Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Tuesday, 16 January 2024 at 10.00 am

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings online, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Membership

Chair - Councillor Jane Hanna OBE
Deputy Chair - District Councillor Elizabeth Poskitt

Councillors:	Nigel Champken-Woods	Nick Leverton	Michael O'Connor
	Jenny Hannaby	Mark Lygo	Freddie van Mierlo
District Councillors:	Paul Barrow	Katharine Keats-Rohan	
	Douglas	McLean	
Co-optees:	Siama Ahmed	Barbara Shaw	

Date of next meeting: *8 February 2024*

Notes:

For more information about this Committee please contact:		
Scrutiny Officer	-	*Email: scrutiny @oxfordshire.gov.uk*
Committee Officer	-	*Scrutiny Team* *Email: Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

January 2024

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 22)

To approve the minutes of the meeting held on 23 November 2023 and to receive information arising from them.

4. Speaking to or Petitioning the Committee

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection.

To facilitate 'hybrid' meetings we are asking that requests to speak or present a petition are submitted by no later than 9am four working days before the meeting i.e., 9am on Wednesday 10th January. Requests to speak should be sent to scrutiny@oxfordshire.gov.uk

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

5. **Chair's Update** (Pages 23 - 48)

Cllr Hanna will provide a verbal update on relevant issues since the last meeting.

There are three documents attached to this item:

1. A report (with recommendations from HOSC) submitted to Oxfordshire CAMHS.
2. A document containing HOSC feedback on the most recent Health and Wellbeing Strategy Document for Oxfordshire.
3. A letter on Epilepsy Medication which has been made available to National Policymakers (please see more detail on this below).

One matter that was advised to the committee in June last year regarding medicines and epilepsy has since been communicated as a central safety alert CAS-ViewAlert (mhra.gov.uk). A letter has been sent by two leading epilepsy charities, Epilepsy Action and SUDEP Action (Oxfordshire based); to the Neurological Alliance who has made this available to national policy makers. Epilepsy Action, SUDEP Action, and Neurological Alliance have requested that this letter be tabled urgently at Oxfordshire JHOSC because of the deadline for ICB action plans in this matter by 31st January. And the likely impacts on Oxfordshire patients, clinicians, and NHS management.

It is **RECOMMENDED** that the committee delegates this matter to the scrutiny officer and Chair to:

1. Liaise with the ICB with A view to an update about the ICB response to the alert and required local action plan to date, and consideration of the suggestion by patient charities that a delay is sought to implementation of this measure because of the severe pressures in the NHS and until adequate resources can be made available to local systems. This is based on an understanding of the likely impacts and how best to support clinicians, patients, and managers.

2. Write a letter to the Chair of the Parliamentary Health Scrutiny Committee requesting consideration of scrutiny of the latest safety alert given; the proposed timescales for implementation, the lack of a national impact assessment, or the lack of resources to support the new requirements.

The Committee is recommended to **NOTE** the Chair's update having raised any relevant questions.

6. Wantage Community Hospital Update (Pages 49 - 142)

Daniel Leveson (BOB ICB Place Director, Oxfordshire); Lucy Fenton (Transformation Lead – Primary, Community & Dental Care
Oxford Health NHS Foundation Trust); Susannah Butt (Transformation Director- Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); Dr Ben Riley (Executive Managing Director- Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); have been invited to present the final co-produced report providing details on both the outcomes of the Public Engagement Exercise around Wantage Community Hospital, as well as on the final offer as to which specific services will be provided at the Hospital following the closure of the in-patient beds in 2016.

Based on the feedback of the HOSC Substantial Change Working Group (to be provided verbally during the meeting on January 16th), the Committee will be required to **AGREE** on:

1. Whether or not to declare the closure of beds at Wantage Community Hospital as a Substantial Change, and,

2. Whether or not to refer to the Secretary of State for Health and Social Care the matter of the closure of beds at Wantage Community Hospital.

PLEASE NOTE the following:

The Committee's Substantial Change Working Group will be meeting on Friday 12th January, where it will be making its final decision on what it will be recommending to the wider HOSC on 16th January. The reasoning behind the Working Group meeting being scheduled at a date that is close to the formal HOSC meeting on the 16th is due to the fact that it is pivotal that the Working Group and the wider HOSC take the outcomes of the Wantage Town Council Health Committee Public Meeting on 11th January into account prior to making a formal decision on whether or not to; refer this matter to the secretary of state and as to whether or not to declare the closure of the in-patient beds at Wantage Community Hospital as a Substantial Change.

The following documents are attached to this item:

1. A report by the Health Scrutiny Officer, outlining the context and explanations as to what it is the Committee will be required to decide on during this item.

2. The final co-produced report on Wantage Community Hospital outlining the outcome of the Public Engagement Exercise and the next steps and recommendations.

3. A list of appendices including; a list of outpatient services delivered at Wantage Community Hospital, the HOSC History of the hospital, a Map of Community hospital inpatient locations, and a statement of support from Oxfordshire County Council on the recommendations being proposed as to how to configure the future services at Wantage Community Hospital.

4. A report by Verve, the independent facilitator used for supporting the Public Engagement Exercise.

5. A letter of support from the Chief Executive of Oxford University Hospitals NHS Foundation Trust on the recommendations being proposed as to how to configure the future services at Wantage Community Hospital.

7. Support for People Leaving Hospital; an update on the Oxfordshire Way (Pages 143 - 152)

Karen Fuller (Director, Adult Social Care) and Ian Bottomley (Lead Commissioner, Age Well); have been invited to present a report on the Oxfordshire Way and the support provided to people leaving hospital.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

8. Response to HOSC Recommendations (Pages 153 - 156)

HOSC has received acceptances and responses to each of the FOUR Recommendations made by the Committee during its item on Winter Planning in its meeting on 21 September 2023.

The Committee is recommended to **NOTE** the responses.

9. Forward Work Plan (Pages 157 - 158)

To **AGREE** the Committee's proposed work programme for the upcoming meetings throughout the remainder of the 2023/24 civic year, having raised any questions.

10. Actions and Recommendations Tracker (Pages 159 - 180)

The Committee is recommended to **NOTE** the progress made against agreed actions and recommendations having raised any questions.

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
a) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 23 November 2023 commencing at 10.00 am and finishing at 3.00 pm.

Present:

Voting Members:

Councillor Jane Hanna OBE – in the Chair

District Councillor Elizabeth Poskitt (Deputy Chair)
Councillor Nigel Champken-Woods
Councillor Jenny Hannaby
Councillor Nigel Simpson (substituting Nick Leverton)
Councillor Mark Lygo
Councillor Michael O'Connor
Councillor Freddie Van Mierlo
District Councillor Paul Barrow
City Councillor Sandy Douglas
District Councillor Katharine Keats-Rohan
District Councillor Lesley McLean
Barbara Shaw

Other Members in Attendance:

Councillor Damian Haywood (for all Agenda Items)

Officers:

Stephen Chandler (Executive Director – People, Transformation and Performance)

Anne Coyle (Interim Corporate Director of Children's Services)

Ansaf Azhar (Corporate Director for Public Health)

Caroline Kelly (Lead Commissioner, Start Well)

Donna Husband (Head of Public Health Programmes- Start Well)

Doreen Redwood (Health Commissioning Manager – Start Well)

Vicky Norman (Head of Service Oxfordshire CAMHS & Eating Disorders, Oxford Health NHS Foundation Trust)

Katrina Anderson (Service Director, Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate Oxford Health NHS Foundation Trust)

Daniel Leveson (Oxfordshire Place Director, BOB Integrated Care Board)

Lucy Fenton (Transformation Lead – Primary, Community & Dental Care Oxford Heath NHS Foundation Trust)

Susannah Butt (Transformation Director- Primary, Community and Dental Care)

Dr Ben Riley (Executive Managing Director- Primary, Community and Dental Care at Oxford Health NHS Foundation Trust).

39/23 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies had been received from Cllr Nick Leverton and Siama Ahmed, with Cllr Nigel Simpson substituting for Cllr Nick Leverton.

40/23 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Cllr Hanna declared her interest as working for the health charity SUDEP Action.

Cllr Hannaby declared that she was Chair of the Wantage Town Council Health Committee.

Cllr Champken-Woods declared his interest as Vice-Chair of Trustees for an Elderly day centre.

Barbara Shaw declared her interest as Chair of Governors at a school, and as Chair of a Heart Charity.

41/23 MINUTES
(Agenda No. 3)

The minutes of the committee's meeting on 23 September 2023 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record.

42/23 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chair invited the registered speakers to address the Committee.

1. **Statement by Cllr Stefan Gawrysiak**

Cllr Gawrysiak highlighted that in December, 7 short stay Hub beds (SSHB) were being removed from Chiltern Court Henley on the Townlands health Campus. This was part of a reduction across the county from 97 SSHB to 63. A further cut to 40 was to happen in April and that this removal by OCC had been done without any consultation with GPs and the local community. These beds were currently fully occupied and were supervised by the Bell and Hart Surgeries.
This meant that the whole of South Oxfordshire was without any SSHB. South Oxfordshire comprises 140,000 residents. These were not Henley beds, these were beds that served postcodes RG9, RG4, OX10, OX9 and OX39.

A frail elderly person, with frail elderly relatives who was discharged from the Royal Berkshire Hospital would be placed in a care homes 20miles and a 2hr Bus journey away. This could not be good for their recovery.

Cllr Gawrysiak highlighted that all local GP's were against this because the burden would fall on them. Also, it was to be noted:

- that even though they run the service they had not been consulted.
- Henley Town Council, Patient Groups as well as himself (Cllr Gawrysiak) as County Councillor had not been consulted.

Cllr Gawrysiak concluded by asking HOSC to investigate and ask the following questions:

1. The location of the 63 beds shortly to be 40, on a map, so we can see the spread of these SSH Beds?
2. Why had there been no consultation?
3. Where were the frail and elderly discharged from the Royal Berkshire Hospital going to go if they needed extra care?
4. Request from OCC the data that this decision had been based on.

2. **Statement by Henley Town Council Cllr Ian Reissmann:**

Cllr Reissmann outlined that he was speaking in his capacity as Chair of the Townlands Steering Group; a community-based committee which invited a wide range of community representatives including 15 Parish Councils from the South of Oxfordshire. The group had also been active for 20 years in the subject of health and social care, and had met a week prior to the HOSC meeting to discuss the closure of the SSHB in Henley. Cllr Reissmann shared Cllr Gawrysiak's concerns outlined in the previous public statement, and that he was concerned that the determining factor behind the closure of the beds may be cost-driven as opposed to being based on patient need. It also seemed inappropriate that South Oxfordshire, which had a

population of 140,000 residents, would have no SSHB. Cllr Reissmann also expressed concern regarding the ways in which the care pathways would work under the proposed reductions of SSHB. The GPs had clarified that they provided the care for the patients occupying the SSHB, and that these beds were fully utilised. Cllr Reissmann added that he had been informed that the beds had only been occupied by patients who experienced delays in being discharged home by Adult Social Care due to capacity issues.

However, not all patients that occupied these beds were doing so specifically for that reason alone. In order for the community, patients, as well as GPs to be reassured, there would have to be confirmation on the figures around the usage of these beds over the last 2 years.

Cllr Reissmann also stated that the lack of public engagement with the community over the closure of the beds had also been a cause of concern amongst residents as well as GPs. Cllr Reissmann also called for the deferral of the closure of the SSHB in Henley pending satisfactory levels of community engagement.

The Health Scrutiny Officer made a statement highlighting that at the point in time of the meeting, the Committee was not in a position to declare the closure of the SSHB as a Substantial Change for two reasons:

1. The current guidance around declaring Substantial Changes indicated that such declarations could only be made over NHS services, and not on services that may be exclusively commissioned by a County Council.
2. If it was determined that prior to commissioning these beds, the intent was for these to be interim and not permanent beds, then declaring their closure as a Substantial Change would not be appropriate.

However, the Health Scrutiny Officer outlined that this did not mean that HOSC did not have the prerogative to scrutinise such closures and to examine the impacts of such closures on local residents.

The Chair outlined that the Committee will be looking into this matter of the closure of the SSHB further, and that a decision on how to proceed would be made in the Chair's update item.

3. Statement by Vale of the White Horse District Council Cllr Dr Debra Dewhurst:

Cllr Dewhurst explained that Cllr Hayleigh Gascoigne and herself were the Vale of White Horse District Councillors for Blewbury and Harwell – which covered the parishes of Blewbury, Harwell, Chilton, Upton and the newly formed parish Western Valley (the Vale portion of Great Western Park).

Cllr Dewhurst raised the issue of Primary Care provision in Didcot and the surrounding area, in particular the planned GP practice for Great Western Park (GWP). It was explained that this was an important issue for their residents and one that was brought up with them regularly. All health centres and GP surgeries in the Didcot area were currently oversubscribed and many had closed their books to new

patients. With 4000 new homes due to be built in the area imminently, this was a problem that needed to be solved urgently.

Cllr Dewhurst further explained that the ICB had delegated powers from NHS England to be the commissioner of Primary Care Services in Oxfordshire. Consequently, the ICB was charged under these delegated powers to ensure appropriate primary medical services were available across Oxfordshire. The ICB therefore oversaw these Primary Care Services and, as the reimbursing body of Primary Care estate rent, effectively decided which premises those services operate from.

A site of 0.2 hectares within the GWP District Centre, currently owned by Taylor Wimpey, had been set aside for primary care provision in the GWP S106 Agreement dated 18 July 2008, together with a health centre financial contribution; but the site was still currently empty/derelict. Cllr Dewhurst added that the S106 was in place to improve infrastructure to mitigate the impact of the development and yet the GWP estate had been fully occupied for some time, adding some 6000-7000 additional residents. Cllr Dewhurst explained that they were aware that the Vale of White Horse District Council was working with Taylor Wimpey and the ICB to have the land and the money transferred to the ICB and to modify the S106 agreement.

Cllr Dewhurst outlined that given the urgent nature of primary healthcare provision in the Didcot area, was there anything holding up this process? It was also enquired as to what the timescales were for having a health centre on GWP. As with all S106 agreements, the money available was time-limited. It was urged that residents were to be given reassurance that this much needed health centre would be built. It was also asked as to what the next step in the process was? Cllr Dewhurst concluded by stating that they all wanted to see the GP surgery being built and put to use as soon as possible.

