxfordshire and Berkshire West will be covered by an Integrated care partnership (ICPs). Each of these ICPs are in different phases of their evolution and an opportunity now exists to set some common principles for their design

Our vision for the development of ICPs

We believe that each ICP should be a clinically led collaboration between the NHS and Local Government and have the following common factors:

Is a vibrant partnership with voluntary, community and the social enterprise sector

ICPs will foster partnerships to develop community assets which provide easy access to a wide range of support.

Operates within a locally designed governance framework which binds the partners

We will make the fullest use of any new, nationally designed systems for ensuring that our ICPs have decision making authority and are accountable to local people.

Will be able to direct how its resources are used to best effect

It is our intention that ICPs will be best placed to understand how resources should be utilised within each ICP and this will be reflected in how services are planned for and delivered

Acts as the main point of interface with Primary Care Networks

With 45 Primary Care Networks across the BOB geography, our three ICPs will offer a more effective interface for the planning and delivery of new services.

Availability of expert resource to ensure local delivery

ICPs will not be able to operate effectively without sufficient expertise and resources to design and embed service change. Each of our ICPs will have access to a designated workforce with a broad skill-mix and experience.

Has its own senior leadership which is represented at an ICS level

We will support our ICPs to ensure they are well led, with executive accountability for outcomes, performance and use of public money. We believe that for the ICS to be successful, representation from each ICP will be essential within the leadership and decision making structures of the ICS.

Utilises shared care records to ensure providers and practitioners have access to the information they need to provide seamless care

What are the benefits of implementing strong ICPs?

We are committed to ensuring that each ICP is well developed to guarantee that each part of our system can deliver the transformation to services required by the Long Term Plan. The NHS is stronger when it works in partnership, whether that is between NHS organisations or with our other partners such as Local Government and their social care teams. We will know that we have created the right model for ICPs when:

- Patients can more easily receive their care from a number of different organisations with no duplication or interruption to their service from crossing organisational boundaries
- Our organisations make best use of our resources, sharing expertise and budgets where appropriate to achieve greater efficiency and more streamlined working
- ICPs are able to make recommendations on how money is best spent, accountable to local people through democratic structures such as Health & Wellbeing Boards
- These local partnerships have strong leadership and governance, with an energised workforce which is committed to working for the benefit of local people
- Primary Care Networks are being well supported by their ICPs and able to implement the new models of care described by the Long Term Plan

Tell Us What You Think:

What is important for you about the development of Integrated Care Partnerships in your area?

What are your views on our vision for Integrated Care Partnerships?

In your view, what are they key features of a successful Integrated Care Partnership?

Identified drivers for reviewing our way of working across the Integrated Care System

1 We need to meet the ask of the NHS Long Term Plan

The NHS Long Term Plan (LTP) published at the beginning of 2019, set out the vision and ambition for the NHS for the next 10 years.

It states that:

*"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level… **This will typically involve a single CCG for each ICS area**. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long-Term Plan implementation" -- NHS Long Term Plan (2019) p29*

Whilst this is a natural development of the work that we have been advancing as three CCGs, it makes our current configuration unsuitable if we are to meet this requirement.

2 Joint arrangements require leadership and management support

During 2019/20, the three CCGs have been designing a mechanism for taking commissioning decisions together. As this process continues to evolve, it is expected that by the end of the year joint decisions will be made with regard to:

- **CCG commissioned services at scale**
- **Primary Care**
- **Specialised Services (in collaboration with NHS England)**

We believe that this is a real opportunity for our patients, particularly to reduce variation between geographies and eliminate 'postcode lotteries'. This way of working will become increasingly difficult however as leadership and management resource currently resides in each of the three separate CCG organisations. To make this way of working operationally effective, we must be able to find a way to build formal organisational and management structures across the ICS geography.

3 We could provide better support for Primary Care Networks (PCNs)

In order to become the delivery vehicles for more local care services, much more will be required of PCNs than can be delivered within the current commissioning arrangements. All transformation funding for PCNs is already allocated at a BOB ICS level and this is likely to continue to be the case. PCNs will require considerable assistance in their development including leadership support and the ability to engage on an equal footing with other partners inside their ICP, some of whom will be long established and of a considerably larger scale.

It is envisaged that with regard to PCNs, stronger collaboration would:

- Support PCNs become capable providers
- Make sure that investment flows to support and maintain transformation
- Take a more rounded view on the maturity and capabilities of PCNs across a broader footprint than a single ICP

4 We need greater oversight and accountability for the ICS

The ICS is a recent development which does not currently have permanent leadership or statutory governance. Neither of these options are sustainable given the vital role it will play in the future strategic commissioning role envisioned for an ICS by the Long Term Plan. We recognise that we need to address this challenge quickly to ensure long term sustainability and effective oversight of the ICS, particularly with the expectation that future investments in service transformation will be allocated at an ICS geography.

5 We have a better opportunity to share expertise and resources

NHS organisations in the BOB geography have a long and successful history of working collaboratively. In common with other NHS organisations, our partner organisations regard workforce shortages as their greatest risk to delivering the ambitions of the NHS. As a merged organisation implemented at a larger footprint, greater support could be provided to ensure that where our providers have the most challenging shortages (e.g. dermatology, bariatrics) greater facilitation could be provided to help resolve this, matching capacity with demand and eliminating postcode lotteries.

Proposals for changes which will help us meet these challenges

1

Appoint a single Accountable Officer and Shared Management Team

We believe that a single Accountable Officer will provide a focal point for leadership and accountability within the Integrated Care System. Our expectation is that this postholder would also assume the role of the Executive Lead for the BOB ICS, enabling a greater degree of statutory authority and accountability for the role. This decision is reserved to CCG Governing Bodies and would be a critical component from which any of the other proposed changes would have to rely on to be effective. By taking this step we would:

- Have individual accountability which mirrors our news way of working
- Provide strong and consistent leadership across the organisation(s)
- Be able to establish a shared resource with significant expertise able to work at scale
- Achieve a greater level of efficiency for the taxpayer, patients and partner organisations

2

Design stronger Integrated Care Partnerships which are constituted using a set of common principles

Our three ICPs will be the main delivery function for our shared ambition to transform the services delivered to patients. A number of approaches may exist to ensure that the three ICPs can be designed to deliver this function and the previous section of this document sets out some of the potential features for your feedback. It is our expectation that each ICP would be:

- A vibrant partnership with voluntary, community and the social enterprise sector
- Operating within a strong, statutory framework which binds the partners
- Able to direct how its resources are used to best effect
- The main point of interface with Primary Care Networks
- Supported with resource to ensure the delivery of local priorities
- Has its own senior leadership which is represented at an ICS level
- Utilises shared care records to support better care across different settings

3

A proposal to create a single commissioning organisation across the BOB geography

In line with the Long Term Plan, there is an expectation that each ICS will 'typically' be covered by a single CCG by April 2021. To address this requirement we would like to engage with our stakeholders to explore their views on reviewing our commissioning architecture to mirror the ICS footprint. This will require the approval of the member practices of the current CCGs as set out in their constitutions. If this proposal was approved, we would:

- Operate more effectively within a statutory framework that reflects the way in which we now work
- Establish common principles to support the design and delivery of changes at a ICP and network level
- Eliminate the inefficiencies of having three separate sets of reporting and regulatory requirements
- Provide a single point of interface for partner organisations and regulators to interact with

Benefits of greater collaboration between our organisations

Better healthcare and health outcomes	Greater collaborative working would provide the best opportunity to support each ICP with its work to improve healthcare, tackle health inequalities and ensure consistency of services in terms of quality and availability across Buckinghamshire, Oxfordshire and Berkshire West.
Better use of clinical and other resource	Through the new Primary Care Networks and Integrated Care Partnerships, GPs and other healthcare providers will focus on developing and delivering services to meet healthcare needs in their neighbourhoods, whilst still being involved in strategic commissioning through their membership of a single commissioning organisation. By working more collaboratively, we could encourage closer working between NHS organisations to better match capacity with demand.
Stronger, consistent commissioning voice and leadership	Closer working would provide a stronger, single and more consistent commissioning vision, leadership, voice and approach. Clinical leadership would have a greater impact, with the development of common principles and sharing of expertise between ICPs and organisations.
Greater support for transformation and local innovation	It is likely that transformation funding will continue to be allocated at a BOB level. Working across the BOB ICS to implement a single, cohesive strategy, accompanied by speedier decision-making, would enhance the pace at which transformation can be achieved. This could deliver better patient health outcomes more quickly and effectively, and improve the consistency of services as well as the approach to commissioning.
More efficient way of working	Closer working would eliminate duplication of some current functions such as payroll and procurement. This improvement in how we work work together would enable us to be more efficient and therefore address priority activities which deliver real benefits for local healthcare, rather than duplicating activity.

These proposals will support the continuing evolution of the BOB Integrated Care System

Relationship with the BOB Integrated Care System

Should the proposal for a single Accountable Officer be supported, it is our intention that this individual would also act at the BOB ICS Lead. This does not mean, however, that the ICS and the CCG(s) are the same thing. Whilst the CCG(s) will continue to be responsible for the legal duties required of them, the ICS will play a broader role in the promotion of collaboration and integrated leadership between public sector organisations across the area. The ICS has collectively agreed the following principles:

1. Activities and decisions will occur as **locally** as they can, keeping close to patients and services.

2. Focus effort at the level where it will be most **efficient and effective** at achieving optimum outcomes.

3. Reduce unwarranted variation in outcomes and value.

4. Avoid wasted effort by **reducing duplication** within the system.

5. Drive consistency of intent, approach and outcome.

6. Align decisions with our long term **population health outcome goals** and our **long term plans and strategy**.

7. Deliver services in a way that is **well understood by our populations and those who deliver care.**

The BOB ICS has an ICP based focus, recognising that system working at a county level is a key driver of much of the transformation across the BOB footprint. The role of the BOB ICS will therefore be to:

Take collective responsibility and secure consensus for patient experience, clinical outcomes, safety and value for money whilst fostering work with partners to design changes which improve all of these things.

Set the strategic agenda for work which develops the health and care offering in each of the three ICPs.

Define common principles of transformation for both system wide and ICP based improvement programmes which improve service delivery and value for money.

Act as a point of support and challenge to partners in the development of improvement schemes, commissioning plans and business cases.

Facilitate the sharing of best practice at ICP, system and wider level between partners.

How to share your response to this document / Next Steps

Please share your views by:

Completing the online survey via your CCG's website

Emailing us at the following addresses:

Buckinghamshire ccgcomms@buckscc.gov.uk
Oxfordshire OCCG.media-team@nhs.net
Berkshire West communications@royalberkshire.nhs.uk

Sending your response by post to:

Buckinghamshire
Buckinghamshire CCG Communications and Engagement Team
County Hall, Walton Street, Aylesbury HP20 1UA

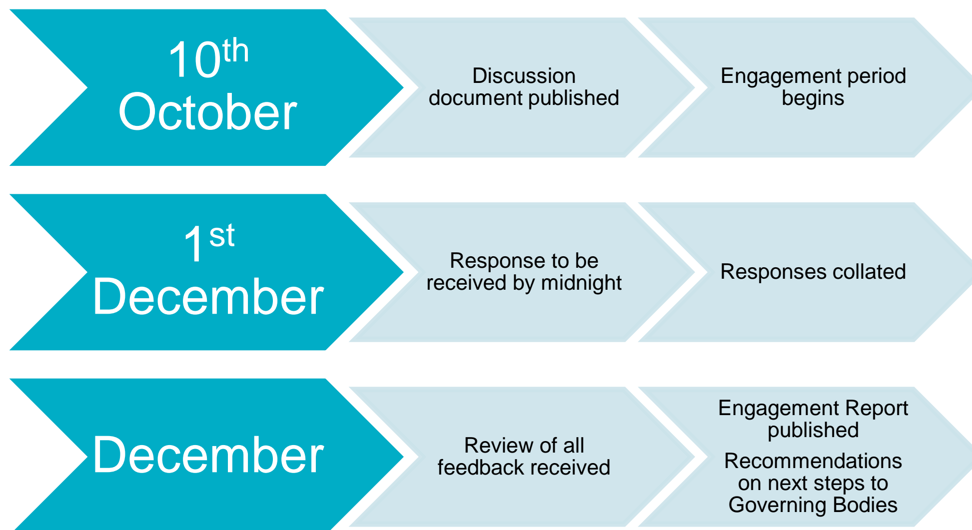
Oxfordshire
Oxfordshire CCG Communications and Engagement Team
Jubilee House, John Smith Drive, Oxford Business Park South,
Oxford OX4 2LH

Berkshire West
Berkshire West CCG Communications and Engagement Team
57-59 Bath Road, Reading RG30 2BA

Next Steps

All feedback received will be fully considered by CCG and ICS leaders and will inform recommendations to CCG Governing Bodies about a single Accountable Officer/ICS Lead, associated supporting management structure and consultation with CCG members on any future possible CCG configuration.