The Committee Chair highlighted that the issue of capital and builds for Primary Care estates was something that the Committee was concerned about, and referred to a Primary Care Workshop that the Committee had previously held, where the Didcot Estate was the case study that was actuality utilised given the particular scenario Didcot was facing. The Chair also referred to the agenda papers for this meeting which contained a letter with recommendations on Primary Care that was submitted to the Secretary of State for Health. It was also highlighted that recommendations around some of the aforementioned challenges had been made by the Committee to the ICB previously.

The BOB ICB Oxfordshire Place Director highlighted that the Didcot project was progressing, and that the ICB were working with Local Authorities as well as Primary Care at the local level. Delays had been around affordability, where the ICB had to approve the Value for Money, as it had to go above the District Valuer amount for rental agreements. It was emphasised that a detailed response was to be provided to the Parish.

The Committee urged for a timely resolution on the district valuation, given the urgency of need in the Didcot area.

43/23 CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH - PROGRESS UPDATE

(Agenda No. 5)

Anne Coyle (Corporate Director of Children's Services); Ansaf Azhar (Corporate Director of Public Health & Community Safety); Daniel Leveson (BOB ICB Place Director, Oxfordshire); Caroline Kelly (Lead Commissioner- Start Well, Oxfordshire Health, Education and Social Care Joint Commissioning across Oxfordshire County Council and the BOB ICB); Donna Husband (Head of Public Health Programmes – Start Well, Public Health & Community Safety Directorate, Oxfordshire County Council); had been invited to present a report with a progress update on Children and Young People's Emotional Wellbeing and Mental Health.

It was highlighted that this item had come to HOSC previously in 2022, where the Committee recommended for urgent prioritisation of funding to support the Children's Emotional Wellbeing and Mental Health Strategy. This item was therefore an update on the effectiveness of the Strategy and its deliverability in the context of children's emotional wellbeing and mental health services overall.

The Director of Public Health informed the Committee that this was a system-wide strategy that was launched over 12 months ago, with a view to how there could be improvements to the emotional wellbeing and mental health of Oxfordshire's young people. It was highlighted that the strategy partly aimed to improve the mental wellbeing of children in a manner that prevented young residents from having to be on CAMHS waiting lists to begin with. Alongside the Children's directorate, Public Health had conducted a needs assessment to look at the underlying need within the County with respect to children's emotional wellbeing and mental health. It was explained to the Committee that it was in this context that the strategy was formulated. The strategy contained four key principles which were:

1. Providing early help and creating supportive environments.
2. Developing a confident workforce.
3. Ensuring positive transitions.
4. Improving access.

The Lead Commissioner for Start Well outlined that there was a digital offer which was currently being tendered, with bids having been received for the new service which was due to start in April 2024. An analysis of the parent course offer was conducted, as well as the use of support groups to understand what was already available, what was working well, and to receive feedback from parents and carers to understand what else could be undertaken in the digital space. There was also work with schools to understand how they operate to support children and young people with their wellbeing and resilience; looking at various frameworks including the I-THRIVE model. The system's dashboard had also been developed to understand the initiatives that were being worked on now and whether they were making a difference to children, young people, and their families.

The Head of Public Health Programmes for Start Well outlined that Oxfordshire MIND had been commissioned to deliver all-ages Mental Health and Suicide Prevention Training. Training is also very much needs-led in its focus and nature. More bespoke

training may also be delivered by the system if that is identified within local communities.

It was also explained to the Committee that in terms of the transitions approach, very focused workshops across system partners had taken place to feed into wider decisions as to whether there would be development of an all-age mental health service with colleagues in Adult Services.

The Committee were informed about the imperative for wider collaborative work within the system for improving the mental wellbeing of children, young people, and their families. Intervention needed to occur at an early stage for services to be effective. Some of the progress in this area included the following:

- Delivering a joint initiative between Early Years and Public Health to target speech and language communication to children before they went to school.

- The Oxfordshire Inclusive Economy Partnership had developed a Charter for employers to demonstrate support for and commitment to making Oxfordshire a fairer and more inclusive place to live and work.

- There were also broader initiatives that occurred in the grassroots of local communities that would inevitably impact on the betterment of the wellbeing of families.

Furthermore, some opportunities as well as constraints were highlighted to the Committee. Some constraints included:

- Increased needs and access for mental health support and services.
- Recruitment challenges for the local community CAMHS.
- Significant financial challenges across the integrated care system.

In terms of opportunities, the Committee were informed that there was a service transformation as well as an improvement in partnership and integrated working. Some examples of this included; a newly commissioned integrated 0-19 years public health service; an Emotionally School Based Avoidance Project; and a CAMHS Thames Valley Link Project. Additionally, there was also a strong commitment to responding to the recent Ofsted/CQC SEND inspection outcomes.

The Committee referred to how the report cited the significance of the BOB Integrated Care Partnership in the context of this strategy. It was enquired as to the contributions that the ICP and its various member organisations had actually made toward the strategy and its effectiveness. It was highlighted to the Committee that this was indeed a systemwide strategy, and the BOB ICB Place Director for Oxfordshire referred to how the Director of Public Health, alongside the Executive Director for People Transformation and Performance were all members of the Place-Based Partnership. It was also explained that a joint commissioning team was in place, which was an indication of joint working between the County Council and the NHS. The Committee were also informed that the partnership working was indeed effective and conducive towards good collaborative work. The Director of Public Health also

explained that a task group was formed to help identify and involve all relevant partners in the strategy.

In regard to a query relating to the role of Cabinet Members/elected officials in the context of the strategy, the Public Health Director specified that Cabinet Members had an opportunity to comment on the strategy at the Health and Wellbeing Board. The Cabinet Member for Children's Services added that it was clear that elected members were involved, but that there was also an academisation of most secondary schools, where the regional schools director had more control over these schools than the County Council had. Since 1991 Local authorities also had little control over the budgets of schools, although the Council could influence how schools utilised funding where possible and necessary.

The Committee referred to how the report highlighted a commitment to addressing gaps in emotional wellbeing services for children and young people. It was queried as to how this process of identifying gaps was carried out, and if there were any gaps that had been identified. The Director of Public Health responded that there were a number of themes that were identified including transitions as well as the digital offer. Workforce was another area that was identified.

The Committee referred to how at-risk children were discussed when the item previously came to HOSC in 2022, and enquired as to whether there was an explicit list of various vulnerable groups, taking into account the NHS CORE20plus 5. The Head of Public Health Programmes (Start Well) explained that there was universal provision in place, but also explained that there were various other strands of work around the Council and the wider system, looking at families through the lens of vulnerabilities. An example of this was how the suicide prevention work was partly related to areas of deprivation. The utilisation of data from the Joint Strategic Needs Assessment (JSNA) would help inform and determine where vulnerabilities existed within the population. The Committee emphasised the importance of transparency and urged that the process of vulnerabilities was simplified and made as understandable and explicit as possible for residents. The Director of Children's services also added that part of the system wide learning and training was about getting everybody on the same page with regards to identifying and supporting vulnerable groups. The Committee were also informed that there was no single way in which children's needs would be met; and the strategy sought to create opportunities across the board in order that Children and Young People could access services in different ways and at different times that were suitable to them.

The Committee queried whether the digital offer would be produced in a manner that took into account the views of children and their families. It was responded that prior to going out to tender, market testing was undertaken to gather feedback on what the most popular apps would be. Children and Young People could not be part of the evaluation panel due to legal processes around procurement not enabling this.

The Committee then enquired as to what the pathway was for moving from digital and non-clinical intervention towards more clinical interventions for children that may require this. It was responded that children can be referred to CAMHS at any stage. There was no prerequisite to have support online before being allowed to access CAMHS. Even whilst receiving CAMHS services children could also continue to

utilise the app. The app constituted an outlet for children and young people to express their views and feelings and to gain peer support. The Committee was also informed that the app was moderated to flag any concerns to statutory services if there was any indication that there was a child at risk who required additional support.

The Committee queried whether there were specific avenues of funding made available for the purposes of delivering this strategy, and whether the current sources of funding were adequate. It was also asked as to whether measures will be taken to explore even further funding. The ICB Place Director for Oxfordshire stated that the system was doing the best that it could to operate effectively within the funding allocations that it currently had, and that services were working thoroughly and extensively to meet the need. There had been additional investment in mental health services over the last few years through the mental health investment standard that had been used in priority areas. The Director of Children's Services added that it was vital that children and young people were heard, and that using a preventative agenda was also an important element of avoiding an escalation to a heavily intense clinical approach.

The Committee highlighted the importance of consistent and effective workforce recruitment and retention for the delivery of any strategy of this nature, and enquired as to how it would be ensured that there was an adequacy of workforce.
Additionally, the Committee referred to how the voluntary sector, Primary Care Networks (PCNs), as well as BOB ICB were recruiting new roles, and queried how confident the system was that it had all professionals identified as part of the whole system regardless of where and who was employing or providing these workers. The BOB ICB Oxfordshire Place Director explained that workforce remained a challenge within the system. The Director of children's services referred to the SEND Local Area Partnership inspection, and outlined that a lot was learned from the inspection and its outcome. The inspection had motivated the reaching out to partners to create an integrated response, and there was an understanding that partners were all working toward the same goals, but doing things slightly differently. The Committee then emphasised that given that workforce in this context would be dealing with children with mental health or emotional wellbeing challenges, it was vital that such staff should also receive adequate support for their own wellbeing; it was then queried as to what support structures were in place to support staff wellbeing. The BOB ICB Place Director clarified that every NHS organisation had a comprehensive health and wellbeing offer. The Committee were informed that there were complexities around this, including how job roles could be framed with regards to career prospects and progression opportunities. The cost-of-living crisis was also cited as having an impact. The Director of Children's Services referred to staff support sessions, and how there was support for staff that was accessible. The Cabinet Member for Children's services added that from a school's point of view, Oxfordshire County Council was one of the few authorities that had retained a joint committee where there was regular communication with trade unions.

The Committee sought confirmation as to whether teacher training for autism/ADHD had become mandatory, and queried the level of uptake for this training. It was also raised as to whether such training was ongoing as opposed to being provided on a one-off basis. It was responded that schools were offered training by the Anna Freud

Centre, and that this was heavily publicised in schools last year. There was also a push from the Department of Education to increase the uptake of this training from the Anna Freud.

The Committee referred to the recent CQC/Ofsted report, which highlighted some systemic challenges around children's Special Educational Needs & Disabilities (SEND) provision, and enquired as to how the inspection's outcome would further inform and influence the priorities and actions undertaken as part of this strategy. It was explained that the inspection's outcome constituted a core element of considerations of how improve the emotional wellbeing and mental health of children with SEND.

The Committee referred to how the report cited a commitment to reviewing the strategy's deliverability, and queried the ways in which there would be adequate and frequent reviewing of the progress made on delivering the priorities of the strategy. It was also asked as to whether there was a single standardised measure across the system that could be utilised across all settings. It was responded that it would be too complex to have a single measure, and that there were various metrics that were measured, although efforts were made to bring that information together where possible. The importance of having qualitative narratives was also highlighted to the Committee. The BOB ICB Place Director outlined that it was also in the context of the Health and Wellbeing Strategy where the system examined overall impacts on overall aspects around life stages including the start well, live well, and age well initiatives taken by the system.

The Committee emphasised the importance of awareness and navigation of the emotional wellbeing services available for children, and queried whether there were any tools in place through which the system was supporting navigation at both the neighbourhood and Place/County levels. The Head of Public Health Programmes (Start Well) responded that PCNs were commissioning some work from Oxfordshire MIND in relation to emotion-based school avoidance, and such commissioning was predicated on the local needs within local communities. The Chair highlighted that it was crucial for all relevant workers within the system and the neighbourhood levels to be aware of other relevant workers and services that may be available for residents. The Committee was informed that there was work on enhancing Social Prescribing, and that there were a number of officers whose key role was to promote the Social Prescribing Approach.

The Committee **AGREED** to make the following recommendations:

1. To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is recommended that piloting such navigation tools in specific communities may be a point of consideration.

2. To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available.

3. To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long-run.

4. To ensure that Children and Young People and their families continue to receive support that is specifically tailored toward their needs. It is recommended that a Needs-Based Approach is explicitly adopted, as opposed to a purely Diagnosis-Based Approach. This could allow for early intervention to be initiated as soon as possible.

5. That consideration is given to the use of a simple and evidence-based standardised evaluation measure, that is suitable across all services that are working on Children's mental health in community settings.

The Committee also **AGREED** to the following Action:

1. To receive a briefing on the use of technology in the context of Children's Emotional Wellbeing and Mental Health Services in the near future.

44/23 OXFORDSHIRE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) UPDATE

(Agenda No. 6)

Vicky Norman (Head of Service Oxfordshire CAMHS & Eating Disorders); Katrina Anderson (Service Director, Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate); Emma Fergusson (Associate Medical Director CAMHS Oxfordshire); had been invited to present a report with data and development updates from Oxfordshire Child and Adolescent Mental Health Services (CAMHS).

The Committee enquired as to whether the cost-of-living crisis had resulted in a decline in the mental health of children and young people, and if so, what role CAMHS was playing in helping to support children and families whose mental health had significantly declined as a result of this crisis. It was explained to the Committee that it was difficult to always identify cause and effect patterns, and therefore it was not straightforward to suggest that the cost-of-living crisis had resulted in a significant decline in children's mental health. However, there had been a significant rise in the rate of referrals to CAMHS Services, as well as in the acuity of those children who were presenting. The Committee emphasised that the service should keep a close eye on the impacts of the covid-19 pandemic as well as the cost-of-living crisis on children's mental health and wellbeing. The BOB ICB Place Director added that during the work undertaken as part of the Health and Wellbeing Strategy, the themes of the cost-of-living crisis as well as the covid-19 pandemic resonated in all these contexts. The Executive Director of Healthwatch Oxfordshire also explained that as part of the work undertaken in the context of the public engagement around the Health and Wellbeing Strategy, the cost-of-living was a significant driver. It was heard that the crisis had generated further stresses on working families, which resulted in an increase in parental stress and which would also have a knock-on effect on children's emotional wellbeing and mental health.

The Committee emphasised that there were national challenges around workforce, and queried the steps that had been taken to secure adequate recruitment and retention of staff. The Committee also referred to how the report mentioned attendances at recruitment fairs as well as the offering of relocation packages and incentive payments, and asked how effective these measures had proven thus far, and whether any further measures would be embarked on. The Head of Oxfordshire CAMHS responded that recruitment fairs were held in Belfast, Dublin, and Glasgow; with two nurses from Glasgow expressing a keen interest in relocating. There was also a CAMHS academy pilot to train people to come into CAMHS. The service was being more creative in how it looked for employees and created job roles, and the service was looking to become as needs-led as possible. For instance, it was explained to the Committee that when considering who to employ for the Eating Disorder Service, it may be more appropriate to recruit a more general nurse as opposed to a purely mental health nurse given the physical aspect of eating disorders. In terms of staff retention, it was explained that the service was not performing too badly on this and that there were staff that remained in their post for years. There were also simple steps taken to support staff in terms of providing very clear job plans to avoid staff becoming overwhelmed, and for them to understand what the Service's expectations were from individual staff members. The BOB ICB Place Director added that as the system further developed, including with the development of the BOB mental health collaborative, one of the increased benefits of such growing partnership working would including single recruitments and job shares.

The Committee referred to how the report mentioned that the service was commissioned to undertake 50 assessments per month but received 150 referrals a month, whilst the waiting time for an assessment was already 3.5 years. It was emphasised that the waiting list was therefore only going to grow. The Committee queried whether the commissioned 350 assessments from the Owl Centre would make a difference to the waiting list. It was also queried whether parents who paid privately for an assessment would gain priority on the list, and whether there were any plans in place to reduce waiting times and prevent inequalities. The Head of Oxfordshire CAMHS responded that when people get referred to the Neuro-developmental Diagnostic Clinic, the service backdates referrals to the day that people actually presented to CAMHS. It was confirmed that the waiting list for CAMHS was not 5 years, and that this was a great misunderstanding of the waiting list period. People were welcome to seek private treatments, and there was clear communication on the kind of service they should expect. The Committee were assured, however, that people receiving private treatment did not gain any priority at all.

The Committee referred to how the report cited the Outreach Service for Children and Adolescents' support for young people whose level of complexity required more intensive services. It was queried as to how successful this outreach service had been operating thus far, and whether there was adequate resource for this service given its importance as well as its complexity. It was also queried as to whether the voices of service users and their families were being adopted in the ways in which CAMHS delivered this service as well as wider CAMHS services in general. It was responded that the service was working to secure the staffing levels and expertise that were required. A participation worker had also been recruited to work alongside the parent peer support workers to continue to hear the voices of families. A system

is used to collect feedback from families. There were additional steps beyond the medical model being adopted such as encouraging social events, including football clubs or meal events. The service also met with the Parent Carer Forum to hear the views from parents and carers from that avenue also. However, it was highlighted to the Committee that there was a recognition that things could improve in this area of working alongside families as well as enhancing the ways through which their voices could be heard.

The Committee emphasised that there seemed to be a great deal of miscommunication as well as misinformation in relation to CAMHS in the public and parent community as well as the medical community. It was enquired as to how the service was combating and addressing this. It was explained to the Committee that the service met with GPs recently where a request for some further information was sought from the service, and that the service would imminently provide an update to GPs to enable them to share relevant information with families regarding how CAMHS operates and the CAMHS services available for residents. It was reiterated to the Committee that there was work required to improve communications work with families, and that a newsletter was being created for the Parent Carer Forum to share in the ensuing weeks.

The Committee enquired as to whether there had been an increasing resort to swifter discharging; and that in the event of swifter discharges, whether the service was balancing the need for swifter hospital flow on the one hand, and the actual needs of patients already in hospital. It was responded that there was a crisis and a home treatment team that ran a home treatment model. The Eating Disorder service also had an enhanced care pathway as well as a hospital at home service. There had been a reduction in Eating Disorder cases. There had also been a reduction in patient admissions. The crisis team would also reach into the ward when patients were admitted and would try to get patients discharged earlier if that was appropriate. There was a recognition by the service that hospital admission was in some cases necessary, but that improvements had been made in being able to treat patients outside hospital settings as much as possible. The Committee also queried the loss of tier 4 level beds across the BOB footprint and how this occurred abruptly, and whether all beds had been replaced in Oxfordshire. It was explained to the Committee that all of these beds were in Taplow Manor, and that most of the children were successfully discharged, and those that were not discharged were transferred to other beds within the provider collaborative. It was emphasised that there was not necessarily a need to replace these beds, and that the preference was for children not to be kept in hospital settings, which was why the hospital at home services were being developed as part of a wider offer.

The Committee referred to how the report cited the Eating Disorder service, and queried the extent to which residents were aware of such services and how to go about accessing them. It was explained that all services were accessed through the Single Point of Access. All CAMHS referrals would occur via this office, which was a well-resourced and staffed office which undertook triaging and consultations with families to help residents access the support that was appropriate to them. This process helped to establish a consistency in approach toward assisting residents in accessing appropriate services. It was also specified that residents could be referred to the Eating Disorder service via their GP.

The Committee **AGREED** to make the following recommendations:

1. For patients to receive effective and elaborate aftercare upon being discharged from hospital; and for there to be close coordination with families as well as with other partners/services within the system for ensuring discharged patients receive adequate and sustainable support upon leaving hospital.

2. To ensure that children and their families who are on waiting lists for treatment receive support so as to avert the prospects of their mental health declining further.

3. For staff to receive adequate training that involves not merely guidance on how to interact with and treat individual patients, but that also involves guidance on how to support the families/carers of Children. It is recommended that a review of existing training programmes is conducted with children and family stakeholders, with a view to all training being co-produced to support staff working with children and families.

4. To work on improving communications campaigns to create a better understanding of the CAMHS service and how it also relates to any other early intervention services.

   The Committee also **AGREED** to the following Action:

   1. That the Committee would be provided with stakeholder communications and briefings as and when these are published/made available by the CAMHS service. This would constitute part of a drive to improve CAMHS communications with stakeholders, elected representatives, and the wider public.

45/23 CHAIR'S UPDATE
(Agenda No. 7)

The Chair highlighted the following points in relation to developments that have occurred since the last meeting on 23 September:

The Chair explained that a document was compiled which collated the views of the Committee on the recent Health and Wellbeing Strategy Update. This was shared with the Committee members and was also shared with relevant Public Health Officers.

The Chair referred to the Short Stay Hub Beds in Henley and expressed that the Committee would be closely looking into the reasoning behind the closure of these beds, as well as any other Short Stay Hub Beds within Oxfordshire.

The BOB ICB Place Director explained to the Committee that the closure of the Short Stay Hub Beds was a decision that had already been made, and that these were

beds that were wrapped up in the broader Better Care Fund and Winter Plan. The Director of Adult Social Care added that these were not NHS beds, and that they were system beds that flexed up and down within the County, with no requirement to go into consultation when doing so. It was also specified that these were beds that were commissioned by the County Council, and that the closures were a part of the Oxfordshire Way of helping people to be supported in their own homes. It was also explained to the Committee that 17 hub beds were also closed in the North of the County.

The Chair referred to a national Healthwatch report which was published a week prior to the Committee's meeting, which explained that whilst there was support for being cared for at home, there were some concerns raised in terms of what was heard in surveys from families. The BOB ICB Place Director confirmed that there had been an increase in the amount of hours that the system was dedicating toward delivering care in peoples' homes, and that there had also been a reduction in the amount of people delayed in hospital beds, with more people being discharged and receiving care at home than in the past. The Committee were therefore informed that the closure of Short Stay Hub Beds had to be seen in the broader context of a Countywide Urgent and Emergency Care programme.

The Committee emphasised that it was pivotal for there to be clear communication behind the reasoning behind the closure of Short Stay Hub Beds as well as details of the alternative services that patients would be expected to receive upon being discharged from hospital. The Executive Director of Healthwatch Oxfordshire also added that whilst this new model of care may be a manifestation of good practice, there was an urgent need for clearer communications with the wider public in relation to this.

The Committee **AGREED** to the following recommendation:

1. To hold an item in its extra meeting on 16 January 2024, to look into the reasoning behind the closure of Short Stay Hub Beds, as well as to receive specific and broader insights into the process of discharging and any national directives or impacts assessments that have been conducted as part of the closure of any such beds within Oxfordshire.

46/23 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 8)

The Chair highlighted that the Committee had received acceptances for and responses to its previously made recommendations. The Committee was pleased that most of the recommendations had been accepted. Acceptances and responses were provided to recommendations made around the following items/areas:

1. Dentistry Provision in Oxfordshire.
2. Local Area Partnership SEND.
3. Oxfordshire Healthy Weight.
4. Health and Wellbeing Strategy.

The Committee had also received an additional progress update response to a recommendation made to the BOB Integrated Care Board in its November 2022 meeting as part of the Primary Care Item. This called for specified roles to be created within the ICB to work alongside District Councils to coordinate the use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care. The ICB clarified that a new post would be in place in the ICB by December 2023 to work on the above.

The Committee **NOTED** the responses to, as well as the progress made toward implementing the recommendations it had made previously.

47/23 HEALTHWATCH OXFORDSHIRE UPDATE REPORT

(Agenda No. 9)

The Executive Director of Healthwatch Oxfordshire expressed the following points to the Committee:

1. The Committee were informed about the reports on community research which stemmed from the emerging community research network that was developing in Oxfordshire. Healthwatch Oxfordshire undertook interviews with both system partners and communities as part of this. The Committee were informed that within the reports developed by Healthwatch, important lessons had emerged for all system partners who were looking into how to better engage with seldom heard communities. Healthwatch had also heard a lot from community members regarding a sense of research fatigue. Community members felt bombarded by services which sought their views and which expressed a commitment to work with them, but did not notice any action or a strong sense that services were building on previous work or research that had taken place.

2. In support of the upcoming Primary Care Strategy, Healthwatch were holding a webinar with the BOB ICB Place Director to speak to members of the public about the strategy with the ICB.

3. The Committee were informed about the footcare report which highlighted the public concerns relating to basic footcare not being provided through the NHS, with residents having to resort to private means of treatment.

4. Earwax removal was another area explored by Healthwatch. Previously, residents would usually receive earwax removal treatments form their GP, which was no longer a service that was available. There was a concern around whether residents would have to seek private earwax removal treatments prior to accessing some of the services for hearing support.

The Committee **NOTED** the report by Healthwatch Oxfordshire, and thanked Healthwatch for its contributions.

48/23 OXFORDSHIRE PLACE-BASED PARTNERSHIP UPDATE

(Agenda No. 10)

Daniel Leveson (BOB ICB Place Director, Oxfordshire) had been invited to present a report with an update on the Oxfordshire Place-Based Partnership.

The following points were explained to the Committee in relation to the Place-Based Partnership.

1. The Partnership struggled with the governance around it, as it did not have formal delegated authority from the ICB. There had been ongoing discussions as to whether or not authority would be delegated, but that national guidance outlined that the engine room of integration should be Place. The Partnership had also been running for approximately a year.

2. The Partnership was developing well, and the Place Director brought the leadership of the Partnership together.

3. A wide array of organisations and stakeholders were represented in the Partnership including the County Council, General Practice, the City and District Councils, the Chief Executives of Oxford Health Foundation Trust and Oxford University Hospitals Foundation Trust, Healthwatch Oxfordshire, and Voluntary Sector Representatives.

4. The ICB Place Director's role was focused on identifying individuals and populations that would benefit from joined-up care.

5. The Partnership focused on bringing resources together for improving outcomes for residents.

6. The Committee were also informed that the Partnership focused on the following priority areas/populations:

    - Children and Young People: including school readiness, SEND, children and young people's emotional health and wellbeing.

    - Adult and Older Adult Mental Health and Wellbeing: including the adult and older adult mental health, those with Learning Disabilities and neurodiversity.

    - People with Urgent Care Needs: including children, adults and older adults with multiple illnesses and frailty.

    - Health Inequalities and Prevention: including the promotion of healthy lifestyles, working with communities and taking into account the role of anchor institutes and major employers.

The Committee queried the steps that the Partnership were taking to establish strong relationships, both amongst its core membership as well as with wider partners. It was responded that Partnership working was going well, and that the Partnership took basic measures including having meetings in-person. There was a clear set of priorities that the Partnership was collaboratively working towards. A maturity matrix

was also adopted, and the Partnership would routinely refer back to this to determine its overall direction of travel. It was emphasised to the Committee that good relationships formed the basis of this Partnership at a fundamental level.

The Committee enquired as to the degree to which transparency was at the heart of how the partnership operated, and whether there were any challenges in this area of transparency. It was responded that the Partnership somewhat relied on trust, and that trust was not always easily measurable. It was also explained to the Committee that the current system in which the Partnership operated did not necessarily enable the Partnership to exercise transparency very well, as the regulatory system had not kept up with this. But there were incremental changes within the system that were necessary, including a stronger understanding of risk and a practice of risk-sharing.

The Committee queried if any reassurances could be provided that the Partnership operated in a manner that avoided duplication of other bodies or their associated activities, such as the Health and Wellbeing Board. The ICB Place Director explained that he was a member of both the Health and Wellbeing Board as well as the Place-Based Partnership, and that this helped to ensure that the Partnership avoided duplication of the Health and Wellbeing Board and its work. It was also added that the Health and Wellbeing Strategy would help with avoiding duplication, and that that would constitute the overarching systemwide strategy for Oxfordshire's health and wellbeing.

The Committee enquired as to whether the Partnership, at Place level, had any role with respect to strategies on capital and capital allocations across Oxfordshire. It was responded that from an NHS point of view, the capital allocations would be run through the ICB in the context of a nationally-run programme. However, the capital programme would be built up from within the three Places of Buckinghamshire, Oxfordshire, and Berkshire West. It was also explained that the only means through which Oxfordshire's hospital infrastructure could be improved would be via accessing small pots of money or vast sums of funding under the New Hospitals Programme.