An engagement report will be published and made available via the CCGs' websites.



We would like to hear your views by midnight on 1st December 2019. Following this we will set out our next steps in due course.

Report to Oxfordshire Health Overview and Scrutiny Committee
November 2019

Health Inequalities Commission Implementation Group
Update report

1. Introduction - The Strategic Approach to tackling health inequalities

It is now 3 years since the independent Health Inequalities Commission (HIC) reported its recommendations to the Health and Wellbeing Board. As agreed by the Health and Wellbeing Board (HWB) in November 2018, the implementation group has now adopted a more strategic approach to this work. This was reported to the Health Overview and Scrutiny Committee in April 2019.

The strategic approach incorporates the following elements

- Adapting and developing existing systems and processes
- Furthering the Prevention Agenda
- Building on Existing Projects
- Leading on sharing good practice

This report will focus on furthering the prevention agenda and reporting on good practice in some new projects funded through the Innovation Fund which was set up in response to recommendation from the Health Inequalities Commission.

This report also includes information on the strategic direction being proposed by Ansaf Azhar, the Director of Public Health for Oxfordshire.

The report to HOSC in April 2019 included information on the other aims of the implementation group and can be found via the link[1] below.

2. The Prevention Framework

The Prevention Framework is a major new resource for the county. It has been written by Dr Kiren Collison (Clinical Chair, Oxfordshire CCG) and Jackie Wilderspin (Public Health Specialist) in collaboration with a range of partners. It was presented to the HWB at their meeting in September 2019 and welcomed as a practical approach to implementing the HWB priorities of Prevention and Tackling Health Inequalities. These are cross-cutting themes in the Joint Health and Wellbeing Strategy. Successfully preventing ill health and reducing the impact of disease needs a contribution from everyone. The Framework sets out to show that socio-economic factors and the built environment have a great impact on our health outcomes, along with our behaviours and our access to health services. This is illustrated in the diagram below:

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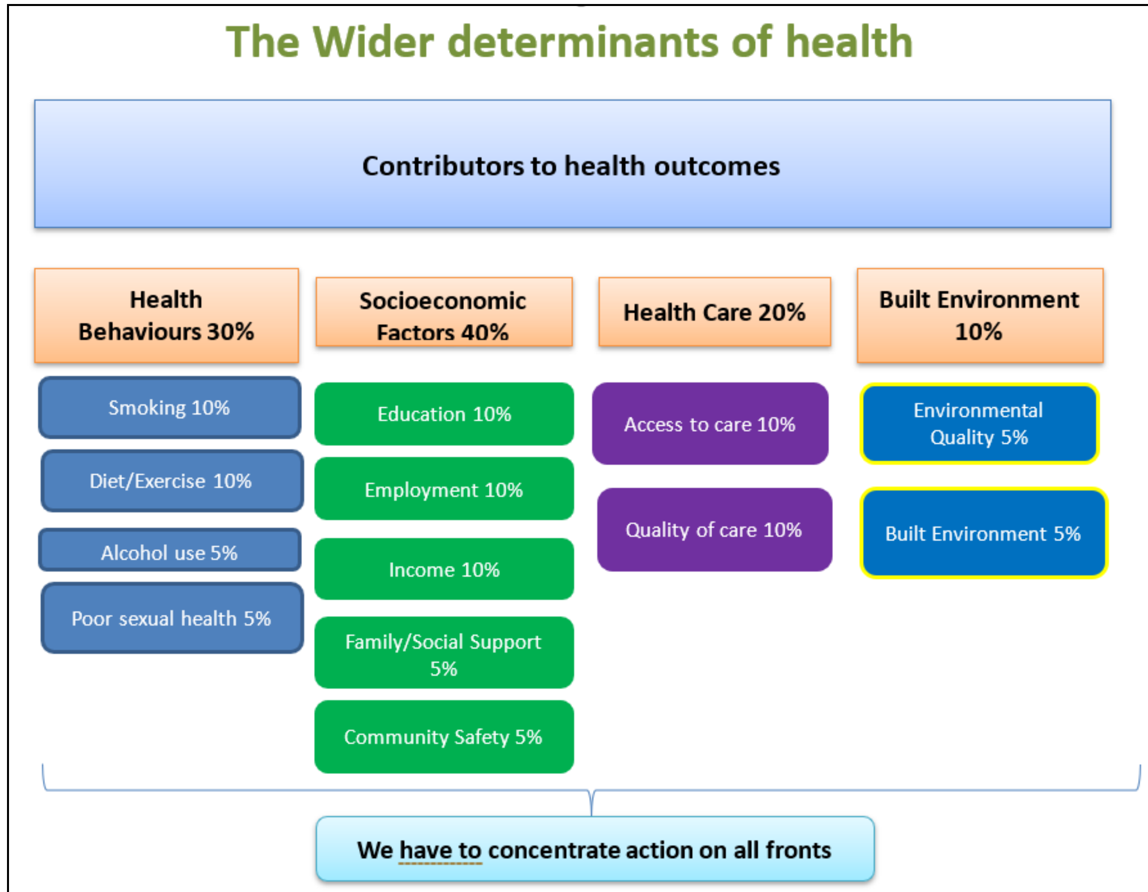
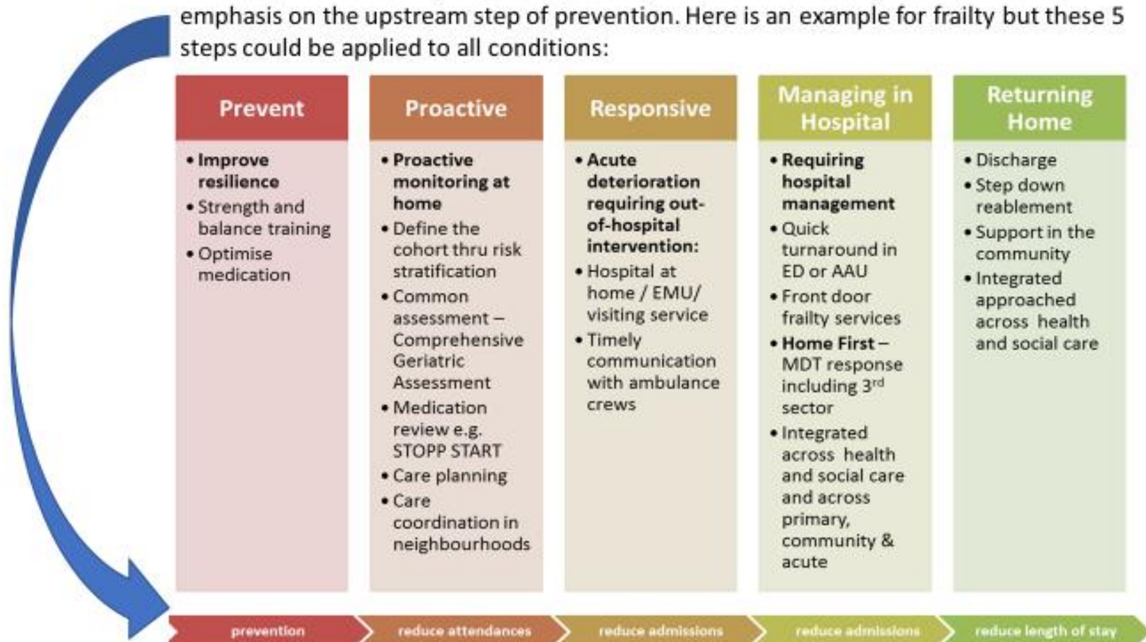
[1] https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=148&MId=5617
Item 22/19



Similarly, the Framework illustrates that prevention can be incorporated into patient care pathways and become embedded in NHS work as illustrated in the diagram below, which uses the example of frailty:



The Prevention Framework comprises a comprehensive guide to prevention priorities across each of these contributors to health outcomes, evidence of good practice for each, lists of existing assets and recommendations. The aim is for it to be used by all organisations in the health and care system.

The Prevention Framework is appended to this paper, along with 3 checklists showing the range of actions that can be taken by different partners to tackle priority topics of

- Healthy Place Shaping,
- reducing cardiovascular disease and
- tackling loneliness and isolation.

Kiren Collison, Ansaf Azhar and Jackie Wilderspin are now promoting a practical guide to how the material in the Prevention Framework can be used to develop and implement action to tackle health inequalities, Prevent ill health, Reduce the impact of disease and Delay the need for care.

3. The focus on inequalities in the Prevention Framework

Health inequalities are often expressed as variations in outcomes for people from particular localities or groups. For example, more people die before they reach the age of 75 in areas identified as "more deprived," which is then reflected in the differences in life expectancy across Oxfordshire. Living in these areas also carries a higher risk of being unwell in middle age (having a shorter "disability free life expectancy"). The Prevention Framework identifies the causes of premature illness and death and outlines the preventable factors, enabling us to plan appropriate actions to improve these outcomes.

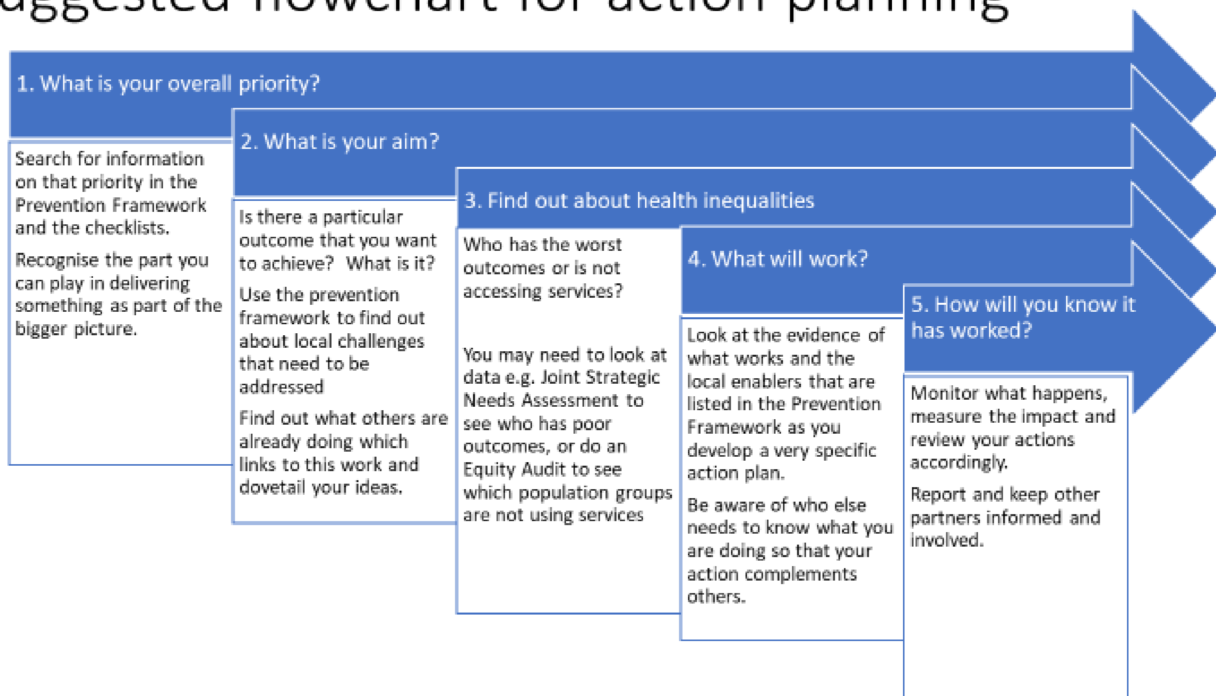
Similarly, some groups of people have higher rates of particular illnesses than others because of their genetic make-up, their gender, ethnicity or age. These factors also need to be identified and mitigated where possible.

It is clear, therefore, that by targeting our prevention initiatives to particular communities or population groups with worse outcomes, we can have a bigger impact on preventing illness and also tackling inequalities.

This is the focus of how the Prevention Framework is being implemented.

To help with this a flow chart is being devised which sets out simple steps for action planning, incorporating a focus on tackling inequalities. This will also enable more reporting of how the inequalities gap is being closed.

Suggested flowchart for action planning



To help everyone access data on inequalities there is a plan for even more information to be included in the 2020 Joint Strategic Needs Assessment. The new Index of Multiple Deprivation (2019) has recently been published, for example, and will be analysed and reported, including at very local (ward) level for some places of multiple deprivation. Similarly, the existing Basket of Inequalities Indicators, devised in response to a recommendation from the Health Inequalities Commission, has been updated and further developed to provide useful information for action planning.

A presentation will be given at the HOSC meeting to illustrate this approach in more detail.

4. Final report on the use of the Health Inequalities Innovation Fund

The Health Inequalities Commission recommended that an Innovation Fund should be established which could be used to fund "*sustainable community-based projects including those which could support use of technology and self care to have a measurable impact on health inequalities and improve the health and wellbeing of the targeted populations.*"

To deliver this recommendation, the Health Inequalities Commission Implementation Group have partnered with the Oxfordshire Community Foundation (OCF) to develop the fund and distribute grant awards.

A total of £12,000 was pledged by local authorities through the Growth Board and matched by the CCG to set up the fund totalling £24,000 in 2018. An additional £2400 (10%) was contributed separately from Oxfordshire County Council to cover the administration fees of OCF.

The applications for grant funding were made directly through the Oxfordshire Community Foundation (OCF) and additional value was realised by combining some OCF funds with the Innovation Fund for some applicants. A wide range of projects were considered. Representatives from the Health Inequalities Implementation Group worked with the OCF in considering and following up the funding applications. The funding was disbursed in 3 phases between November 2018 and September 2019. All the money has now been allocated and projects are in progress. The impact of the projects will be reported to the HIC Implementation Group in due course.

The following allocations were made:

Phase one funding allocations

The first phase of funding was combined with the OCF Tampon Tax Fund (from the Department for Digital, Culture, Media and Sport). The grants assessment was held in November 2018. Contributions were awarded to:

Aspire Oxfordshire – Gym Bus (£5225 contribution)
Aspire are launching a 'Gym Bus' for Oxfordshire to take sports and physical activity sessions to disadvantaged women across the county to provide them with essential early intervention support and help them take their first steps towards positive life changes such as work experience, training, employment, volunteering and secure housing.

Ark-T – "HerSpace" workshops and self-care retreats (£5,000 contribution)
Ark -T run creative programmes to enable people to learn practically how to raise self-esteem and build healthy relationships. They also help in developing essential life skills and supporting progress into education, training, volunteering and employment.

'HerSpace' is an afterschool term-time club for 12 to 18 year old teenage girls where participants develop practical art and design skills which could lead to employment opportunities, build arts and social leadership skills, project management, communication skills, time-management skills and learn about physical and nutritional health creatively.

Home Start Oxford – support to families (£1,775 contribution)
Home Start provides training, matching and support of volunteers who offer support, friendship and practical help to families (primarily mums) with under fives, who are vulnerable, isolated or under stress. They work with families with multiple disadvantages and complex needs, including domestic abuse, substance abuse, mental health, learning difficulties, and the greater risks around safeguarding and exploitation that can follow.

Phase two funding allocations

The second phase of funding was combined with the OCF Loneliness and Isolation Fund. The grants assessment was held in February 2019. Contributions were awarded to:

Sound Resource – singing project in Banbury (£3450 contribution)
Sound Resource run fun, inclusive, participatory singing sessions which bring adults in the community together in a friendly social setting. Sessions are guided by experienced community singing practitioners using a wide range of material.

Bookfeast – Tea Books reading project (£2550)
Bookfeast is an Oxfordshire charity dedicated to developing the habit and enjoyment of reading. They create projects that encourage people to both read more and to enjoy both reading and talking about books. TeaBooks groups run in a variety of settings across Oxfordshire. They are planning to trial the use of tablet computers to increase accessibility of e-books & e-audio books.

A Public Health colleague has made visits to establish links with each of the projects funded in phase 1 and 2 and it is expected that the same will be made for phase 3.

Phase 3 Funding allocations

The third phase of funding was combined with the OCF Community Friendship Fund. The grants assessment was held in September 2019. A contribution was awarded to:

My Life My Choice – Gig Buddies project (£6,000 contribution)
My Life My Choice (MLMC) is a self-advocacy organisation for people with learning disabilities. Gig Buddies pairs up volunteers with adults with learning disabilities, mental ill health and older adults to support them to get out and do the things they enjoy and expand their social circles. Through these pairings and regular group events, the project aims to reduce social isolation and loneliness.

The HIC Implementation Group agreed that there have been considerable benefits of working with OCF in this way. These include

- Opportunities for collaborative funding
- OCF leading on the administration of the grant schemes using their already established assessment and monitoring processes.
- An opportunity to make connections with a range of community and voluntary organisations who are in contact with OCF.
- Finding out about new processes for grant funding such as the Good Exchange funding platform which OCF use. https://thegoodexchange.com/

The Innovation Fund has been dispersed and is now closed. Now that all funding has been allocated, OCF will continue to manage the grant on behalf of the HIC Steering Group and will be gathering monitoring data to report back to us a year after each grant award.

A good working relationship has been built between the HIC Implementation Group and OCF and so discussions have started around how the HIC Implementation Group could work with OCF more strategically going forward.

5. Next steps - the Director of Public Health's proposals for a strategic approach in areas of multiple deprivation.

Since his appointment to the post of Director of Public Health in August 2019, Ansaf Azhar has been scoping the priorities for public health in Oxfordshire. He is now in the process of writing his first Annual Report for Oxfordshire and will bring a draft to HOSC in February 2020 for discussion.

The emerging priorities that Ansaf has identified include

- The need to focus on small areas of multiple deprivation in the county
- The development of small area profiles and community asset mapping
- The power of Healthy Place Shaping as an approach to improving health and wellbeing, incorporating planning and the built environment, community activation and access to services.

Dr Kiren Collison, Clinical Chair, Oxfordshire CCG
Ansaf Azhar, Director of Public Health
Jackie Wilderspin, Public Health Specialist

Annex

1. Prevention Framework and Checklists for priority topics are item 9 on the HWB agenda for September 2019 which can be found here:

https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=897&MId=5627

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Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21 November 2019

Title of Paper: Update report on the Mental Health Support Teams and the Child and Adolescent Mental Health Service four week wait national pilot

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with a progress report on implementing Mental Health Support Teams (MHSTs) in Oxfordshire schools. It will also explain how the new MHSTs fit within the overall Children and Adolescent Mental Health Service (CAMHS) provided by Oxford health NHS Foundation Trust.

The paper also updates on progress with the Oxfordshire four week wait pilot, funded by NHS England.

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

Oxfordshire Health Overview and Scrutiny Committee: Report on the Mental Health Support Teams (MHST) pilot and the Child and Adolescent Mental Health Service (CAMHS) four week wait national pilot

1. Introduction

This paper is presented at the request of the Oxfordshire Education Scrutiny Committee, following its deep dive into secondary school attendance. It will update members of HOSC on progress with implementing Mental Health Support Teams (MHSTs) in Oxfordshire schools. It will explain how the new MHSTs fit within the overall CAMHS provided by Oxford Health NHS Foundation Trust (OHFT). It will look at how the new teams fit with the pastoral care offer that is the responsibility of each school and with wider services that support children's mental health and wellbeing.

The paper also updates members on progress with the Oxfordshire 4 week wait pilot, funded by NHS England, which aims to test the best way to reduce waiting times for CAMHS and support setting of a new national CAMHS waiting standard.

2. Mental Health Support Teams

Oxfordshire Clinical Commissioning Group (OCCG) secured NHS England funding to pilot four new MHSTs in Oxfordshire schools. Each team will cover 8,000 students. The first phase of the pilot is well underway with two teams established in Oxford City covering all primary and secondary schools. Plans for two additional teams were launched in October with primary and secondary schools in the Banbury and Bicester area. There are thirty-five schools participating in Oxford City and thirty-nine schools invited to take part across the Bicester and Banbury area. The schools were chosen following a needs assessment and agreed by the multi-agency CAMHS Assurance Board. This methodology will be used to recruit new schools if and when OCCG is successful in further bidding to NHS England. The pilots run until March 2021 and are subject to national evaluation.

Mental health support teams will consist of specially trained staff linked to groups of schools. They will offer individual and group help to young people with mild to moderate mental health issues including anxiety, low mood and behavioural difficulties. The new teams will also carry out targeted group sessions and whole school assembly work and where appropriate can offer group parenting classes that aim to help parents with children's social and emotional health issues.

The MHSTs will work with the designated school mental health lead. This is a new role in schools and will provide a link for every school, with the MHSTs and with more specialist mental health services. The teams are part of the Single Point of Access to CAMHS meaning that where a child needs referral to more intensive services they will be referred direct. This will mean that schools will find it much easier to contact and work with mental health services. It will also support schools to

develop their whole school working and pastoral approach to mental health and wellbeing. The new teams will be managed by Response from the Third Sector Partnership but based in the local area.

Mental health support teams will be the link between the NHS and schools. They will work alongside other people who provide mental health support including:

- school nurses
- locality and community support services
- educational psychologists
- school counsellors
- voluntary and community organisations
- social workers

The pilots are subject to quarterly assurance monitoring by NHS England and will be part of a national evaluation.

3. The 4 week wait pilot and waiting times for CAMHS

Oxfordshire is amongst a group of twelve Clinical Commissioning Groups in England that are working with NHS England to develop a national access standard and test ways to reduce waiting times for CAMHS. The pilot is designed to embed learning from the national implementation of the Cancer Standard that is now in place. The original bid was for 25 additional staff to increase capacity in services and to reduce the waiting times, starting with those children with the longest waits.

Over the past six months the focus of the pilot has been on getting children waiting the longest time seen. An online provider called Healios (www.healios.org.uk) has been commissioned to provide assessments and interventions. The service is used by many other areas of the country and is well evaluated. There has been excellent feedback from families who have accessed the service in Oxfordshire. In September Healios began seeing children waiting for the Neurodevelopmental Pathway (Autism and Attention Deficit Hyperactivity Disorder).

At the same time the Trust and OCCG are working with NHS England Improvement Team to complete demand and capacity modelling in CAMHS. This will identify improvements in patient management and flow through services to ensure that the new resources are used in the most efficient way and increase capacity to offer appointments to children.