The Committee referred to how the report mentioned learning and the experiences of other Place-Based Partnerships, and queried how Oxfordshire's Place-Based Partnership had been learning from the activities and experiences of other partnerships. It was responded that the ICB Place Director had been in close contact with various networks including in Manchester and West Yorkshire, which were two Places that had been held up as good examples. It was also emphasised to the Committee that there was a benefit to having three Place-Based Partnerships under the BOB ICB footprint, as all three Place level Partnerships did and could collaborate effectively to drive improvements to health and wellbeing collectively.

The Committee enquired as to how the partnership would develop a culture of learning and evaluation, and how any learning and evaluation of the Partnership's activities would be implemented in practice. It was responded that learning and evaluation was a practice that was undertaken across the system, and that evaluation was being undertaken alongside other partners such as the University of Oxford, particularly in relation to the Partnership's health inequalities work. The BOB ICB Place Director also referred back to the Partnership's maturity level, which would

be used to test the degree to which the Partnership was performing well and effectively achieving its aims and priorities.

The Committee referred to how the report mentioned the importance of a shared vision and purpose for the Partnership, and queried how this vision and purpose was being developed as well as the degree to which this had been achieved. It was responded that the overall vision of the Partnership would be determined by the systemwide Health and Wellbeing Strategy, and that the NHS would operate in a manner that supported the development as well as the delivery of the strategy.

The Committee referred to how the report mentioned the Mental Health Outcomes Improvement Programme. It was queried as to what this programme entailed, and how it would improve the ways in which the Partnership worked on improving mental health in the county. It was explained to the Committee that this was a whole system programme. In the past, contracts for specific services were commissioned. However, moving forward, the Partnership would work towards bringing the system together to agree on Adult and Older Adult mental health services but with a long-term vision to create a more integrated all-age mental health service. It was explained that the hope was to create an outcomes-based contract that was focused around incentivising the right outcomes as opposed to simply incentivising the activities undertaken as part of mental health services.

The Committee referred to how the report made reference to shared data and information, and enquired as to whether there were any examples that could be provided on how the Partnership was supporting this at both the population as well as the individual levels? It was also queried as to whether there was any means through which such data and information sharing could be enhanced. It was responded that there was a lot of work undertaken within the County Council as well as the wider system. An example that was cited was that the County Council and the ICB would be aware of residents who had experienced a fall, and how residents in particular areas may be more prone to experiencing falls. It was also added that there were some barriers around information governance to some extent, and that people may understandably be nervous regarding how their personal health data was utilised. Another example of where shared data and information was working well was around the hospital at home between community and acute providers, where there was an increased use of a single system. It was added that by approximately January to February 2024, the system would have a shared care record which would constitute a repository of information from acute, community, mental health, primary care, and local authority providers.

The Committee emphasised that there were recent challenges related to workforce recruitment and retention, which were not unique to Oxfordshire but nationwide. It was queried as to how this would affect how the Partnership operated, as well as whether the Partnership would take collective measures to address these challenges. It was responded that there was a workforce shortage, and that there was a workforce plan that was proving difficult to recruit to. The Committee was informed that further steps would be taken within the Partnership as well as the wider system to try to improve not only staff recruitment but also retention. There was a need to pool resources as much as possible within the system so as to be able to deliver

services effectively and make use of existing staff in the most efficient and effective manner.

The Committee **AGREED** to make the following recommendations:

1. For the Place-Based Partnership to operate in a manner that avoids duplication of other bodies or their associated activities; including the health and wellbeing board.

2. For the Place-Based Partnership to consider collective work around finding avenues to improve oral health throughout the county, particularly for vulnerable groups or disadvantaged communities.

3. To develop robust processes through which to monitor the effectiveness of the Place-Based Partnership and its work, and to ensure transparency around this.

4. To develop robust principles and processes around transparency of decision-making within the Partnership, so as to mitigate the loss of place-based statutory board CCGs which were open to the public.

49/23 WANTAGE COMMUNITY HOSPITAL UPDATE

(Agenda No. 11)

Daniel Leveson (BOB ICB Place Director, Oxfordshire); Lucy Fenton (Transformation Lead – Primary, Community & Dental Care OH NHS Foundation Trust); Susannah Butt (Transformation Director-Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); Dr Ben Riley (Executive Managing Director- Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); were invited to present a report providing an update on the Public Engagement Exercise around Wantage Community Hospital.

The Committee emphasised that it was crucial that they were aware of the progress made as part of the public engagement exercise around the future services to be delivered at Wantage Community Hospital, as well as for there to be clarity on the degree to which adequate co-production had been at the heart of determining how future services at the hospital would be configured following the closure of the inpatient-beds some years ago.

The Committee sought reassurance on the degree to which viable offers were being made as to the future of the hospital's services. It was raised and discussed that the HOSC Substantial Change Working Group had been involved in close and continuous scrutiny of the public engagement exercise, and that the working group had held monthly check-ins with Oxford Health and the ICB to be kept up to date with as well as to discuss the exercise. The Working Group had also produced a report with its own recommendations to HOSC, which had been published as an addenda to the original agenda for this meeting.

The Committee thanked Oxford Health as well as the ICB for their efforts around the co-production exercise on the hospital's future, and outlined that this was the closest

that the system had ever been previously in helping to determine which services should be delivered on the ground floor of the hospital following the closure of the inpatient beds. The Committee also thanked all stakeholder groups which also partook in the exercise.

It was also discussed that the survey that was distributed as part of the exercise had come to an end, and that verve (the independent facilitator of the exercise) were in the process of collating the findings.

It was also raised that there were three scenarios as to how future services could be delivered on the ground floor of the hospital, and that these scenarios were discussed as part of the public engagement exercise, which included:

1. Clinic based services (tests, treatment and therapy) for planned care appointments.

2. Community inpatient beds and the alternatives when care in people's own homes was not possible.

3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.

The BOB ICB Place Director explained to the Committee that the NHS understood and appreciated that the community in Wantage wanted clarity on the future of the hospital's services since the closure of the inpatient beds, and that they wished to see a resolution. It was also highlighted to the Committee that immense time, effort and resource was invested into the public engagement exercise in Wantage, and that the exercise was well worthwhile.

The Committee emphasised that it was imperative for there to be clarity on what the final offer would be in terms of what specific services would be delivered on the ground floor of the hospital. It was also stated that the offer should be made as imminently as possible, and that such an offer had to be sustainable and long-term in nature.

The Committee **AGREED** to the following recommendations made by the HOSC Substantial Change Working Group:

1. Defer the decision as to whether the closure of beds at Wantage Community Hospital constitutes a Substantial Change.

2. Defer the decision on whether to refer to the Secretary of State for Health and Social Care the matter of the closure of beds at Wantage Community Hospital.

3. Agree an Extra HOSC meeting to be scheduled in mid-January, to make a final determination as to whether to make a referral to the Secretary of State is necessary in relation to the removal of beds at Wantage Community Hospital, and as to whether to declare the removal of the beds as a Substantial Change.

The Committee agreed to the aforementioned recommendations in light of the fact that the final co-produced report that would highlight the outcomes of the public engagement exercise was yet to be finalised and published. The Committee understood that the co-produced report would form the basis of its ultimate decision on whether to declare the closure of the inpatient beds at Wantage Community Hospital as a substantial Change, as well as whether to refer this matter to the Secretary of State for Health. During its extra meeting in January, the Committee would have received the final co-produced report and would then be in a position to make its final decisions on the above.

50/23 FORWARD WORK PLAN
(Agenda No. 12)

The Committee **AGREED** the proposed work programme for the upcoming meetings throughout the remainder of the 2023/24 civic year.

51/23 ACTIONS & RECOMMENDATIONS TRACKER
(Agenda No. 13)

The Committee **NOTED** the progress made against agreed actions and recommendations.

..... in the Chair

Date of signing .....

OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC): CAMHS Update Item

REPORT BY: SCRUTINY OFFICER (HEALTH), OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 23 November 2023, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report containing data and development updates from Oxfordshire Child and Adolescent Mental Health Services (CAMHS).

2. The Committee felt it crucial to receive an understanding of key developments and data trends within the Service. It found it highly crucial to receive a separate update specifically from CAMHS, as it understands the importance of CAMHS' work and its contributions to mental health for children and young people in the county.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes initiatives by the NHS and its partners to ensure that adequate measures, preparations, and services are in place to cope with potential increases in demand for children's emotional wellbeing and mental health services. When commissioning this report on the CAMHS update, some of the insights that the Committee sought to receive were as follows:

   - Whether the Covid-19 pandemic as well as the cost-of-living crisis have had an impact on children's mental health within the county, and if so, if there is a recovery from this trend.

   - The existence of any potential KPIs relating to CAMHS, and how the service is meeting set targets.

   - Information on waiting times for CAMHS services (including a rough outline of waiting periods, whether these are optimal/being reduced, and whether patients continue to receive some form of support whilst remaining on waiting lists).

   - Whether there is an increased demand for CAMHS services, and if so, how this demand is being managed.

   - The degree to which there is a single point of access.

   - Information on referrals processes and how efficient and effective these are.

- The degree to which staff receive adequate training, and if there are any training-related targets or improvements that still need to be met.

- Details of any work undertaken with schools for the purposes of addressing children and young people's mental health.

- How children and young people are having an opportunity to provide input into the designing and commissioning of services.

- How CAMHS services will complement wider work and efforts within the system to improve health and wellbeing overall.

- Whether there is an adequate level of resources and workforce within CAMHS.

SUMMARY

4. The Committee would like to express thanks to Vicky Norman (Head of Service Oxfordshire CAMHS & Eating Disorders); Katrina Anderson (Service Director, Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate); Doreen Redwood (Health Commissioning Manager, Start Well) for submitting the CAMHS report and for attending on 23 November 2023 to answer questions from the Committee. The Committee would also like to thank other officers who also attended and contributed towards this item including Stephen Chandler (Director of People, Transformation and Performance); Ansaf Azhar (Director of Public Health); Anne Coyle (Interim Director of Children's Services); and Daniel Leveson (BOB ICB Place Director, Oxfordshire).

5. A key aspect of the discussion revolved around the impacts of the cost-of-living crisis. The Committee was keen to understand the degree to which this crisis had resulted in a decline in the mental health of children and young people, and whether CAMHS was playing any role in helping to support children and families whose mental health had significantly declined as a result of the crisis. It was explained to the Committee that it was difficult to always identify cause and effect patterns, and therefore it was not straightforward to suggest that the cost-of-living crisis had resulted in a significant decline in children's mental health. However, what could be said was that there had been a significant rise in the rate of referrals to CAMHS Services, as well as in the acuity of those children who are presenting.

6. The Committee emphasised that the service should keep a close eye on the impacts of the covid-19 pandemic as well as the cost-of-living crisis on children's mental health and wellbeing. The BOB ICB Place Director added that during the work undertaken as part of the Health and Wellbeing Strategy, the themes of the cost-of-living crisis as well as the covid-19 pandemic resonated in all these contexts.

7. The Executive Director of Healthwatch Oxfordshire also explained that as part of Healthwatch's work undertaken for the public engagement around the Health and Wellbeing Strategy, the cost-of-living was a significant theme. Healthwatch reported that the crisis had generated further stresses on working families, which resulted in an increase in parental stress which would have a knock-on effect on Children's emotional wellbeing and mental health.

8. Moreover, the Committee emphasised that there were indeed national challenges around workforce, and queried the steps that had been taken to secure adequate recruitment of staff. It was outlined to the Committee that recruitment fairs were held in Belfast, Dublin, and Glasgow; with two nurses from Glasgow expressing a keen interest in relocating. It was also explained that the service was being more creative in how it looked for employees and created job roles, and was looking to become as needs-led as possible.

9. Additionally, the importance of staff retention was also raised by and discussed with the Committee. it was explained that the service was not performing too badly in this regard, and that there were staff that remained in their post for multiple years. There were also simple steps taken to support staff in terms of providing very clear job plans to avoid staff becoming overwhelmed, and for staff to comprehend what the Service's expectations were from individual staff members. The BOB ICB Place Director added that as the system further developed, including with the development of the BOB mental health collaborative, one of the increased benefits of such growing partnership working would include single recruitments and job shares.

10. Furthermore, the topic of CAMHS waiting lists was also discussed with the Committee. The Committee was informed that every effort was made to reduce waiting lists. It was also agreed that patients should continue to receive support whilst on waiting lists.

11. Related to the above, another theme of discussion revolved around whether parents who paid privately for an assessment would gain priority on the list, and whether there were any plans in place to reduce waiting times and prevent inequalities. The Committee emphasised and was also assured that this would not be the case, and that patients receiving private treatment would not gain any priority at all.

12. Moreover, staff training was a key point of discussion during the meeting, and the Committee raised that all Mental Health Workers should receive adequate training on how to interact not only with patients, but also with their wider families. It was agreed that it was crucial for family members to understand as well as to feel involved in the services that children and young people were receiving from CAMHS.

13. The Committee also raised crucial points relating to discharging. It was queried as to whether there had been an increasing resort to swifter discharging, and urged that if this was the case, that the imperative for swifter hospital flow was carefully balanced with the actual needs of patients already in hospital. The Committee were informed that patients received effective

aftercare upon being discharged from hospital. However, it was raised by the Committee that close coordination with other partners/services within the system was pivotal so as to enable discharged patients to receive adequate support in the long run upon leaving hospital.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are some key points of observation that the Committee has in relation to CAMHS services. These key points of observation relate to some of the themes of discussion during the meeting on 23 November, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Discharges and effective aftercare: The Committee understands that swifter discharging may constitute a positive step for two reasons. Firstly, swifter discharging may be ideal for the purposes of helping to ensure swifter and more efficient hospital flow. Avoiding lengthy and inefficient discharging would allow for patients that desperately require admittance to be given the opportunity to receive hospital treatment. Secondly, some patients may genuinely prefer to not remain in hospital for prolonged periods, and may prefer to receive support and treatment at home where possible. However, despite the appropriateness and importance of swifter discharging in certain contexts, it is vital that discharges are undertaken in a manner that ensures that patients have the necessary support upon leaving hospital, with a view to avoiding future cycles of the worsening of their conditions and readmission. Often, patients would continue to require support even upon leaving hospital, particularly in the weeks and (potentially) months subsequent to discharge depending on the severity of their ill mental health. Therefore, clear processes must be in place, and there is a key point about having clear infrastructures of support for patients who are discharged. This would require close coordination and communication with the families of discharged patients, so as to provide them with the tools of support also.