Recruitment to new funded posts is also underway and will provide significant extra capacity in the service. Recruitment is an ongoing challenge and the Trust has adopted several strategies to support qualified staff to get jobs and sustain their working lives in Oxfordshire. Oxfordshire CAMHS has also worked with the Third Sector Partnership to develop and recruit a new staffing group from the voluntary

sector. This has allowed the Trust to have access to a work force that is much more successful in recruitment and provides a robust workforce who can offer short term interventions for low-moderate mental health issues. This has greatly improved the ability to sustain a viable workforce as well as increase capacity to see more young people in more intensive CAMHS.

Despite these changes, waiting times for CAMHS remain a challenge. The challenge is national as well as local. Demand for services continues to rise but the service benchmarks well against the national CAMHS access target. Nationally 34% of children who need CAMHS should have their needs met. In Oxfordshire this is currently 64%.

Performance around waiting times is monitored monthly by OCCG through the contractual process and additional steps have been taken to monitor and reassess children who have waited more than 16 weeks. OCCG is assured that all children on the waiting list are clinically reviewed at 16 weeks. The aim of this is to provide proactive contact for the family, to review the clinical needs and to provide support options while waiting for an appointment. Families are now offered the option for self-referral back to the single point of access, where a young person or parent can speak directly to a clinician.

4. Conclusion

Both pilots are still in the early stages of development. The MHSTs are giving us the opportunity to test how services (schools, school nurses, LCSS) can work together to support children's wellbeing and offer intervention early where issues arise. The four week wait pilot has three stands; to reduce children waiting longest, to make the current services more efficient and to test what capacity is needed to reduce waiting times in a sustainable way. It is not possible or appropriate for children's mental health to be the responsibility of one sector or one service alone. It is only by working together now and in the future that we will be able to build the services we all want to see.

healthwatch Oxfordshire

Healthwatch Oxfordshire Report to Health Overview Scrutiny Committee November 2019.

1 Oxfordshire Wellbeing Network

By the time HOSC meets in November the first Oxfordshire Wellbeing Network event would have met. There are 91 people registered representing 72 different organisations ranging from small community groups, parish councils, large voluntary organisations, patient participation groups, district councils, and officers from both health trusts and Oxfordshire County Councils. There are nine Health and Wellbeing Board members planning to attend.

2 Patient Participation Groups

Healthwatch Oxfordshire continues to support the development of **Patient Participation Groups** (PPGs) across the county. The October PPG Forum focussed on how the patient voice can be heard in the developing Primary Care Networks and the report can be found at https://bit.ly/33ItLLh

3 Mental health

Healthwatch Oxfordshire has taken a broad, focus on mental health services throughout 2019.

This theme has been integrated into ongoing projects as well as through a brief questionnaire which has been distributed online and in community settings. 106 people have completed this to date, with additional information on mental health gained through other projects including Armed Forces Families Access to Health, and Boaters' Access to health.

Whilst we have not analysed the full data nor reported on our findings, certain themes are emerging including:

- Much support is 'life saving' and helpful and people value the professionalism, empathy, and understanding from staff, including GPs and mental health professionals. Services such as the Haven are really welcomed for supporting people in crisis.
- People are aware that staff are stretched, and that services are under-funded, and this is of concern - including to staff who would welcome an Oxford weighting to help with the high costs of living in the county.
- Other comments have included, long waiting times to access support, even if in crisis, long waits for specialised support for complex needs, long waits between initial contact and start of support, limited amount of sessions and desire to have more face to face support.
- Others have highlighted the need for more support with autism and mental health, more support in transition from CAMHS to adult support,
- Still more improvements to be made with communication across Oxfordshire Mental Health Partnersship services to support continuity of care.

In early 2020 we plan to continue our mental health theme and focus on areas of health inequality:

1. We will be working with community networks in Oxford to understand more about how the BAME community view mental wellbeing and mental health support. This will build on the work carried out in 2018-19 on Men's Health and continue to work with this group taking a community-led asset building approach. A report will be produced in Spring 2020.
2. Plan to work with the Sunshine Centre in Banbury to explore parents and young families' views of mental health and wellbeing support for 0-5year olds.

4 Boaters and bargees

Early November Healthwatch Oxfordshire launched a survey on boaters and bargees access to health and social care. 200 questionnaires were distributed to boaters within Oxford city river and canal network, alongside a leaflet highlighting GP access produced by Oxford City Council and Oxfordshire Clinical Commissioning Group. The Healthwatch Oxfordshire survey goes beyond Oxford city to reach boaters on Oxford canal from Banbury southwards; 150 surveys have been distributed. We report on our findings in 2020.

5 Outreach

We continue to get 'out and about' across the county and have visited a range of groups including coffee mornings, garrisons and bases, market stalls, and other community-based groups, in order to speak to people about their experiences of health and social care.

6 Feedback Centre

We continue to receive reviews of specific services via our website review facility. From September to the beginning of November we had 53 reviews including 11 about hospitals, 10 each about GP surgeries, mental health services, and physiotherapy services; seven about opticians, and four about emergency care.

7 Oxfordshire Health and Wellbeing Board – Children's Trust Board

We welcomed Dan Knowles as the new Healthwatch Oxfordshire Ambassador Children's Trust Board, parent representative.

8 Influence, informing, impact, and outcomes

The following table gives a brief answer to the 'so what?' question by identifying where our work has had an impact and produced outcomes and changes. We are proud of the 'smaller' actions as much as of the changes we achieve by reporting what we hear and supporting the Oxfordshire voice to be heard. Future reports will include updates on open actions / recommendations and identify new outcomes and impacts of our work.

8.1 Influence & informing, Impact & Outcomes

July – end September 2019 - a round-up of outcomes, impacts and some answers to the 'so what?'' question.

Healthwatch Oxfordshire Action / Report	Recommendations / actions	Response / Outcome/s	Open / closed
Enter & View Reports on visits to Oxford Health NHS Foundation Trust acute wards	**Recommendations** Wintle Ward: 1. That they painted walls to brighten up the ward 2. That the number of leaflets in the welcome pack be reduced with all available leaflets being on display. Also review safety of using staples in leaflets 3. To update the 'you said, we did' board 4. The recruitment of a Full Time Modern Matron Vaughn Thomas Ward 1. Recommendation - 'Consider providing a one-sided A4 information sheet for new patients with basic information such as mealtimes, visiting times, how to speak to staff etc. 2. Considering creating a messages of hope board / tree to inspire newly admitted patients.	Provider response 1. Décor – This is out (of) our control but can definitely see if the trust will be willing to consider feature walls in rooms or social areas. 2. Welcome pack – Will discuss in our team meeting, and patient meeting what they would prefer but also to communication team about the use of staples. 3. We have appointed a new lead for "You said and we did", to ensure its updated monthly. 4. Since your visit a Matron has been appointed for 6 months secondment. Provider response: 1. This is something that we have taken on board and are working on this week and next so will be in place shortly. We also have a notice board with a "typical day on the ward" from a patient experience.' 2. This was planned by the OT who left so we will pick this up. We do have a notice board which displays the feedback from 'Iwantgreatcare.'	Open 6-month follow up check then close

Healthwatch Oxfordshire Action / Report	Recommendations / actions	Response / Outcome/s	Open / closed
Healthwatch Oxfordshire conducted a 'secret shopper' exercise acting as a member of the public wanting to tell someone about their concerns for a neighbour. Why – we wanted to know how easy it is to use the inter web to find out how and who to tell. Report read out to the Oxfordshire Safeguarding Adults Board meeting.	OSAB Chair said' 'we have much to do'. Engagement comms group to address access problems particularly regarding the OSAB web site. OSAB communications & engagement group recommendations to Board: 1. To pursue a single web page for all 'concern' telephone numbers. 2. Recommend that the OSAB web page is designed for professional use and that the contact telephone number for OCC to raise concern is prominent for people to call if not a professional. 3. Option to complete a form on-line to remain but form to be simplified.	September OSAB members agreed to implement the recommendations.	OPEN 6-month repeat exercise.
Young Carers Report	Performance Scrutiny Committee Deep Dive into Young Carers. Report 6 Sept 2018 and follow up 4 July 2019. Healthwatch Oxfordshire brought stakeholder groups together to discuss young carers in the city – Oxfordshire County Council, schools, youth groups	Cites Healthwatch Oxfordshire report by Be Free Young Carers and recommendations Healthwatch Oxfordshire report highlighted issue of young carers and directly influenced the Deep Dive with similar findings. Oxford Youth Conference to include workshop on Young Carers and voluntary sector response to developing provision	Closed Open
Following the production of the Men's Health – NHS Check report funded by Healthwatch Oxfordshire and Video that was widely promoted including presentation at Health Improvement Board, Health	The council (Oxfordshire County Council Public Health) would now like to build on the Healthwatch report by designing and conducting a piece of behaviourally informed qualitative research to gain full insights into drivers behind why men are less likely to take up the NHS Health Check offer.	Waiting on action	Open

Healthwatch Oxfordshire Action / Report	Recommendations / actions	Response / Outcome/s	Open / closed
Inequalities Commission Good Practice Session			
BOB STP Maternity Report Oxfordshire data shared with Oxford University Hospitals NHS Foundation Trust	Awaiting response – meeting with OUHT set for early December.		Open
Men's Health Project video	Diabetes UK 'We are planning to run our webinar on "Engaging Diverse Audiences" on 11th December, and we were wondering whether you or someone from the Men's Health project would be available to talk about the project? We can show the video, but would be great if someone could introduce it and be on hand to answer any questions that might arise? It's such a fantastic example and would be great to use as a case study.	East Oxford United to introduce case study on webinar. National exposure to the way of working, and BAME men's health issues. Building capacity for voice of community to be heard through speaking direct about their experiences.	Closed
OX4 Report		Referenced in the OCCG Primary Care Commissioning Committee Paper 6.1 Deprivation and Health Inequalities written by Dr Kiren Collison, Clinical Chair OCCG	Closed
HWO Report NHS Long Term Plan – Oxfordshire Findings		Mental Health section of BOB response to NHS LTP references Healthwatch report	Closed
Luther Street PPG video	NHS England wanted to involve GP practice working with homeless in their Inclusion Conference on Primary Care Networks. They had seen our video with Luther St PPG. HWO linked NHS England with Luther Street Practice Manager.	Healthwatch Oxfordshire film provided link to GP practice working with homeless for NHS England in support of event for Inclusion Health practices, in particular to look at how such practices will work with PCNs (Inclusion Health Specialist Practices Event: London Oct 2019)	Closed

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Oxfordshire Joint Overview and Scrutiny Committee.
21 November 2019

Chairman's Report

1. Committee briefings and communication

1.0 The committee received three written briefings since its meeting in September 2019. These are in the Appendix of this report and are on:

Appendix	Name	From	Received
1	Oxford City Community Hospital Oct briefing note	OCCG	01/10/2019
2a & b	Chipping Norton First Aid Unit briefing and change toolkit	OCCG	09/10/2019
3	BOB ICS News Bulletin Oct	OCCG	15/10/2019
4	Trusted Assessor Briefing (action from the previous meeting)	OCC	26/09/2019

2. Following up from HOSC on 19th September 2019

EU exit planning

3.1 During the committee's consideration of the CCG update on the 19th of September, HOSC requested information on risk assessments undertaken on EU exit planning. The CCG have confirmed that the Department of Health and Social Care wrote to all providers and commissioners of health and care services in England sharing EU Exit Operational Readiness Guidance. This guidance set out the local actions to be taken to prepare for EU exit without a ratified deal. OCCG, OUH and OHFT have all, in line with this guidance, carried out readiness planning, local risk assessments and planned for wider potential impacts. Each organisation is required to identify a Board member as the Senior Responsible Officer (SRO) for EU Exit preparation; these are:

- OCCG Director of Governance
- OUH Chief Operating Officer
- Oxford Health Director of Corporate Affairs and Company Secretary

3.2 Each of these SROs has attended the NHS England regional workshops held in February and September. The three NHS organisations have linked with the Local Health and Resilience Partnership and Local Resilience Forum to ensure a co-ordinated approach across the system. The system wide A&E Delivery Board is also sighted on plans.