The Committee understands that poor emotional wellbeing or mental health can, in some instances, take prolonged periods to recover from. It is important that this is recognised, and as such, that decisions over discharging and aftercare are based on this logic and understanding.

Recommendation 1: *For patients to receive effective and good quality aftercare upon being discharged from hospital; and for there to be close coordination with families as well as with other partners/services within the system for ensuring discharged patients receive adequate and sustainable support upon leaving hospital. It is also recommended that discharged patients and their families receive clear signposting to appropriate help.*

Waiting Lists: The Committee understands that being on a waiting list is an inevitable part of the process of receiving CAMHS support. However, there is a crucial point about waiting lists not needing to be unnecessarily lengthy, particularly for vulnerable children or even children from disadvantaged backgrounds. Whilst poor mental health can manifest in any child from any background or social status, careful consideration should be given to the wider context of a child's position. Certain children (including those with SEND as well as others) can be more susceptible to not only developing ill mental health in the very first instance, but could also be more prone to experiencing rapid deterioration in their mental health, particularly if support is not provided early to them.

Furthermore, it is also the case that whilst remaining on waiting lists, children and their families should be regularly communicated with. Having regular and adequate communication with those on waiting lists can help in two ways:

1. It can help provide clarity to children and families that their symptoms and experiences are being taken seriously, and as such can constitute a good form of reassurance; which can also help reduce the tendency for further mental health deterioration.

2. Having regular communication with those on waiting lists can help the service to understand what ongoing or new mental health challenges have been experienced by children whilst being on the waiting list.

It is equally vital that those on waiting lists should receive support so as to avert the worsening of their condition. This should particularly be the case for those with SEND or those from vulnerable population groups. Hence, the Committee urges that the use of Early intervention should also extend to those on waiting lists.

Recommendation 2: *To ensure that children and their families who are on waiting lists for treatment receive appropriate communication as well as support so as to avert the prospects of their mental health declining further.*

Staff Training: It is imperative that staff receive the training that is appropriate to their role, be this training that is clinical or non-clinical in nature. The Committee feels that training is important not only for the purposes of being able to interact with and treat individual patients, but that it must also revolve around how to interact with as well as support the families or carers of Children. The families of patients can be heavily impacted by the poor mental health experiences of their child, and this could even result in poor emotional wellbeing and mental health on the part of an affected child's relatives. Additionally, the Committee feels that it is also pivotal that staff are trained in a manner that would enable them to help equip families with the appropriate tools

and skills to also be able to support the emotional wellbeing and mental health of their child. Whilst the Committee recognises that children may require specialist support from trained professionals, it is also felt that families can constitute a good support network for affected children in a manner that could supplement the professional support that such children might receive from professionals. Such an approach may also further empower families and/or carers to "cope" with the mental health challenges of a child under their care.

Moreover, parenting training encouraging peer group support is used effectively by the local authority for parents of formerly looked after children to support families. Such an approach may potentially be helpful in empowering all families living with mental health challenges.

Furthermore, it is imperative that any such training that staff receive is as co-produced as possible. This is important for three reasons:

1. Families may develop further confidence in CAMHS services and would feel that their views and experiences are also being taken seriously and into account.

2. The designing, commissioning, and delivery of CAMHS services would significantly benefit from receiving insights from those children and families who have experienced mental health challenges first hand.

3. Staff may be more likely to (as well as be equipped to) further take the interests and personal experiences of patients and their families into account when providing support to a child. This may also help to increase staff empathy toward patients and close relatives.

Therefore, the Committee calls for a timely review of existing training programmes, and for children as well as family stakeholders to be consulted in the spirit of ensuring that staff training is as co-produced as possible.

Recommendation 3: *For staff to receive adequate training that involves not merely guidance on how to interact with and treat individual patients, but that also involves guidance on how to support the families/carers of children. It is recommended that a review of existing training programmes is conducted with children and family stakeholders, with a view to all training being co-produced to support staff working with children and families.*

Improving CAMHS Communication Campaigns: The Committee recognises the existing communications work undertaken by CAMHS as well as other relevant NHS and system partners to improve awareness and understanding of Children's mental health and emotional wellbeing. However, the Committee feels that there may be a point about further expanding and enhancing CAMHS communication campaigns so as to reach residents Oxfordshire-wide. It is also crucial

that system partners work collaboratively to help improve residents' understanding of the services that are available. It can often be the case that some residents and families do not have sufficient knowledge and understanding of what constitutes mental ill health, or how the signs of mental health or emotional decline may exhibit in a child. Therefore, a CAMHS communications campaign to help improve awareness and understanding of children's mental health would be highly valuable for the County. Additionally, there is a point about residents being able to understand the CAMHS related services that may be available (or Early Intervention services more broadly), as well as which specific services a child may be eligible for. The Committee also urges the CAMHS service to consider adopting a communications campaign that would also keep children and families on waiting lists regularly informed of how they can take measures to support their own emotional wellbeing and mental health whilst awaiting further professional help and intervention. It is also crucial, however, that residents are also aware of how the CAMHS service relates to any other early intervention services that may exist in the system.

Recommendation 4: *To work on improving communications campaigns to create a better understanding of the CAMHS service and how it also relates to any other early intervention services.*

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Members Present during the meeting who **AGREED** to the aforementioned recommendations:

Councillor Jane Hanna
Councillor Elizabeth Poskitt
Councillor Nigel Champken-Woods
Councillor Jenny Hannaby
Councillor Nigel Simpson
Councillor Mark Lygo
Councillor Michael O'Connor
Councillor Freddie van Mierlo
District Councillor Paul Barrow
City Councillor Sandy Douglas
District Councillor Katharine Keats-Rohan
Councillor Lesley McLean
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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January 2024

Health and Wellbeing Strategy Feedback

Report of the Oxfordshire Joint Health Overview and Scrutiny Committee

INTRODUCTION AND OVERVIEW

The Joint Health and Overview Scrutiny Committee considered a report by the Director of Public Health on Updating the Health and Wellbeing Strategy for Oxfordshire during its meeting on 21 September 2023.

The Committee would like to express that it recognises the immense work being invested into developing and updating the Health and Wellbeing Strategy, and thanks system partners for their overall contributions to this work.

The Committee understands that the existing document they are providing feedback on does not constitute the official and finished strategy document per se, but that it is a draft version yet to be ratified by the Health and Wellbeing Board.

HOSC's scrutiny of the Health and Wellbeing Strategy is guided by and focused on some of the following areas:

- The extent to which public consultation is at the heart of the work on updating the strategy.
- Whether there is any new information on relevant public health patterns that would be used to inform any changes to the strategy.
- How effective partnership working has been around coordinating and implementing the Health and Wellbeing Strategy thus far.
- How the strategy particularly aims to target and support health and wellbeing amongst marginalised or deprived communities.
- The extent to which there is synergy between the Health and Wellbeing Strategy and the Integrated Care Strategy.
- Details of any criteria that may be adopted to assess the effectiveness of the strategy's design or delivery.
- How the strategy will continue to work on promoting healthy living habits overall, and its interaction with other County-wide Public Health initiatives, including the work on promoting healthy weight.

KEY POINTS OF OBSERVATION ON THE DRAFT STRATEGY DOCUMENT:

This section highlights some key observations and points that the Committee has in relation to the draft Health and Wellbeing Strategy document. Much of these observation points are centred around ensuring clear coordination between system partners around the strategy, as well as ensuring effective transparency, delivery, and input from disadvantaged communities. Some of these key points of observation were also touched upon during the formal HOSC meeting item on the strategy's update on 21 September 2023.

Health and Wellbeing Strategy Principles:

The Committee firmly believes in the imperative of strong underlying principles that will guide the strategy moving forward. Having a clear set of principles is an important ingredient of having a clear sense of direction for the strategy. Ultimately, it is the principles that the strategy is built around which will also ensure how we can measure its effectiveness overall. Below are some key observation points on the strategy's three principles of Health Inequalities, Prevention, and Closer Collaboration.

> ***Health Inequalities:*** The Committee is highly supportive of the principle of tackling health inequalities. Health inequalities remain rampant within Oxfordshire, and only through collective system-wide initiatives and efforts will the prospects of reducing health inequalities be consummated. The Committee agrees that it is, as the draft document states, everybody's responsibility to reduce unfair and avoidable health differences amongst residents. However, there is also a point about ensuring effective responsibility and accountability for this. All system partners should take ownership of certain responsibilities and activities that they can undertake in their own relevant capacities to work toward tackling health inequalities. The County Council also has a key part to play here, in part through ensuring effective economic allocation and management of funds so as to ensure inequalities are reduced. The Committee is also pleased to see the strategy's emphasis on good access to healthcare as being a strong foundation for tackling inequalities and reducing isolation and loneliness, and urges for greater coordination amongst partners within the system and for each relevant commissioners or providers to reduce barriers to access and to ease the means through which residents are able to receive support/treatment/care.
>
> The Committee notes that the ICB strategic plan included, for Oxfordshire at place, a focus on the Core20PLUS5 aimed at reducing health inequalities (for adults) which are maternity, severe mental illness, chronic respiratory disease, early cancer and hypertension. The Core20PLUS5 is about broadening inclusion of groups who experience social exclusion beyond the list of protected characteristics. With regards to children for instance, this includes children with learning disabilities, children with multi-morbidities, specific inclusion of young carers, looked after children/care leavers and those in contact with the justice system. Five clinical areas are

identified for acceleration; asthma, diabetes, epilepsy, oral health, and mental health. We welcome the draft Health and Wellbeing Strategy's overall commitment to a system wide approach to increasing access to health services and to reducing years of life lost and increasing the quality of years. We would welcome the monitoring of Oxfordshire's trends of years of lives lost, including deaths from a broader range of conditions and populations at risk. It remains unclear, however, about the synergies of the draft strategy with the Core20PLUS5 and the ICB strategy at place, and which inclusive public engagements are planned to progress this as part of detailed planning.

This also requires collective efforts by the system to increase transparency and awareness amongst residents around what services are available to them and how they can go about accessing these. Furthermore, the Committee recognises that the strategy refers to residents at greatest risk of health inequalities as well as to the challenges around those residing in rural areas. However, the strategy could benefit from some further insights into who these groups are and what can be done to support such groups.

The Committee welcomes the recognition of rural inequalities and how this contributes to isolation and loneliness. The recognition of some of these rural communities experiencing huge development is also welcomed. Indeed, the Chief Medical Officer's 2023 Annual Report emphasises the existence of inequalities in Rural Areas. However, the draft strategy document makes no mention of rural communities experiencing the impact of a serious strain on infrastructure and services. Whilst there is a commitment to working with partners on planning to include particular public health interventions, the Committee would like to see this extended to ensure that localities experiencing these dramatic increases in population are included. The strategy actions list the most deprived communities and pilot areas, but it would be helpful to understand how growing rural inequalities will be included and how prioritisation can be given by partners to spending funds held for these communities experiencing the highest growth to avoid untimely delays in provision which would support health and wellbeing (Vale of the White Horse is identified).

Prevention: Prevention is an indispensable principle for any health and wellbeing strategy. The strategy should (as it does), by its very nature, contain a prevention agenda that is about having a more holistic understanding and approach to health and wellbeing as opposed to a purely medical or reactive model to health. The Committee supports the key principle of Prevention and feels that there are deaths which are avoidable through having effective prevention measures in place. The Committee is pleased to see that the strategy outlines the three different forms of prevention as being Primary, Secondary, and Tertiary in nature, and urges for clear and further specificities within any future delivery plan for the strategy around how these forms of Prevention will be implemented and effectively monitored.

Closer Collaboration: The Committee endorses the principle of closer collaboration. Given that this is a system strategy, collaboration should inexorably remain at the heart of how services and support for residents is delivered. Indeed, without closer collaboration, the first two principles around tackling health inequalities and ensuring effective prevention cannot feasibly be achieved. It is good to see how the strategy reflects on the lessons learnt from the Covid-19 pandemic and how communities and organisations can come together to collectively achieve positive outcomes; and any additional lessons learnt from other scenarios would be useful so as to inform a stronger understanding of how to best work well together through reflecting on what works well and how to make potential improvements in this area of collaborative working. It is also good to see the plans for digital as an enabler for sharing of data across health and care as an example, and to see across each part of the strategy how barriers and enablers to collaboration are clearly recognised.

Healthwatch have also made significant contributions in producing models for community-based research, and it is good to see this contribution reflected in the strategy document as the work with Healthwatch is another key aspect of collaborative working which could potentially even be expanded. Whilst endorsing the principle of collaborative working, the Committee also urges for there to be effective monitoring of not only the activities and outcomes being achieved by the strategy, but also of the degree to which there is closer collaborative working per se. It is therefore recommended that a future delivery plan for the strategy also includes a mechanism for monitoring the degree to which collaborative working is proving effective and timely in addressing any potential challenges within the system as and when they arise.

The Committee notes the overall commitment to recognising different local communities, to a dialogue of equals, and to the importance of engagement. There are a number of immediate actions under each life course stage and action on enablers identified already. However, there are no identified actions under each life stage and under enablers regarding the development of the plan for engagement with different communities and how this will be progressed in a timely way to influence the action/delivery plan.

Life Course Stages:

The Committee endorses the life course approach outlined within the document and adopted by the strategy. This is an important aspect of a strategy that aims to support health and wellbeing of residents overall. This is part and parcel of having a greater understanding of the kind of support residents might require at various stages of their lives. People's needs will indeed change throughout their lives, and the Committee supports the clearly structured outline and categorisation of three different life stages.