3.3 The CCG confirmed that HOSC can be assured the issues raised in the Yellow Hammer Report have been incorporated into the plans. Also OUH, OHFT and OCCG took information to their respective boards looking at emergency preparedness, resilience and response to EU Exit planning:

3.4 OUH: **Oxford University Hospitals NHS Foundation Trust Board Meeting Highlights13 March 2019** : **TB19/03/18 Emergency Preparedness, Resilience and Response - EU Exit Planning**

3.5 OHFT: **EU Exit Planning** **31 January 2019 Appendix: Chief Executive's Report - EU Exit Operational Readiness**

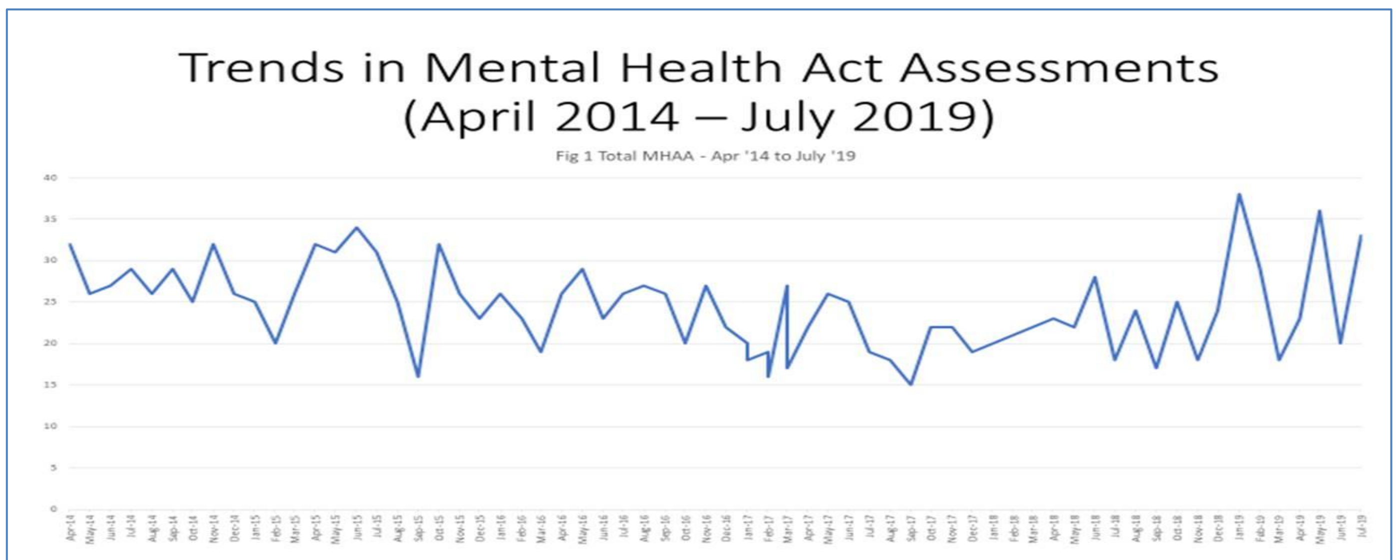
3.6 OCCG: **https://www.oxfordshireccg.nhs.uk/documents/meetings/board/2019/01/2019-01-31-Paper-19-06-EU-Exit-Operational-Readiness.pdf**

Winter Planning

3.7 During the committee's consideration of the Winter plan 2020/21, HOSC requested a briefing on Trusted Assessors. This was provided on the 26th of September and is included (as referenced above) as appendix 4 of this report.

3.8 The committee requested information on how they would be communicated with during the winter period. It was confirmed that communications with the committee over winter will be provided in the CCG's regular update to HOSC at their meetings. This means an update will be provided in November 2019, February 2020 and April 2020 or by exception when required.

3.9 Information was requested on section 136 (mental health crisis) incidents. A graph is provided (below) which shows a varying pattern of section 136 incidents over the last few years.



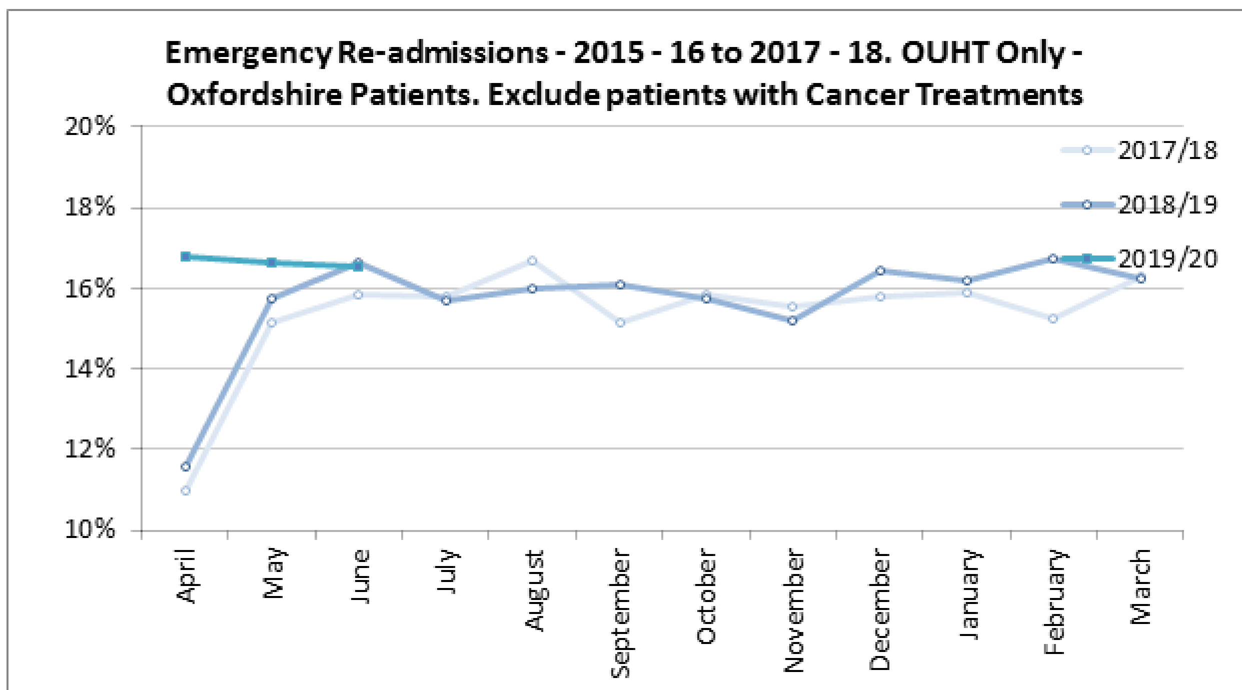
- We are not able to say definitively whether the number of section 136 will increase, stabilise / plateau or decrease. The trend looks like it is overall on an increasing trajectory but there have been spikes in the past that then resolved back to the average. However the increase could be attributed to:

- A change in legislations in 2017 which meant that no S136 were allowed in police custody and there was an increase in the places where people could be taken on a S136

- There has been an increase in people being placed on a S136 in police custody and taken to a place of safety and there has been an increase in people being placed on a S136 in emergency departments

- There has also been an increase in people from other areas on a S136 in Oxfordshire.

3.11 The committee requested information on readmissions data. It was confirmed that the Emergency Re-admission Rate is reported nationally and excludes patients with cancer treatments. The graph below shows that the rates have remained relatively stable over the last few years. Numbers for April 2017/18 and 2018/19 are being reviewed as it appears that there is a data collection issue.



3.12 HOSC requested information on the Emergency Medical Unit (EMU) activity. It was confirmed that the predicted growth for 2019/20 is 2.5% (additional 194 contacts).

3.13 The committee asked for information on ‘acuity’. The CCG have confirmed that “generally acuity means that the patient group is more complex, with a number of underlying conditions and co-morbidities which means that the resources required to manage the patient are higher and more intense. This may mean that the patient will require a longer length of stay and/or that discharge arrangements and onward support may also be more complex. The increased complexity over winter usually manifests in patients with respiratory conditions”.

3. HOSC Training

3.0 On 13th September 2019 HOSC members had a half day training session which consisted of; an introduction to health scrutiny for the newer members of the committee and served as a refresher for the more long-standing members. The training also covered how to effectively scrutinise an Integrated Care Systems (ICS).

3.1 In the afternoon of the 13th September members were also given a presentation by the CCG on Primary Care Networks within Oxfordshire.

4.0 Co-opted Members

4.1 After the last HOSC meeting on 19th September 2019 Mrs Anita Higham OBE decided to resign as a co-opted member of HOSC. We will be advertising for a new co-opted member to join the committee in the new year.

5.0 BOB Integrated Care System

5.1 As the new Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) develops stakeholders are being asked to engage and share views on a number of areas. HOSC is engaging with this process. In early October stakeholders were asked to submit views on the priorities within the BOB ICS interim report. A copy of the HOSC response to this is included in Appendix 5.

5.2 HOSC members are now being asked to share views on the future commissioning arrangements which will be collated and submitted by the 1st December deadline.

6.0 Task and Finish Group: OX12

6.1 The HOSC OX12 Task and Finish Group has met two more times since the last HOSC meeting; 8th October and 6th November. Summaries of each meeting are loaded onto the OX12 project area of the CCG website, they can be reached at the following link:

https://www.oxfordshireccg.nhs.uk/about-us/planning-for-future-health-and-care-needs-in-wantage-and-grove-ox12.htm

6.2 Members of the Task and Finish Group will be holding a meeting with the Stakeholders in the new year, to hear views from them, as a follow up session to the one held on 22nd May. Members also attended a Solution Building Workshop on 18th September.

6.3 The group was on track to complete the work prior to Christmas, however the recently announced general election and period of Purdah has meant that deadlines have needed to be extended. This is to account for the delay in publication of key pieces of information from the NHS and the early December Health and Wellbeing Board meeting being moved to the end of January 2020.

6.4 The Task Group are planning to meet a final time in January after which the draft recommendations will be finalised, and a final report will be produced. This will be shared with the Project Group to enable them to consider actions to the recommendations, before being presented to HOSC at the next meeting.

7.0 Horton HOSC

7.1 The Horton HOSC met on the 19th of September 2019. The meeting sought to discuss and reason why the outcome of the work was recommending the CCG Board to "Confirm the decision made in August 2017 to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future."

7.2 Members heard from a number of speakers including MPs, local councillors and the Chair of Keep the Horton General, all in disagreement with the decision. The considerable experiential evidence was also queried with health partners as this was all pointing towards two obstetric-led units being the preferred option for the county and wider Horton catchment area. Concerns were also raised around the engagement with the committee in terms of evidence not being forthcoming, queries remaining unanswered and quality of evidence or information being presented.

7.3 Members unanimously agreed that if the CGG Board proceeded to confirm the decision in their meeting on 26th of September 2019 there were sufficient grounds to refer this back to the Secretary of State based on the following two requirements:

- Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has been adequate in relation to content.
- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents.

7.4 At the Board meeting on 26th of September 2019 the CCG Board confirmed the decision to create a single obstetric unit at the John Radcliffe Hospital and establish an MLU at the Horton, for the foreseeable future. As such, a referral letter is being drafted and will be submitted to the Secretary of State imminently.

7.5 It was agreed to revise the Terms of Reference of the Horton HOSC to enable it to continue with an expanded remit, allowing scrutiny of development of a masterplan for the Horton General Hospital (for the patient flow population across Oxfordshire, Northamptonshire and Warwickshire).

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NHS
Oxfordshire
Clinical Commissioning Group

Update for Oxfordshire HOSC: Temporary Closure of City Community Ward

October 2019

Current position

The ward was temporarily closed to patients on 31st May 2019.