The Committee is concerned however, that End of Life is omitted as a life stage, particularly since the experience of the pandemic. Experiences of end of life have

become more complex through the pandemic and the cost-of-living crisis; whether families are expecting death or experience a sudden unexpected death. The Committee would welcome inclusion of end of life in the draft strategy and anchor institutions who are supporting families across Oxfordshire with rising demand and complexity.

Below are some observation points for the other three life stages:

Start Well: It is positive to see that there is a recognition of the need to support residents in the earliest stages of their lives. The Committee feels that the first five years of Children's lives can often receive less attention that they should be. Whilst there is a plethora of support for Children and Young People, adults, and the elderly, there should be greater focus on the needs of Children under 5, as it is through this age where if Children receive the right form of attention and support, they are more likely to live healthier and fulfilling lives, in both a mental and physical sense. Through adopting a prevention and proactive-like approach toward children under 5, it is less likely that such children may have to attend Emergency Departments in Hospital or be admitted as inpatients. This therefore creates less pressure on the system in the long run. The Committee also recognises and supports the adoption of the UNICEF approach as a manifestation of an ambition to learn from and adopt lessons and standards driven globally. In terms of offering more leisurely and wellbeing classes during pregnancy and early years, this is certainly a positive step and the Committee urges that the strategy formulates clear mechanisms of how this will work; including how to possibly work with community-based organisations to facilitate this.

The Committee welcomes the recognition of care givers. A check-in with women after birth is the leading recommendation from MBRRACE (2024), and would not only help tackle rising maternal post-natal mortality but would be protective of the wellbeing of children and protective of disease in women in later life.

Furthermore, Transitions between children and adult services is identified nationally as a risky time for people experiencing inequalities. It would be helpful to see how transition issues will be taken forward.

The Committee fully supports the need for early intervention. HOSC scrutiny of children's mental health services in 2022 highlighted the importance of identification and intervention for high-risk children. The Committee would welcome explicit recognition in the strategy of higher risk children taking account of SEND and the Core20PLUS5. Local communities may already have some early interventions in place and a mapping of these would be useful ahead of introducing much needed additional support so that the strategy works well with communities.

Furthermore, regarding the immediate actions, how will children (at risk) who struggle more to join activities and platforms be enabled; and how will commissioning be developed to ensure that young people, including young people at risk, are at the heart of procurement.

Live Well: The Committee supports all initiatives to help residents live healthy and fulfilling lives, and recognises the attention placed on this by the strategy. It is indeed the case that excessive exposure to tabaco, unhealthy weight, and alcohol can negatively impact people's health, and that these exposures can often occur simultaneously. Therefore, the strategy should adopt an approach that is as holistic as possible in tackling all three of these harmful exposures, particularly when they present in amalgam. It is good to see that the strategy acknowledges that deprived communities are more susceptible to the above as well as to unhealthy eating, and the Committee urges that clear plans are in place to both support such communities in this context, as well as to effectively monitor how these overall objectives and initiatives will actually translate into real improvements on the ground. There is also a crucial point about effective collaborative work around these areas also, as residents would need to benefit from having a network of support for these challenges. Relevant partners within the system should do all within their capabilities to work together to create a healthy living environment on a macro-level, as well as to provide micro-level support to those who need it. Mental health support is also a crucial ingredient of a prevention and environmental approach towards living well, particularly for vulnerable/deprived communities and those with excessive exposure to tabaco, alcohol, or unhealthy weight. The Committee recommends support measures and hopes these are adopted given the commitment in the draft strategy to help. HOSC has also scrutinised smoking and would welcome a sentence explicitly recognising the important of continuing work with other stakeholders to give balanced messaging discouraging children from taking up smoking and vaping.

Involving employers and organisations is crucial. Given that workforce is the primary enabler of the strategy, is monitoring of the activity levels of the workforce welcomed by the workforce? Will enabling schemes such as cycle to work be encouraged with all employers, large and small? Will the strategy be developed with a view to maximum inclusivity to support employers to recruit and retain from the largest pool?

Age Well: The strategy positively includes recognition of the need for residents to age well, and not just to live well. Ageing well is something that all residents deserve, and should be at the heart of how the strategy is designed and implemented. The Committee is aware, through its members' interaction with elderly constituents, that not only do long-term conditions tend to affect residents with age, but that such residents could become anxious regarding the support that they feel they would require to live a comfortable and fulfilling old age. It is pivotal to ensure that the commissioning and provision of care services for the elderly involves effective and routine monitoring of these services so as to ensure that elderly residents eligible for care do not suffer from inadequate care or neglect. It is also the case that elderly residents may find it complex to access information online, which could also complicate their awareness of, as well as their receipt of health or care support that they may be eligible for. The Committee urges that the Health and Wellbeing Board works to increase awareness of as well as access to services amongst the elderly; particularly for those who may not be technologically literate or who

may not have the capacity to access the internet. Furthermore, given that social isolation tends to affect elderly residents, the Committee endorses the strategy's aim to keep elderly residents more socially connected. This would require collective efforts from many partners within the system, and would prove highly beneficial for the overall mental health and wellbeing of the elderly.

The Committee welcomes the recognition of the vulnerabilities of those living in rural areas and those with long-term conditions who experience loneliness. When struggling, a whole range of community agencies and elected councillors may be looked to for help. The Committee notes the inclusion of local faith organisations and GPs as providing institutional help but would like to see this widened to include a community-mapping of organisations providing help so that the details of the strategy's plan work well for communities.

The Committee welcomes local coordinators, but would like to know how these will match up with local NHS neighbourhoods? The Committee is also very interested in new models of care and what the planned public engagement will be around these. Additionally, the inclusion of climate change is critical, as well as recognition of where this has synergy with local communities who are concerned about avoiding long journeys to access services necessary for their health and wellbeing.

Building Blocks of Health:

The Committee agrees with the strategy's emphasis and identification of building blocks of health. Through identifying building blocks of health and wellbeing, the system can take measures to collectively address some of the challenges around these building blocks. Building sustainably healthy communities is crucial for ensuring that residents have an ability to live relatively comfortably, and to enable them to adopt healthy living habits that will be conducive to a healthy lifestyle. If residents are concerned about basic needs such as housing, employment, or cost-of-living, then they risk becoming stuck in a never-ending cycle of living a life under pressure and not having the time, resources, or the mental capacity to engage in healthy eating or adequate physical activity/exercise. The Committee endorses the strategy's commitment to action along the areas of the built environment and community activation, but calls for greater clarity on the system's commitments around New Models of Care.

Below are some further specific observation points in relation to the strategy's emphasis on the building blocks of health. Some of these themes were addressed during the most recent scrutiny item that the Committee held during its meeting on 21 September 2023.

Healthier Homes: The Committee appreciates that the strategy lays emphasis on housing as being a significant element of the building blocks of health. It is not merely individuals experiencing homelessness/rough sleeping that can suffer from threats to their overall health and wellbeing, but also those residents that may reside in overcrowded or unsuitable

accommodation. It is important that system partners collectively and collaboratively work to both understand the impacts of housing in health, as well as to formulate ways to actually improve residents' living conditions. Energy efficient homes are also crucial for two reasons. Firstly, this can reduce the added financial burdens of high energy costs, which have been compounded by the fuel crisis. Secondly, an energy efficient home will be conducive to residents' overall physical and mental wellbeing through being able to light up their homes as well as make use of their heating systems so as to live comfortably through the winter. This would also reduce susceptibility to illnesses also. In the immediate actions around this, the strategy will benefit from expressing commitments not only around raising awareness of support available for residents for improving energy efficiency or even for disability facilities in their homes, but also around making the process for seeking support being made easier.

Financial Wellbeing and Healthy Jobs: The Committee recognises that the strategy refers to the challenges around the cost of living. The cost of living can have a negative effect on the overall health and wellbeing of residents. It is positive to see that the strategy appreciates and acknowledges the detrimental impact of the cost-of-living as well as long-term deprivation on residents' mental and physical health. The Committee therefore calls on the system to work closely together in developing a firm understanding of how financial or employment pressures are impacting on the health and wellbeing of residents. With regards to the immediate actions around this area, it will be useful for the strategy to outline greater clarity on the kind of emergency support that residents should expect to receive during the cost-of-living crisis.

Vibrant Communities: The Committee firmly believes in the centrality of communities as well as their vibrancy toward healthy living; and in doing so is supportive of the strategy's emphasis on supporting vibrant communities. Essentially, given the importance of empowering vibrant communities, the strategy would benefit from expanding on how communities would be further empowered and the kind of support they might expect to receive.

Enablers:

The Committee feels that it is a positive step to see the strategy's factoring in of enablers. The identification of enablers helps to formulate a framework that would allow the system to determine its own capacity levels as well as the resource that is required to deliver the strategy. Perhaps one factor that should encompass most of the enablers outlined in the strategy document would be a 'culture change'. If there is a culture change around how the system perceived and contemplates health and wellbeing holistically, then this would support the other enabling factors as well as the overall perception and attitude toward supporting residents' health.

***Anchor institutions*:** The Committee strongly welcomes the emphasis on anchor institutions. It will be useful to know if a draft list of relevant anchor institutions exists. Given the importance of building local community

resilience and recognising the differences across different local communities, what will the role of elected local members be, who know their communities as well as Town and parish councillors? Additionally, perhaps there could also be reference to Democratic forms of scrutiny, including considerations as to whether HOSC could be included as an Anchor institution. It will be useful to understand if there is a list of the voluntary sector organisations that are included in Oxfordshire's anchor institutions for health and wellbeing, as well as how they have been selected.

Workforce: The Committee feels that it is positive to see that the strategy recognises that staff are the system's greatest strength, and welcomes the commitment to local recruitment and to reductions in the use of agency staff. The Committee also recognises that recent challenges around workforce recruitment and retention are not unique to Oxfordshire but are being experienced nationwide in relation to health and care services. Given that these workforce challenges are overarching in nature in that they could affect a multitude of services which can involve those contributing to what the strategy refers to the building blocks of health, it is crucial that these workforce challenges are adequately taken into account in the efforts to deliver the strategy. Only through having sufficient resource will the strategy's aims and objectives be deliverable. It is also crucial that system partners work on promoting a culture and infrastructure for supporting the wellbeing of staff. Additionally, there is a need for further encouragement for people to pursue careers in health and wellbeing. Whilst the strategy outlines a commitment in renewing interests in these careers, this would require specific efforts by various system partners to encourage careers in their own respective areas.

The Committee also welcomes recognition of the importance of SMEs. It is important that the procurement weighting is changed but also that good practice exemplars for health and wellbeing are identified early that evidence co-production, with a view to an overall ambition of increasing years of life lost and improving the quality of years at the centre of services and pathways.

In addition, the Committee welcomes the earlier commitment in the draft to voluntary sector leadership in Oxfordshire; and would like to see explicit recognition of voluntary sector workforce contributions in Oxfordshire working on health and wellbeing and how this will be enabled by the strategy.

Data and Digital: The Committee believes in the importance of the need to effectively acquire data, and to then utilise this data for the purposes of analysing information and patterns and drawing conclusions. Only through doing this can improvements to health and wellbeing be achieved at a time when demand for services has increased. The Committee welcomes the strategy's commitment to utilise quantitative and qualitative data on people's health needs, their experiences in using services, and on health outcomes. It is pivotal for there to be coordinated and effective data

sharing within the system so as to ensure that knowledge of patients/residents is readily available for relevant services/bodies to be able to provide support to residents in a coordinated manner and to avoid patients having to repeat their story multiple times. Furthermore, given the recent failings highlighted by the most recent CQC/Ofsted report on Childrens' SEND provision, it is now far more crucial that technology is harnessed to share and pool data and information around Children with SEND who may be more susceptible to developing mental or even physical health challenges. It will therefore be crucial for any future delivery plan of the strategy to outline potential timelines around how to maximise the use of technology for the purposes of acquiring and sharing data within the system. It will also be useful to understand what public engagements will take place on the digital inclusion charter and on any wider digital strategies at place. It will be important for increasing public trust that the security issues identified by the recent IT outage at Oxfordshire Health are rectified and learnt from, and that social value and public engagement is a critical component of all artificial intelligence adopted in the future to support the strategy.

Importance of input from Disadvantaged Groups:

Being a County-wide strategy, inclusivity should be engrained in the strategy's development and in its implementation. Key partners should collectively work on making information on the availability of services as explicit as possible, particularly for disadvantaged population groups. That input from disadvantaged groups should be fed into the strategy can be promoted in three ways:

1. There should be an explicit understanding of what the concept of disadvantaged groups implies; in other words, which specific population groups are experiencing the greatest disadvantage.

2. The known concerns and experiences of disadvantaged groups should be taken into account when formulating and delivering the strategy.

3. Disadvantaged groups should have an opportunity to provide direct input into the strategy inasmuch as possible; as well as into monitoring the deliverability and effectiveness of the strategy overall.

CONCLUDING REMARKS

The Committee would like to thank relevant Cllrs and Officers for enabling the Committee to have sight of a draft version of the strategy document prior to its official publication, and intends to maintain ongoing scrutiny of the Health and Wellbeing Strategy. Moving forward, the Committee would like to be updated with, and to receive evidence of the measures taken as part of a delivery plan for the strategy, and of the effectiveness of its future deliverability.

The Committee reiterates the importance of co-production and of continuing to work closely with residents to understand their concerns, struggles and experiences. Only through continuing to do so can the strategy prove to be co-produced, transparent, effective in nature.

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November 2023

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18th December 2023

Dear Georgina and Colleagues,

RE: Patient Safety Alert NatPSA/2023/013/MHRA

The following issues are raised by Epilepsy Action and SUDEP Action in response to the recently released Patient Safety Alert **(NatPSA/2023/013/MHRA)** and the prescribing of sodium valproate.

As two leading charities representing service users, families, and carers, we would like to take this opportunity for you to consider the following risks as a provider of services.

We are aware that 27% of boys and girls are currently prescribed valproate, so the directive will be a significant change in practice for children as well as young adults. This medicine is the most effective for controlling generalised seizures, which the MHRA's public impact assessment recognises.