- Staff Consultation was completed on 7th June 2019. All staff members have been redeployed across Community Hospital wards and have settled well.
- Oxford Health NHS Foundation Trust (OH) Patient Liaison Advice Service (PALS) continue to ask all community hospital inpatients if they experience issues with being visited by family members or being placed further away from home for their rehabilitation. This will enable them to look at the home location to see if there is a negative impact on patients displaced from City postcodes. There continue to have been no issues raised.

Recruitment

- We have had a full review of our recruitment activity including allocating senior operational oversight to the process.
- We have had considerable success throughout the period since temporary closure at all bands, including at ward management level and registered general nurses.
- External candidates recruited are going through employment check processes with a view to start dates throughout October.
- Once staff commence employment with Oxford Health NHS Foundation Trust, they will be inducted on other community hospital wards in readiness for reopening City Community Hospital. All candidates are fully aware of the temporary closure of City Community Hospital.

Re-opening

- We took a paper to our Board on 25th September with a recommendation to re-open City Community Hospital. Our plan is to have 12 beds open from the middle of November.
- This recommendation was supported, and we are now actively working towards this timeline.
- Our plan is to bring the City Community Hospital team back together at the end of October to manage induction, training and practical arrangements that ensure we meet this timeline.

Maintaining Bed Provision

- This re-opening will have no impact on Stroke beds. These beds remain at the full 20, based at Abingdon.

- We aim to open an additional 4 beds at City, making the total at that site, 16 beds from early in 2020 to support the system during the Winter period.

October 2019

NHS
Oxfordshire
Clinical Commissioning Group

Chipping Norton First Aid Unit - Briefing

Chipping Norton First Aid Unit (FAU) has been running since 2011. It is staffed by a team of highly qualified Specialist Practitioners (both Paramedics and Nurses) with experience and expertise in the treatment of minor injuries. The service is provided by NHS South Central Ambulance Service Foundation Trust (SCAS). The FAU currently treats the following types of injuries:

- Simple injuries that cannot be treated/managed with a home first aid kit
- Cleaning and simple stitching of wounds
- Insect bites and stings
- Minor burns and scalds
- A foreign body in the eye
- Bumps to the head where there has been no loss of consciousness
- Bruises
- Sprains

The FAU operates mainly out of hours:

- 5.00pm – 9.00pm Monday to Friday
- 10.00am – 9.00pm weekends and Bank Holiday

Currently, the Chipping Norton FAU operates out of the Chipping Norton Community Hospital Building. The proposal is for the service to move and to be provided from the Chipping Norton Health Centre that is on the same site, opposite the hospital building.

In 2015, Chipping Norton Health Centre relocated to be on the same site as Chipping Norton Community Hospital. Prior to this, the practice operated out of a town centre building.

Why the need to change?

The wide variation in services provided across the country in minor injuries units, urgent care centres, first aid units and others have led to confusion amongst the public about what services offer and how best to use local services. To reduce confusion, NHS England has issued guidance[1] to reduce the variation that now requires urgent care to be designated as either:

- Accident and Emergency – full hospital department operating 24/7

or

- Urgent Treatment Centre (open for 12hrs every day) providing treatment and diagnostics, GP-led

[1] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

Other urgent access health services need to be part of primary or community care services; this includes first aid units. The guidance advises as follows:

Paragraph 13
Commissioners, supported by NHS England, should review current provision, impact and local health needs assessments against the below standards and make a plan for each existing facility, alongside current provision and plans for extended GP access, subject to local consultation and following proper procurement process where appropriate. We know that many services will already offer, or be close to offering, this level of service, and others will need local investment to meet the standards. Other services, that will not meet the new standards, may become an alternative new community service; this may be a GP access hub.

OCCG must now make sure Oxfordshire is compliant with this new guidance and is keen to ensure valued services are retained in local communities wherever possible. By moving services into a primary care setting, we can avoid any requirements to close walk-in services.

The way urgent care services are monitored nationally is changing from 31st December.

The proposal for Chipping Norton FAU to move from Chipping Norton Hospital building to the Health Centre building would ensure the service could continue and remain compliant with national delivery of urgent care pathways. Thereby we can preserve this valued local service for people in the Chipping Norton area.

The CCG directly approached Chipping Norton Health Centre to assist us in finding a means to retain the local service. The practice have been very helpful and are asking for no additional resources. The CCG are most grateful to the practice and the ambulance service for offering to find a solution as without their help we would need to look to close this service.

This change will be tested and reviewed as a means to deliver a nationally compliant way of securing the local first aid/injury services we wish to preserve. We will test the benefits we can gain for patients and we will be closely monitoring and using the learning to roll out to other relevant sites.

The service itself will not change and will continue to be provided by the same highly skilled clinicians, with the same opening hours and will continue to be open to anyone – regardless of which GP practice a patient is registered with.

Benefits of the change
Although the need for this change comes from national guidance, there will be clear benefits for patients with the co-location of the FAU with the Chipping Norton Health Centre and the on-site pharmacy. The clinicians working in the FAU, local GPs and pharmacists are all supportive and are keen to see the First Aid Unit services

continue to provide a service to local people and to explore what further benefits can be achieved.

Bringing the FAU under the same roof as the GP practice will deliver benefits from the start with many more being anticipated as the clinicians working in the FAU, Health Centre and Pharmacy explore opportunities.

The clinicians working in the First Aid Unit are enthusiastic about this move. The benefits will be for patients and those working in the service including:

- Following the move, the clinicians at the FAU could have access to patients' notes (subject to governance arrangements) which will improve communication help to improve safety, efficiency and patient care. Initially this would be for patients registered at Chipping Norton Health Centre but this could be expanded using the EMIS hub facility to any patient registered with a GP practice in Oxfordshire.
- The integrated IT will provide more seamless care to patients and ensure better monitoring to inform future development and delivery of the service.
- There are already plans for further joint working, which might include a Saturday dressing clinic.

GPs at Chipping Norton Health Centre believe this move will see the following benefits for their patients and patients of other GP practices:

- In addition to the FAU clinicians having access to a wider range of dressings and medical equipment, a good example of where the service would improve would be point of care blood testing at the Health Centre. This would be available for patients attending the FAU. This can be used to identify CRP (marker of infection), to conduct a full blood count and to measure serum electrolytes. This would not typically be available in an FAU and will allow more complex patients to be managed by the paramedic if needed. This would be available regardless of whether the practice was open and the paramedic will be able to do point of care tests and speak to the out of hours GP and manage cases with telemedicine.
- Better collaboration is being planned between the teams during the cross over time when both the health centre and the FAU are operating, GPs will be able to help SCAS with advice, prescription and support where needed. Having the FAU within the health centre will allow patients who are suitable to be seen by the FAU but not able to attend before 6.30pm to be smoothly handed over to the FAU team.
- There are opportunities for shared learning and training between SCAS and the health centre staff, for example advanced life support to better care for patients.
- Easy access to pharmacy for patients to additional advice, medication and equipment if required.

- The risks associated with lone working will be significantly reduced. Currently the FAU service is delivered within a building where there is no other consistent out of hours service. The pharmacy is open for the majority of the opening hours of the FAU and a pharmacist will be on site to provide additional advice and support if needed.

There will be a reduction in financial uncertainty by moving from a system where the cost is calculated by the number of patients treated to one where it is calculated based on the service that is provided. The streamlining of services will also help to avoid duplication.

The GP practice is **not** benefitting financially from this move.

Future proposal

Currently the FAU is located within the Community Hospital Building. The Chipping Norton Health Centre is located on the same site, adjacent to the hospital. The proposal is for the FAU to be relocated within the health centre which will have no impact on patients' ability to access the service.

There will be no change to the current opening times and SCAS will continue to provide the service.

The FAU will be accessible to all patients, regardless of which GP practice they are registered with.

OCCG, SCAS, the GP practice and pharmacy are supporting this change as a way to preserve this service for local people. They will be exploring what more can be achieved to enhance the care of patients.

Public Meeting

A public meeting is being organised so that patients from the local area can come and see where the FAU will be based and how it will integrate with the other services in the building. The meeting will be:

7.00pm – 8.00pm on Wednesday 23 October 2019 at Chipping Norton Health Centre

The meeting is open to all and people will hear more about how the service will work and the possible benefits of the move. There will be an opportunity to talk to the clinicians involved and to ask questions.

The meeting will be widely publicised in the local press and via local GP practices.

The health centre currently helps to fund a local volunteer bus service that helps patients needing to get to the practice. It is liaising with them about finding a volunteer driver so they could run the service help people wanting to come to the meeting.

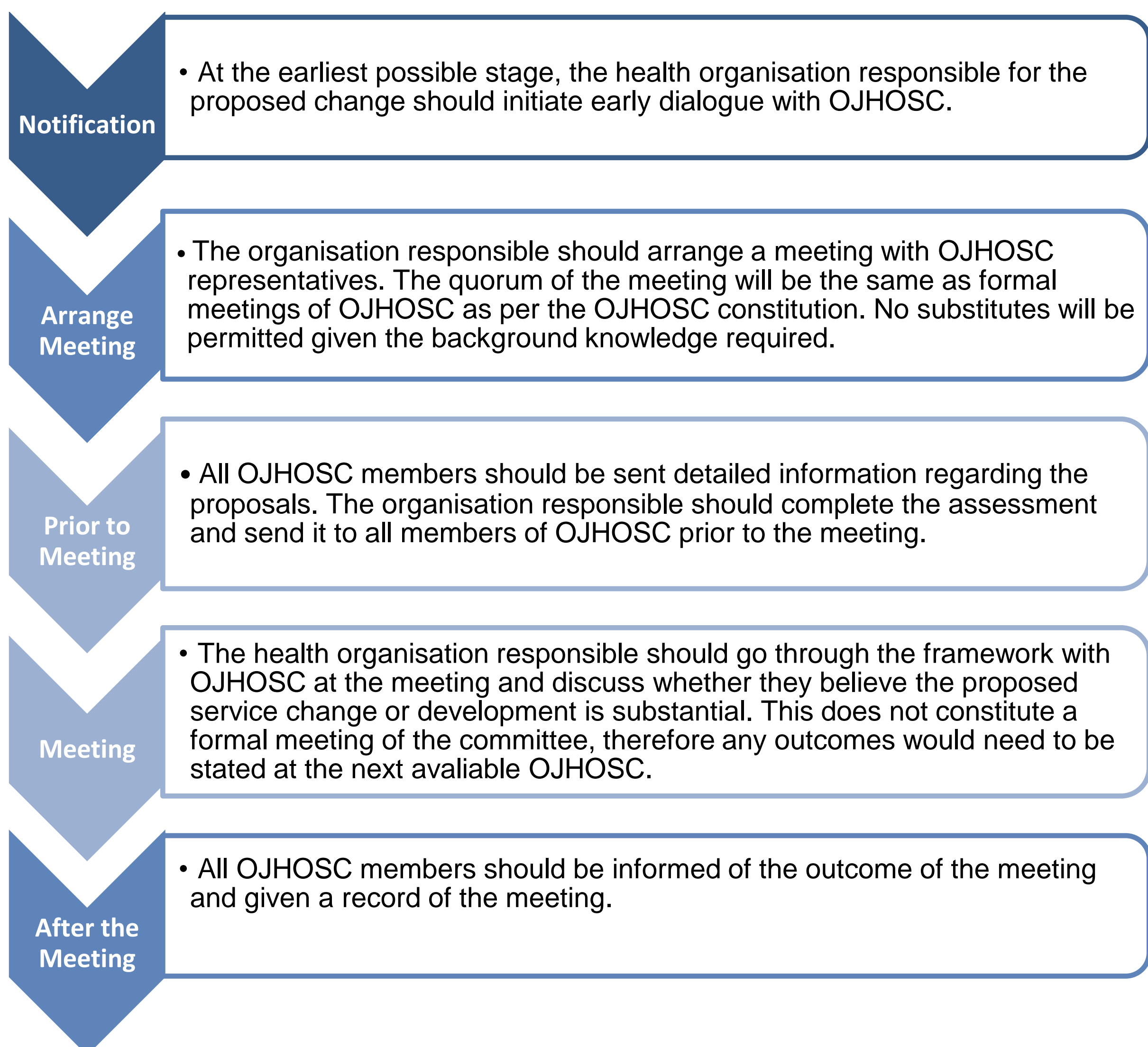
Oxfordshire Joint Health Overview and Scrutiny Committee
Substantial Change Assessment

1. Purpose:

NHS bodies and health service providers have a duty to consult health scrutiny bodies on substantial variations and developments of health services. This document sets out a framework for assessing substantial change in Oxfordshire and has been created in line with the Department of Health's (DH) Local Authority Scrutiny Guidance (2014) and the Centre for Public Scrutiny health scrutiny guidance (2005).