Context:
We have set out all known risks from the user perspective, these being our members, people with epilepsy, their families, and carers. Whilst this directive is to address newly diagnosed men and boys under 55yrs and all women and girls aged under 55 years, we know phase 2 will go onto address all boys and men under 55yrs on sodium valproate.

a) The directive states that an implementation group be formed which includes patients with experience. Given the timeframe, where is the assurance and scrutiny that 'Informed Consent 'and an ability to challenge the decision by the individual is not eroded or dismissed? This is the cornerstone of this change in practice, and one that must be preserved at all costs.

Newly diagnosed patients and patients whose seizures are not controlled will remain at risk for possible serious harm. Whilst there may not be the additional risk of switching from an effective to a less effective medication, informed consent relating to treatment selection will require patient centered communication, specific to that individual.

This is critical for a woman or man who has been effectively controlled on sodium valproate and explicit in their wishes to remain on the drug. Not being able to access a drug which in many cases is the only available option to provide full seizure control, maintain a quality of life (e.g. drive, hold down a job) or prevent SUDEP (MBRRACE 2023 Reports | MBRRACE-UK | NPEU (ox.ac.uk)) is unacceptable.

SUDEP is the leading cause of death for people with epilepsy. The NCEPOD - Epilepsy: (2022) report states that people with epilepsy attending ED are a high risk population, with only 13.5% having had SUDEP as a considered risk. This included

not using existing safety tools recommended by national surveillance bodies (maternal and learning disability deaths and NHS RightCare https://sudep.org/checklist-resources; https://sudep.org/epilepsy-self-monitor). This is further supported by additional research which indicates that active generalised seizures and nocturnal seizures increase the risk of SUDEP, and that early diagnosis and treatment is vital in prevention.

b) The implementation group must include clinicians and group members who are conversant in epilepsy and the associated implications experienced by people who have tried multiple alternatives.

It is acknowledged that the level of experience in commissioning neurology services and in the delivery of such services is nationally diverse and poorly resourced in many ICB localities. There must be confidence and enough skill to advocate for people who wish to have the 'best life', which means upholding their decision and access to treatments.

c) Given the requirement that all prescriptions must hold two signatories to proceed, and that these be independent and not associates or accountable to the first signature within the workplace, it remains unclear who they will be and what the implications will be to the patient and carer.

It seems that there is little understanding nationally on how to apply this directive, which would indicate that there will be no standard application, with each local area delegated to resolve this at pace. This will test the equity in review and case management. The evidence to date is that access to neurological services for patients is not equal or equitable across the countries and regions.

The available workforce is limited and in places severely under resourced, which has been reported on through many health economies (e.g. Northern Ireland patients waiting 4 years for neurological review).

The number of patients managed in primary care by a GP is unknown, introducing patient pathways which will burden an already stretched secondary care service.

c) As both a provider and commissioner the monitoring and risk management arrangements will be pivotal in providing assurance to patients that the systems and processes are in place to safeguard patient safety; and that the correct treatment plans are in place to ensure that patients are correctly informed, given time to discuss and are part of the structured review process (PPP and annual health check).

There is a danger that off-licence prescribing will become increasingly requested and at the extreme become the norm.

d) The CQC or National Patient Safety team should regulate this directive. They should be defining how this will be reported as a patient safety incident and not the ICB or place. Are we now moving to a 'Never Event' situation and if so, does this fall

under NHS Resolution should all steps not be implemented? Again, in the first instance patients newly diagnosed will be exempt, as they will not have been prescribed sodium valproate, but existing patients will need to be assessed and become part of this risk management / patient safety process.

e) What are the timescales for implementing the process given the expectation of the MHRA statement:

'At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes'.

How realistic is this, and how will patients be communicated with to register informed consent or decline? To provide this level of review in primary and secondary care requires a full pathway review, with clear roles and responsibilities. The available resource will impact on delivering these pathways and, significantly, have the largest impact on people most at risk of health inequalities. This risk will be delegated to local areas.

f) Who will be auditing the existing PPP measures and risk assessment compliance? Assurance that the audits are mandatory and will be accountable to the Board of the ICB for monitoring – This needs to be understood to inform our membership.

g) The pathway for the management and monitoring of sodium valproate and pregnancy has been in place for several years, however poor compliance was reported in the Cumberledge Report 2020. This is further supported by research from Epilepsy Action and SUDEP Action which demonstrated that women in a number of cases had not been fully informed of the harms related to ASM's (https://www.epilepsy.org.uk/involved/campaigns/epilepsy-medications-in-pregnancy-survey-results).

We have also seen a near 50% increase in SUDEP for women and pregnancy (MBRACCE 2023) including women not informed of SUDEP Valproate and risk of abnormal pregnancy outcomes: new communication materials - GOV.UK (www.gov.uk).

The pathway for unplanned pregnancy needs to be in place – where is the assurance that this will be managed, and that girls and women will receive the counselling and information they need?

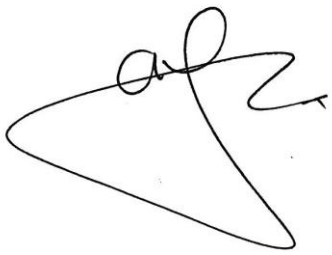
h) As ICBs are developing their digital strategies public trust will be fundamental to this. ICB reporting measures will require review. Currently they only include the digital valproate platform measured outcomes for reduction of valproate prescriptions https://digital.nhs.uk/data-and-information/publications/statistical/mi-medicines-and-pregnancy-registry/valproate-use-in-females-aged-0-to-54-in-england-april-2018-to-september-2020 . These need to be supplemented with social value outcomes to

support ICB programmes tackling health inequalities in children NHS England » Core20PLUS5 infographic – Children and young people and programmes to make improvements for people with learning disability and autism.

We believe that a national communication to all NHS trust medical directors last week recognises that standards of care are likely to fall because of pressures in the NHS. Given this information and the lack of available resource we do not believe it is possible to implement this directive safely without deferring the deadline of January 31st, 2024. This also will impact on setting realistic timescales to implement not only phase one, but phase 2 of the policy.

Thank you for taking the time to consider our concerns in support of all patients, their carers and family. Should you wish to discuss further please do not hesitate to contact us.

Kind regards,



Alison Fuller
Director Health Improvement and Influencing
Epilepsy Action

Jane Hanna OBE
Director of Policy and Influencing
SUDEP Action

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

16 JANUARY 2023

Consideration of whether the closures of the inpatient beds at Wantage Community Hospital constitute a Substantial Change, and whether this matter should be referred to the Secretary of State for Health and Social Care.

Report by Health Scrutiny Officer, Dr Omid Nouri

RECOMMENDATIONS

The Committee is **RECOMMENDED** to:

1. Based on the feedback of the HOSC Substantial Change Working Group (to follow verbally at the meeting on 16 January), to Agree whether to declare the closure of beds at Wantage Community Hospital as a Substantial Change, and,

2. Agree whether to refer to the Secretary of State for Health and Social Care the matter of the closure of beds at Wantage Community Hospital.

CONTEXT:

1. The Inpatient services at Wantage Community Hospital were temporarily closed in July 2016, and they have reopened since. The Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) has been involved with scrutiny of the inpatient bed closures ever since, and members have been attempting to find a resolution with the NHS. A more long-term history of the events surrounding the closure of inpatient services including the inpatient beds at Wantage Community Hospital has been included in the agenda papers for the Committee's 30 June 2023 meeting. Annex 1 - Wantage Community Hospital Timeline.pdf (oxfordshire.gov.uk)

2. This references a previous process called the OX12 project which involved working with the community between 2018 and 2020 and a HOSC working group. The final report recommended the likely permanent closure of the beds but had not included any explicit outcome on planned alternative provision. The timeline also references the refurbishment and bringing back of maternity services with live births during 2022 by Oxford University Hospitals NHS Foundation Trust following HOSC scrutiny and funding contributed by the Wantage Hospital League of Friends as well as a number of temporary pilot hospital services that were introduced by Oxfordshire Health.

3. During 2023 HOSC was updated again by Oxfordshire Health about the future of Wantage Community Hospital, having completed a substantial change toolkit. The working group met with members of Oxfordshire Health, the Integrated Care

Board (ICB) and the County Council with a resulting recommendation agreed by HOSC on 11 May 2023 that any decision whether to refer to the Secretary of State be deferred until a stakeholder event was convened to provide an opportunity to confirm an agreed process and timeline for co-production of a resolution.

4. On 30 June 2023, the Committee convened an extraordinary meeting to discuss the co-production stakeholder event which took place on 28 June as well as the decision on whether to refer this matter to the Secretary of State. The committee considered whether the co-production stakeholder event had on balance demonstrated an improvement for the previously worked with community. The feedback from stakeholders attending had been that it had, and they wished to continue to work with the NHS to find a way forward to secure the future of hospital-like services at the hospital and local area. Oxfordshire Health, the ICB, Oxfordshire County Council, and the Wantage Town Council Health Committee representatives agreed to continue with the process of co-production.

5. It was proposed and agreed by the Committee that:

    1. The ICB and Oxford Health continue to co-produce with Wantage Town Council Health Committee and its invitees, and following receipt of the draft report from the independent facilitator, agree next steps, to include:

- progressing unfinished co-production work from the workshop on action-planning
- to agree how best to involve the wider-circle of invitees as discussed at the meeting
- plans for co-production to meet a final timeline of presenting to HOSC in November 2023.

    2. That the ICB and Oxford Health give assurance that there is sufficient capacity to deliver its engagement exercise to time.

    3. That the ICB and Oxford Health meet with representatives of Vale of the White Horse District Council to improve understanding of how CIL money allocated to health can be accessed in a timely way, and that this knowledge is jointly communicated by the NHS and the Vale of the White Horse District Council to the Wantage Town Council Health Committee.

    4. That representatives of the ICB, Oxford Health and Oxfordshire County Council meet with members of the Oxfordshire Joint Health Overview and Scrutiny Committee Working Group on Substantial Change on a monthly basis, which would be virtual, to discuss progress on co-production against agreed timelines.

6. Following the establishment of the HOSC Substantial Change Working Group in February, the Working Group members have held five meetings, and have made recommendations to HOSC and given advice to help facilitate the co-production process.

7. As per the agreement stipulated during the aforementioned 30 June HOSC meeting, the Working Group has held two online check-ins with representatives of the ICB and Oxford Health on **30 August and on 24 October** regarding the engagement with the local stakeholder reference group and the planned wider public engagement. As part of these check-ins, the Working Group requested and discussed information around the following areas:

   - Details of and timelines for the initially planned public engagements/stakeholder events.

   - The potential options available for retaining treatment options in light of the inpatient closure at the hospital, and the opportunities and constraints around these options.

   - Details around the NHS's commitment to commission a private public research organisation to undertake surveys and feedback into the process and any future decisions made, and to check that the public engagement would be co-produced.

   - Details around the appraisal principles that would be taken into account when developing alternative treatment options for patients (including travel, access, workforce, funding, quality of care, estates available etc).

   - Details of the Survey that was being launched to receive feedback from residents (including the nature of the survey, the type of questions that would be asked, whether the feedback/responses would be received in a qualitative or quantitative format, and how this feedback would be operationalised/measured).

   - Outcomes of all the stakeholder events that had taken place, and details of any feedback received from these sessions.

   - Details of which potential alternative treatment options had not been adopted due to them not being considered feasible.

   - Details of any of the alternative treatment options which may have dependencies on other factors which need to be taken into account.

KEY POINTS OF CONSIDERATION

Below are some key points of consideration that the Committee should take into account when making a final decision on this matter.

Nature of Public Engagement exercise:

8. The HOSC Substantial Change Working Group recognises that immense effort has been invested by Oxford Health as well as the ICB for the purposes of engaging with the public and the immense effort of the stakeholder reference group; especially a small working 'sub-group' established out of this reference

group which was agreed to support co-production and working towards a resolution.

9. The stakeholder reference group established as part of the Public Engagement Exercise has included the following:

   - Wantage Town Council
   - Grove Parish Council
   - Vale of White Horse District Council
   - Wantage Hospital League of friends
   - Wantage Patient Participation Groups
   - OX12 Project representatives
   - GrOW Families
   - SUDEP Action
   - Wantage Rural and OX12 Village
   - Sanctuary Care
   - Oxfordshire County Council
   - BOB Integrated Care System & Board (ICS & ICB)
   - Oxford Health NHS Foundation Trust
   - Oxford University Hospitals NHS Foundation Trust
   - Wantage Primary Care Network (PCN)
   - Vale Community Impact
   - Community First Oxfordshire
   - Healthwatch Oxfordshire

10. Three workshops were held with community stakeholders (the stakeholder reference group) in June, July and December 2023. Weekly meetings with the smaller sub-group were held since August, which generated outcomes including an agreed evidenced statistic of the current and predicted population growth and a co-produced set of power point slides for use in public engagements. The stakeholder reference workshop event in December 2023 fed back the outcome of a wider public engagement exercise on preferred options for hospital services and detail on the sustainability of different options; including on enablers and constraints. The sub-group has worked since then to comment on the report to HOSC, and the Wantage Town Council Health Committee has organised a public meeting for the 11th January.

11. Several wider public stakeholder events have taken place, some of which took place online and others of which were held in-person. The purposes of these stakeholder events/sessions was to understand the perspectives of the public and service users on how the future services at Wantage Community Hospital should be configured.

12. An independent consultancy was utilised by the NHS since August 2023, which provided advice and led the wider engagement work with the public for the remainder of the duration of the Public Engagement Exercise. On behalf of HOSC, Cllr Jane Hanna attended several of these sessions in her capacity as Chair of the Committee. The Health Scrutiny Officer has also attended some of

these sessions for the purposes of observing the nature and effectiveness of the Public Engagement exercise. Cllr Barrow and Cllr Hannaby have on occasions also acted as observers.

Future of Wantage Community Hospital Services:

13. The co-production stakeholder work undertaken in the context of the Public Engagement Exercise should be understood as a means to an end, which is what the future services of the hospital will be given the temporary closure of the in-patient beds in 2016. A key factor which the Committee will need to take into account is the degree to which every effort has been made to ensure effective input from the co-production work and wider participants' feedback and views into how the Hospital and hospital-like services would be configured. The Working Group is again pleased to see that the co-production work did produce an outcome on the need for the NHS to respond, which resulted in the setting out of the three scenarios clearly. It should also be noted and remembered that the Maternity Unit on the first floor will remain in place, and that the engagement exercise has been around the future configuration of the services that will be delivered on the ground floor of the hospital; including considerations as to whether other estates will be utilised to supplement the service offer.