Under Section 7 of the Health and Social Care Act (2001) the NHS is required to consult relevant overview and scrutiny committees on any proposals for substantial variations or developments of health services. A '*substantial variation or development'* of health services is not defined in regulations. This assessment is designed to help Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) to help identify whether proposed variations or developments in services are 'substantial'.

2. Process:



3. Assessment Framework

A. Background Information
1. Name of responsible (lead) health organisation:
Oxfordshire Clinical Commissioning Group
2. Brief description of the proposal (please include information about timelines and whether the proposed change is temporary or permanent):
Currently, the Chipping Norton First Aid Unit (FAU) operates out of the Chipping Norton Community Hospital Building. The proposal is for the service to move to the Chipping Norton Health Centre that is on the same site, adjacent to the hospital building. All other aspects of the service – activity and opening times remain the same. This small switch in location will enable us to integrate the current service (whilst maintaining its current form) into a primary care pathway, allowing access to advice from a wider range of clinicians and most importantly ensure it is complaint with new national urgent care pathways retaining this service to the population of Oxfordshire. This approach will work to showcase the integration with primary care which will enable us to retain all other similar facilities in local settings. The CCG can bring a paper to HOSC in November to describe our proposed approach to retention of services in each area driven by the national requirements to demonstrate integration with Primary care.
3. Why is this change being proposed? What is the rationale behind it?
National guidance[1] requires a review of walk-in type services. The national concern is that the wide variation in urgent care walk-in services provided across the country in minor injuries units, urgent care centres, first aid units and others have led to confusion amongst the public about what services offer and how best to use local services. To reduce confusion, NHS England has issued guidance that now requires urgent care facilities to be designated as either: • Emergency Departments (ED) – full hospital department operating 24/7 Or • Urgent Treatment Centre (UTC) (open for 12hrs every day) providing treatment and diagnostics, GP-led Other urgent access health services need to be part of primary or community care services; this includes first aid units. Primary care networks are being developed to offer a strengthened approach to further support the range of care available for patients and will support our vision for retaining all local urgent access services by integration with GP leadership.

[1] https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres/
The UTC principles and standards: https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf
The quick guide: https://www.england.nhs.uk/wp-content/uploads/2019/08/quick-guide-improving-access-to-utc-using-dos.pdf

The well regarded service in Chipping Norton would continue to be provided by SCAS, with the same opening hours and will continue to be open to anyone – regardless of which GP practice a patient is registered with.

The national pathway alternatives of a full Emergency Department or even a UTC would not be viable options for Chipping Norton FAU catchment so this route will work to preserve the service locally.

4. What are the main factors driving the change? Please indicate whether they are clinical factors, national policy initiatives, financial or staffing factors.

The main factor driving the change is the NHSE requirement for urgent care facilities to be designated as either EDs or UTCs. However, discussions between clinicians from SCAS and the Health Centre have identified many additional benefits for patients and staff in integrating the service.

5. How does the change fit in with the wider strategic direction of healthcare in Oxfordshire and the Health and Wellbeing Board?

Oxfordshire's health and care system is looking to integrate services to improve safety, care, and efficiency and reduce duplication. This move will allow further integration and collaborative working between the First Aid Unit, the GP practice and the pharmacy. Clinicians have already identified several areas where integration will deliver improvements and more is anticipated. Visibility of care records (where agreed by the patient), point of care testing and access to prescriptions are significant patient benefits widening the options for SCAS staff to keep the patients' care local and avoiding travel to John Radcliffe or the Horton. The national direction of travel is toward integration and OCC are signatories of the Integrated Care System approach in recognition of the benefits brought from bringing like services together.

6. Description of population affected:

The First Aid Unit is open to anyone, regardless of which GP practice they are registered with. This includes anyone living in the local area and visitors. The service will not change so no impact on population.

7. Date by which final decision is expected to be taken:

The direction of travel is set out clearly here and the decision will be confirmed following the second meeting with local public where this small change will be explained.

8. Confirmation that HOSC have been contacted regarding change - including. date and nature of contact made:

A briefing has been sent to HOSC along with this template on Thursday 4 October 2019.

B. Assessment Criteria

1. **Legal Obligations:** Have the legal obligations set out under Section 242 of the consolidated NHS Act 2006 to 'involve and consult' been fully complied with?

Yes (please delete as appropriate)

Comments:

- There is no change to the service being proposed so the requirement is one of

engagement

- The proposal has been presented and discussed at the public meeting of the North Oxfordshire Locality Group in September 2019. This meeting is supported by Healthwatch Oxfordshire and is attended by PPG members and members of the public in the North Oxfordshire Locality (that includes Chipping Norton). This meeting took place in Chipping Norton.
- Meetings have been held with South Central Ambulance Service (who provide the FAU) and Chipping Norton Health Centre. Representatives of the League of Friends have attended and one of these meetings was also attended by Councillor Hibbert-Biles.
- A further meeting is planned on 23rd October where the facilities can be viewed by the public.

2. **Stakeholder Engagement**: Have initial responses from service users (or their advocates) and other stakeholders such as Healthwatch indicated whether the impact of the proposed change is substantial?

No (please delete as appropriate)

There have been some concerns raised that have been responded to:

- Concern about whether the service would be restricted to patients of Chipping Norton Health Centre.
  OCCG have confirmed the service would remain open to anyone.
- Concern about how people will be made aware of the change.
  OCCG have committed to wide communications to patients of neighbouring practices and publicity using local media.
- Concern has been raised about the impact on Chipping Norton Hospital of removing this service from the building.
  OCCG have responded that Chipping Norton Hospital is a thriving hub being the base for a wide range of community services provided by a range of different providers including a midwife led unit and various maternity clinics, a range of diagnostic and outpatient clinics. None of these is reliant on the First Aid Unit operating out of the same building and because these services are largely daytime services, there is little opportunity for further integration or support available for lone workers in the FAU.
- There have been questions about why the move is necessary at all.
  The briefing provided to stakeholders will be published on the OCCG website that clearly sets out the rationale for the change and describes the wide clinical support for the move and the benefits for patient care.
- There have been questions about a consultation.
  The view of OCCG is that the change is not significant (as set out in this document). Patients who currently use the service will continue to be able to, no changes to opening hours are proposed, the location is the same site and so there is no impact on access. The only impacts that will result from the change will be improvements to patient care and the service, all fully supported by local clinicians involved in planning and delivering local health care.

3. **Stakeholder Engagement:** Does the service to be changed receive financial or 'in kind' support from the local community?

No

4. **Stakeholder Engagement:** Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?
Representatives of The League of Friends of Chipping Norton Community Hospital have expressed concerns that moving the service out of the hospital will compromise the future of the hospital. There is no other service operating in the hospital that is dependent on the FAU. The Practice is not requiring funding for relocating the FAU so this proposal will not detract from funding into the Community Hospital. There is a wide range of diagnostic and outpatient care provided in the hospital by a wide range of healthcare providers. We would seek to work with colleagues across health and social care to identify additional services that could be delivered from this site.
5. **Staff Engagement:** Have staff delivering the service been fully involved and consulted during the preparation of the proposals?
Yes (please delete as appropriate)
The clinicians in the health centre, pharmacy and SCAS have been fully involved. There is significant enthusiasm for this change with benefits for patients being identified as immediately available and further benefits to come as integrated working develops.
6. **Staff Engagement:** Do staff support the proposal?
Yes (please delete as appropriate)
See response to question 5 above. This change is very well supported by the clinicians directly involved in delivering the service and those that are anticipating the benefits of closer working.
7. **Patient Impact:** Does the proposed change of service has a differential impact that could widen health inequalities (geographical, social or otherwise)?
No (please delete as appropriate)
There will be no impact on health inequalities other than potential to improve care received by all patients.
8. **Patient Impact:** How many people are likely to be affected?
The FAU saw 2,700 patients in 2019/19. There is no direct effect on these patients as they will continue to be able to access the same service at the same site but with enhancements.
9. **Patient Impact:** Will the proposed change affect patient access? If so how?
No (please delete as appropriate)
The health centre is on the same site, adjacent to the hospital. There will be no impact on access for patients.
10. **Patient Impact**: How will the proposed change affect the quality and quantity of patient service?
The proposed change should enhance the quality of patient service when clinicians working in the FAU have: • Access to medical record for local patients improving the care to patients and communications with patients GPs • Access to onsite diagnostics at Chipping Norton Health Centre (e.g. point of care testing) • Access to GPs providing clinical support where there is an overlap in service provision.

- Access to pharmacy for medication, equipment and advice

11. **Patient Impact:** Does the proposal appear as one of a series of small incremental changes that when viewed cumulatively could be regarded as substantial?

No

12. **Patient Impact:** How will the change improve the health and wellbeing of the population affected?

As per question 10 above.

13. **Wider Impact:** Will the proposed changes affect: a) services elsewhere in the NHS b) services provided by the local authorities, c) services provided by the voluntary sector?

This service will be used to showcase and evidence the benefits of integration with primary care and the means to retain local urgent care options whilst remaining compliant with national urgent care pathways. We will use the learning to support the further roll out of integration of primary care into our other urgent care settings to ensure we retain the level of care currently enjoyed by all patients in each of our urgent care facilities.

14. **Standards**: How does the proposed change relate to the National Service Framework Standards?

Patients will be managed in the same way as they are currently. The National Service Framework Standards will not be impacted.

15. **Risk:** What could the possible negative impacts of the change be? What mitigations are in place to reduce any potential negative impacts of the proposed change?

No negative impacts are anticipated.

C. Outcome/Decision

1. Is this considered to be a significant change by provider?

No (please delete as appropriate)

This is not a significant change and engagement is being undertaken

2. Is this considered to be a significant change by HOSC?

Yes/No (please delete as appropriate)

<u>Possible Outcomes:</u>

Consultation is Required

- If the health organisation and OJHOSC representatives agree that the proposal does represent a substantial service change or development, the formal consultation with OJHOSC should commence.
- *HOSC must be provided with:* The date by which the responsible organisation intends to decide whether to take the proposal forward.
- The date by which the responsible organisation requires the health scrutiny committee to provide any comments. ***N.B.*** *It is expected that any formal consultation would be undertaken by the commissioner of the service.*

Consultation is Not Required:

- If the health organisation and OJHOSC representatives agree that the proposal does not represent a substantial service change or development, then formal consultation with OJHOSC is not required.
- Best practice is that the health organisation should continue to engage scrutiny and the public in the development of the proposal and onwards to public consultation in accordance with Section 242 requirements.

Agreement Cannot Be Reached:

- If agreement cannot be reached between the health organisation and OJHOSC representatives, then all reasonable, practicable steps should be taken towards local resolution.
- Further meetings may be conducted with wider OJHOSC members or other stakeholders such as Healthwatch, carer/user groups, the voluntary sector.
- If it continues to be impossible to reach agreement both sides may jointly or independently pursue the options open to them under their respective statutory instruments, such as escalation to the Secretary of State or to the provider's Board.

N.B. *The OJHOSC representatives may prefer not to make a final decision about whether formal consultation is required at the meeting and choose to notify the organisations involved once a decision is made.*

Note on Consultation Processes

The Department of Health's (DH) Local Authority Scrutiny Guidance (2014) states the following in relation to consultation processes:

"The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed."

- It is therefore understood that the process of assessing substantial change should take place as part of broader meaningful engagement with local communities
- The relevant health organisation is responsible for engaging and consulting all relevant local people. It is expected that this will include locally elected representatives where the service change will have an impact (parish, district, county and MPs).

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS

NEWS BULLETIN

Buckinghamshire Oxfordshire and Berkshire West Integrated Care System

October 2019

Updates Published on ICS Five Year Plan

The ICS has published two updates on the development of its five year plan. September saw the publication of an interim report **Improving Health and Care in Buckinghamshire Oxfordshire and Berkshire West.** More recently, the ICS has published its "draft technical submission" to NHS England/NHS Improvement in response to the requirements of the NHS Long Term Plan implementation frame work www.longtermplan.nhs.uk/publication/implementation-framework/. An executive summary of the draft submission has also been published.

September's interim report describes the range of organisations involved in the BOB ICS, how they work together and how they are developing their priorities and plans for the next five years. The BOB ICS five year, one system plan will set out how all ICS partners will work together locally and together at scale to meet the current and future health and care needs of the communities they serve. It will describe how the BOB ICS will deliver the requirements of NHS Long Term Plan (www.longtermplan.nhs.uk) and address BOB ICS's specific priorities. The draft technical submission is a much longer document, as it contains detail in relation to how the goals of the Long Term Plan would be delivered in the BOB ICS area.

A number of documents are being published as the ICS five year plan develops. These aim to provide Boards, stakeholders and the public with current information throughout the planning process, and to support Boards in their consideration of the BOB ICS plan and its "technical submission" to NHS England/NHS Improvement. The timeline is as follows:

9th September	BOB ICS publishes **Improving Health and Care in Buckinghamshire Oxfordshire and Berkshire West** as the first step in developing the BOB ICS Five Year Plan Views are invited on the BOB ICS suggested priorities by 18th October
Early October	Publication of the draft of the "technical submission" sent to NHS England/NHS Improvement and supporting Executive Summary – this will describe the responses to the deliverables required in the Long Term Plan. Places to share templates with local partners.
18 October	Deadline for stakeholders to give their thoughts and views on the priorities described in **Improving Health and Care in Buckinghamshire Oxfordshire and Berkshire West**
Up to 20th October	Boards consider BOB ICS plan as it develops, using briefing pack, first draft technical submission narrative and templates
By 1st November	Boards to have signed off BOB ICS final technical submission
1st November	Final technical submission sent to NHS England/NHS Improvement
End of December	BOB ICS five year plan published, following review by NHS England/ NHS Improvement
On-going	Continued engagement with communities and stakeholders

Views Sought on the Future of NHS Commissioning Arrangements

CCG and ICS leaders have launched a period of engagement to gather views on future arrangements for NHS commissioning in Buckinghamshire, Oxfordshire and Berkshire West. This first stage of engagement, which will help inform CCG Governing Body decisions about next steps, was launched on 10th October and will continue to 1st December 2019.

To support the engagement process, an engagement document has been produced which outlines proposals for new two ways of working:

- Local working in each of the three counties through Integrated Care Partnerships
- Wider, at-scale working across the three countries through an Integrated Care System

The three CCGs in the BOB area are already working together to jointly commission some services, such as 999 and 111, and take single joint decisions on behalf of the whole population, where appropriate.

They are now beginning work to set up a further two commissioning boards in addition to the existing BOB Primary Care Board. One board would be for services that are commissioned across all the CCGs in BOB, such as ambulance services, and the other for specialised commissioning. This move would further enhance joint working and bring the number of commissioning boards working across the ICS to three. All three commissioning boards would work across the ICS but continue to report to the CCG Governing Bodies

As these new ways of working become more established, the engagement document aims to describe why the management and structure of the existing organisations needs to change and how it could help support all partners to work in a more efficient way which will benefit the local population.

A copy of the engagement document and details of how to respond are available on the BOB website.

ICS Programme Director Appointed

Sam Burrows has been appointed to the role of BOB ICS Programme Director and deputy to Fiona Wise, ICS Executive Lead. Sam will be seconded from Berkshire West CCG where he is currently Deputy Chief Officer and Director of Strategy. He joins the ICS on Monday 21 October on a fixed term secondment to 30 June 2020.

Sam joined Berkshire West CCG in May 2016 where he has overseen the development of new models of care for the Berkshire West health and care system. He has worked in hospital management and commissioning roles for NHS organisations in London and the South of England, prior to a number of years practising as a management consultant with a focus on healthcare improvement. Some of the programmes of work which Sam has been involved with include; a leadership role within a large and complex hospital reconfiguration programme, the transformation of elective waiting times for a major European health economy and the delivery of a £130m cost improvement programme for the NHS in London.

New Head of ICS Programme Management

Ben Gattlin has joined the core ICS team as Head of ICS Programme Management from Buckinghamshire CCG. Ben takes in the role from Gaurav Puri, who left BOB ICS at the end of September. Ben can be contacted by email at b.gattlin@nhs.net or on 01296 587239

Trusted Assessors

What are Trusted Assessors

A trusted assessor will be acting on behalf of and with the permission of multiple organisations, to carrying out an assessment of health and/or social care needs in a variety of health or social care settings. In line with CQC regulation 9, Which states a care needs assessment must be undertaken before providing a service.

Where an existing service user has been admitted to hospital, regulation 9 does not necessarily require the provider to physically see the person when reviewing their needs and planning the re-start of their care on discharge. The assessor is not directly employed by the organisation responsible for the assessment but is trusted by that organisation to do it on its behalf and if a provider is confident that they can rely on information provided to them and based on this information they are able to meet the person's needs, they do not necessarily need to see them in person.

How does Trusted Assessment work in Oxfordshire?

People can sometimes wait too long for discharge from hospital resulting in poor experience of the health and care system and poorer outcomes. The use of a Trusted Assessor can reduce the numbers and waiting times of people awaiting discharge from hospital and help them to move from hospital back home or to another setting speedily, effectively and safely. Trusted Assessors are a key element of best practice and a key deliverable as described in next steps on the NHS five year forward plan. Oxfordshire uses a trusted assessment model in several settings across the health and social care system:

Short terms Beds

As a system, we are in the final stages of a procurement process to purchase short stay care home beds for people leaving hospital. These beds will be available for people requiring further assessment or time to make decisions regarding onward care arrangements. Trusted assessment is an integral part of this service model, to ensure that people can move quickly from a hospital bed to a short stay care home bed without unnecessary delay.

Homecare

Work is currently being undertaken to implement a trusted assessments scheme for Homecare to help support quicker hospital discharges. The scheme would consist of three trusted assessors who for impartiality and non-organisational bias will be employed by the Oxfordshire Association of Care Providers (OACP). The assessors will be based mainly in the John Radcliffe with some presence in the Horton Hospital. They will undertake assessments on behalf of homecare providers with people who have been identified as ready for discharge, thus reducing delays in this process. Currently care providers have to come into the hospitals to do this themselves but they are not able to always respond quickly as desired.

Expected benefits of this project include:

- Improved outcomes for people in Oxfordshire and their families
- Reducing the number of bed days in acute hospitals
- Significantly improving the level of trust and communication between hospital staff and providers
- Reduce the time providers spend on arranging hospital discharges.
- Opportunity to test a model of Trusted Assessment in Oxfordshire.
- Co-produce solutions to improve processes.

In Oxfordshire, both the Urgent Care Group and the Home First Project (both comprising health & social care partners) have agreed this is a key deliverable for Winter 2019 with anticipated measurable impacts on Delayed Transfers of Care and efficient use of homecare resources.

Trusted Assessment is being considered as core part of Homecare 2020, the homecare recommissioning project being led by OCC. The learning from the TA scheme will be used test proof of concept for the new homecare model.

The aim is to start the scheme in November 2019, with the intention of the project running for 1 year and if successful it will be embedded in the Homecare 2020 model which is due to start on the 1st of October 2020.

We have been trying to recruit to these roles with some complications, if we are not successful in filling the posts following the closure of the current advert then we will be looking at other options to manage the expectations across the system.

OXFORDSHIRE
COUNTY COUNCIL

Date: 16th October 2019

To: OCCG.media-team@nhs.net

Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC)
County Hall
New Road
Oxford
OX1 1ND

Contact: Martin Dyson
Direct Line: 07393 001252
Email: martin.dyson@oxfordshire.gov.uk

Dear BOB ICS Team,

Re: BOB ICS Interim Report response

Thank you for the opportunity to comment on the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ISC) interim report. I have shared the report with the members of the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) and collated the responses as follows.

We welcome the aspiration for more partnership working across the area and the potential for a streamlining of systems, which in turn should not only help create a smoother service for patients and residents, but also staff having to navigate and use the various systems. The challenge however will be making that work in practice.

It is also encouraging to see the focus on a bottom-up approach, allowing more people to have greater control over their health and care.

At the moment it's challenging to comment on the priorities, without additional detail behind it. As high-level priorities they appear appropriate, however some clarity is needed around how 'places' are to be held to account for support/delivery, as it is not clear who is responsible. Another aspect of the priorities that'll be interesting to see, is how they are planned to interlink with each other.

As a Health Overview and Scrutiny Committee we'd like to feed in and understand the following challenges:

System Design:

- How is awareness of the NHS long-term plan being promoted and shared locally, to help residents understand how the ICS will work and support that?
- How well are residents and patients being engaged in the design of the ICS? At the moment there doesn't appear to be much widely publicised information available to the public, enabling them to engage with the process.

- The timeline appears tight to be able to both engage meaningfully and then translate that into possible amendments to the BOB priorities.
- Are considerations being given to the projected increase in population in Oxfordshire and beyond, and how is that being factored into the design, in order to help future proof it as far as possible?
- How will Overview and Scrutiny, in the three respective areas be involved in the design and implementation of the system?
- If system leaders are responsible for consulting and engaging their wider populations, what is being done to ensure that is consistent across both Oxfordshire and the wider BOB area? Who would be responsible for overseeing that?
- Are we clear on the constraints within the system, so as to manage the public's perception on what is achievable?

Governance Arrangements:

- Has a board already been established? If so, who sits on it, and are partnership meetings already taking place?
- Where do scrutiny committees sit within the governance arrangement?
- Who will be part of local decision-making processes at the place-based level?
- How will the respective Health and Wellbeing Boards work with the ICS and locally based integrated partnerships? (What happens if there are conflicting health priorities for example)
- How will conflicts and disagreements be managed in the system?
- How will accountability be managed between the separate NHS Trusts and organisations within the current legal framework?
- Is there agreement and consensus between all providers and commissioners on the approach to the ICS? Are there points of divergence?
- How will complaints, feedback and learning about a variety of organisations and providers be integrated and shared across the system?
- How are provider alliances being developed locally and what progress is being made to ensure they can be sufficiently mature to manage complex integrated contracts?

Health:

- Will there be changes in accessibility to services for certain residents (i.e. services rationalised and moved over county boundaries), which may impact on those patients that live remotely?
- How will the ICS work with a large number of distinct Primary Care Networks (PCNs)? And are they sufficiently resourced to do the work expected of them?
- How will the ICS ensure that tackling health inequalities is central to the way the new system operates? How well are health inequalities understood and evidence-based solutions identified?

Other considerations:

- What are the key financial challenges for the ICS? How will financial balance and sustainability of the system be achieved within expected funding allocations?

- How will the ICS work with the community and voluntary sector?
- How is it planned to ensure the voice of the local people doesn't get lost?

Yours Sincerely

Cllr Arash Fatemian
Chairman of Oxfordshire's Joint Health Overview and Scrutiny Committee

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