14. The current services delivered on the hospital site include the following:

- ***Ground floor*** – a variety of planned services (clinical assessment, tests, treatment, therapy, follow ups) for the local community. Various specialist outpatient clinics have been delivered as a trial for the past 18 months, alongside these services. The hospital is also utilised as a base for some local outreach community services, including school nurses and vaccination teams).

- ***First floor*** – maternity services.

15. As part of the Engagement Exercise, the Community and stakeholders were presented with three scenarios as to how future services could be delivered on the ground floor of the hospital. These include:

    1. **Clinic based services** (tests, treatment and therapy) for planned care appointments.

    2. **Community inpatient beds** and the alternatives when care in people's own homes was not possible.

    3. **Urgent care** (minor injury, illness and mental health issues) access needs on the same day.

16. The process around finding a resolution and determining the future services to be delivered at the hospital has taken place over several months. Below are a couple of reasons as to why it was important that sufficient time had been invested into this co-production exercise:

Timescale for future configuration of the Hospital: Timescales have been utilised for the purposes of delivering a wider Public Engagement Exercise. However, it has also been crucial for explicit clarity on any timescales around not only the final decisions on the future of the services to be delivered on the ground floor of the Hospital, but also around how soon such services could begin to be delivered. It is pivotal for there to be clear timescales around the Hospital's future for two reasons. Firstly, seven years have passed since the closure of the hospital's inpatient beds. Secondly, now that the Public Engagement Exercise has completed, there needs to be an indication as to when decisions might be made as to how to configure the services on the ground floor. Namely, if the hospital beds are to be permanently closed, is there an alternative provision that is acceptable to the community.

Clarity on Barriers and Enablers: The HOSC Substantial Change Working Group has been pleased to see that there are three different scenarios being presented to local residents as to which services can be provided on the ground floor of the hospital. Nonetheless, it was imperative for there to be further clarity relating to any potential barriers or enablers around which potential services (including those presented in the three scenarios) could be feasibly provided and resourced. In order for the Committee to have been in an ideal position to make an ultimate decision as to whether to declare the closure of the beds as a substantial change/whether to refer this matter to the Secretary of State, it was vital for there to be clarity on whether the degree to which any potential future hospital-like services of the hospital could actually be resourced. It was, and it remains crucial that further progress is made with the Vale of White Horse District Council and the NHS in agreeing on the amount of CIL funding available now to support this.

17. In its previous meeting on 23 November 2023, the Committee held an item to receive an update on the Public Engagement Exercise. This occurred prior to its completion. During this item, the Committee agreed to the following recommendations made by the HOSC Substantial Change Working Group:

    1. Defer the decision as to whether the closure of beds at Wantage Community Hospital constitutes a Substantial Change.

    2. Defer the decision on whether to refer to the Secretary of State for Health and Social Care the matter of the closure of beds at Wantage Community Hospital.

    3. Agree an extra HOSC meeting to be scheduled in mid-January to make a final determination as to whether to make a referral to the Secretary of State is necessary in relation to the removal of beds at Wantage Community Hospital, and as to whether declare the removal of the beds as a Substantial Change.

18. The reasoning behind the aforementioned recommendations which HOSC agreed to were as follows:

1. To allow the successful completion (and the publication of the co-produced report) of the Public Engagement Exercise conducted by the NHS around the hospital's future.

2. To receive greater clarity on the levels of resources available for, and the barriers and enablers around, the potential future services to be offered at the hospital.

NEXT STEPS:

19. In its Extra meeting on 16 January 2024, the Committee will hold an item to review the final report produced by the NHS and key stakeholders. This report will detail the nature of the Public Engagement Exercise. Key attention will be placed on the degree to which effective and adequate co-production has taken place and whether the proposal in the report would not be in the interests of the health service in its area.

20. The substantive outcomes of the Public Engagement Exercise will also be discussed, and the Committee will be required to make an ultimate decision as to whether to both declare this matter a Substantial Change and to refer this to the Secretary of State.

21. The Working Group felt that it was vital that the Committee convened this Extra meeting for the above purposes in early to mid-January at the latest, given that the current arrangements/procedures around referrals to the Secretary of State will be subject to change by the Government on 30th January 2024. It is anticipated that the nature of the changes to the process of referrals will be such that the Secretary of State may no longer be required to formally consider and intervene in matters when a referral by a Health Overview and Scrutiny Committee has been made. More information on this can be found on this link to a document produced by the Centre for Governance and Scrutiny which provides a rough indication as to what the expected changes to the referral powers will be. BLOG: DHSC confirms new health scrutiny arrangements to start in January - Centre for Governance and Scrutiny (cfgs.org.uk).

22. The Committee's Substantial Change Working Group will be meeting on Friday 12th January, where it will be making its final decision on what it will be recommending to the wider HOSC on 16th January. The reasoning behind the Working Group meeting being scheduled at a date that is close to the formal HOSC meeting on the 16th is due to the fact that it is pivotal that the Working Group and the wider HOSC take the outcomes of the Wantage Town Council Health Committee meeting into account and the public meeting planned for the 11th January, prior to making a formal decision on whether or not to; refer this matter to the secretary of state and as to whether or not to declare the closure of the in-patient beds at Wantage Community Hospital as a Substantial Change.

LEGAL IMPLICATIONS

Below are the details on the legal processes and procedures around the decisions the Committee will have to make on 16 January including on:

1. **Declaring Substantial Changes.**
2. **Referring matters to the Secretary of State.**

23. Under the 2013 Regulations providers of health services have a responsibility to consult over substantial developments or variations to the provision of health services in an area.

Regulation 23(1) states:

"where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—

(a) consult the authority;

(b) when consulting, provide the authority with—
(i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and
(ii) the date by which R requires the authority to provide any comments under paragraph (4);

(c) inform the authority of any change to the dates provided under paragraph (b); and

(d) publish those dates, including any change to those dates."

Health Overview and Scrutiny Committees (referred to as 'the authority' here) have the power to refer a matter to the Secretary of State under Regulation 23 (9) in the following circumstances:

"The authority may report to the Secretary of State in writing where—

(a) the authority is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed;

(…)

(b) the authority considers that the proposal would not be in the interests of the health service in its area."

24. Should the Committee decide to make a referral to the Secretary of State it must do so as set out in Regulation 23(11) and include the following details:

(a) an explanation of the proposal to which the report relates;

(b) in the case of a report about the adequacy of consultation, the reasons why the authority is not satisfied

(c) in the case of a report under about whether the change would be in the interests of the health service in the area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority;

(d) an explanation of any steps the authority has taken to try to reach agreement with the responsible person

(e) an explanation of the reasons for the making of the report; and

(f) any evidence in support of those reasons.

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January 2024

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Wantage Community hospital next steps and recommendations
January 2024

A report co-produced with the Wantage Community Hospital Stakeholder Reference Sub-group

Submitted on behalf of the Stakeholder group by:

Name	Organisation
Dr Ben Riley (Executive director primary community and dental care)	Oxford Health NHS Foundation Trust
Daniel Leveson (Place director Oxfordshire)	Buckinghamshire Oxfordshire & Berkshire West ICB
Cllr Jenny Hannaby (Chair)	Wantage Town Council Health Sub-Committee

See appendix E for statements of support from partner organisations

Executive summary

Since June 2023, local stakeholders from the Wantage and Grove area and NHS partners have worked collaboratively with weekly meetings and three wider workshops to co-produce a proposal for the future role of Wantage community hospital. We are committed to keeping the hospital open and developing its services to improve the health and wellbeing of local residents.

The project has reviewed local priorities, supported by activity data and public engagement to agree 'How can we use space in Wantage Community Hospital to benefit the health and wellbeing of the local community'. This report brings together the work done to date and makes recommendations on next steps.

Following confirmation by Oxford University NHS Foundation Trust that the maternity services will continue to be provided on the first floor of the hospital, it was agreed that these services need not form part of the wider public engagement work.

A key principle throughout this work has been that whatever is decided must be sustainable so that it can be maintained for the community moving forward. Two of the most important principles of sustainability are the extent to which services match the local need, and their affordability in the context of the overall NHS budget. Consideration has also been given to both the workforce (ability to recruit staff) and estates (space in buildings and capital costs of any adaptations). All of these factors have been considered in recommending the role of the hospital moving forward.

Three types of care have been considered within this project based on the co-produced priorities agreed with stakeholders:

- Inpatient beds and the alternatives
- Planned care
- Urgent care

Since the Wantage community hospital inpatient beds were temporarily closed in 2016 there have been a number of changes to the role of community hospitals. More preventative care reduces hospital admissions. More complex care can be provided at home. When people are admitted to hospital, we work to enable them to return home more quickly after their stay. This improves outcomes for patients and their families and reduces the need for inpatient beds. Although there was some feedback around difficulties with coordination and support, it was acknowledged there has been a significant increase in the services to enable people to return and remain at home since 2016 and further plans are in place to continue to strengthen these services.

Reinstatement of inpatient beds has been considered carefully. The minimum sustainable size of an inpatient unit has been identified as 18-20 beds. This is a result of changes to modern safety standards and sustainability of staffing. This is more than were provided in 2016 (12 beds) and significantly more than the current local need of c. 5 beds/month. Additionally, the space needed would require closure of the current outpatient services pilot. Alongside consideration of the inpatient beds at the hospital, the need to include Wantage in the countywide review of end of life care has also been identified as a recommendation to support stronger palliative care.

If inpatient beds are not re-opened within the hospital, there would be an opportunity to maintain the pilot clinic services and significantly increase the number of these clinics. Two types of clinic services have been considered in this work, planned care and urgent care. Both types of clinics would require the ground floor to be redeveloped to maximise clinic space and remove remaining inpatient infrastructure. Community Infrastructure Levy (CIL) funding has been identified and if this path is agreed, the NHS partners are

committed to working with the local community to develop an application for this funding to expand the offer in the Wantage area. NHS partners are also committed to dedicating appropriate additional resource to co-produce the business case to deliver this.

Since 2021, a pilot of outpatient clinics including Ophthalmology (eyes), ENT (hearing) and mental health services have been offered at the hospital. These services have been largely well received by the local community and were positively reported on as part of the engagement work. Data shows that these planned care services are the ones needed most frequently by the majority of patients. This also aligns with the local population trends towards an older population and those with complex care needs who will require continuity of care via planned outpatient services.

There are a range of urgent care services currently available to residents of Wantage including a Minor Injuries Unit (MIU) in Abingdon and Accident & Emergency departments in Oxford and Swindon. The type of service required for this type of care and the frequency with which it is needed is much more varied then planned care. The most popular services identified by the engagement were those with an x-ray service, either an MIU or an Urgent Treatment Centre (UTC). However the cost and challenges associated with staffing this are significant.

Looking to the future, it is important that services are able to address this challenge of the growing number of people living with long-term health conditions. An option has been identified to bring together a team of expert clinicians to provide urgent care for those with identified health conditions who are experiencing a deterioration in their health. This would enable patients living with long-term health conditions or frailty to access a local, holistic care offer, reducing the need for admission to hospital. This care could be provided within the same type of clinical facility as outpatient clinics. It is therefore recommended that specialist urgent care is included within the development of a business case for clinic-based services in Wantage.

In summary, based on the co-production work and considering the evidence and findings from the engagement completed with local residents, it is therefore recommended that the community inpatient beds are confirmed to be permanently closed in order to develop the ground floor to provide an expansion of clinic-based services which will provide a mixture of both planned care and targeted urgent care services.

In order to deliver this, NHS partners intend to work with the local community to progress with an application to the Vale of White Horse District Council for Community Infrastructure Levy (CIL) funding for the adaptations against the allocated £600k of funding available for healthcare related capital development. If this approach is agreed, our ambition would be to complete the business case and adaptations to the building during 2024 with services transferring from the start of 2025. It is understood from our liaison with the District Council that a CIL funding application could be supported subject to its demonstration of meeting the changing healthcare needs of the community as a result of local housing related growth and developments which through the co-production process all partners are confident can be readily demonstrated.

Summary of report recommendations

In relation to inpatient beds and the alternatives:

- Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage Community Hospital are permanently closed.
- In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.

In relation to planned care services:

- ICB, OHFT and OUHFT work to confirm the outpatient services currently being delivered in Wantage Community Hospital.
- ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.

In relation to urgent care:

- Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.
- Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.

Contents

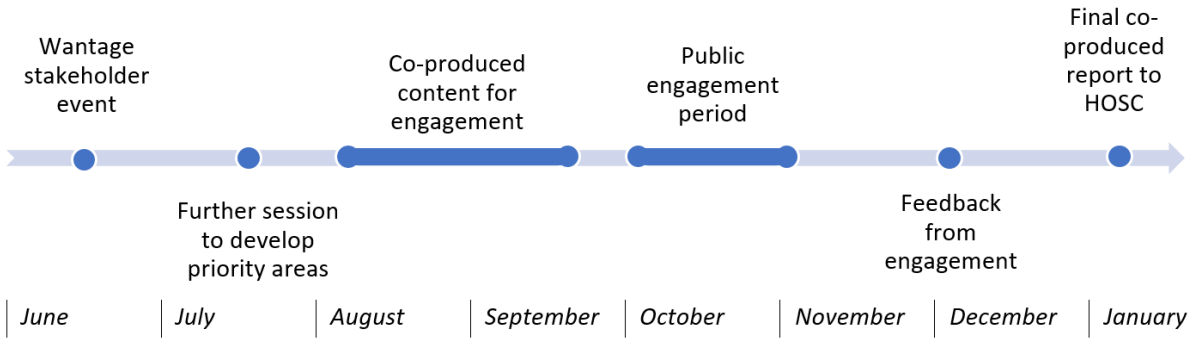
Introduction & context

1 The objective of this project is to work with the local community and stakeholders to agree 'How can we use the space in Wantage Community Hospital to benefit the health and wellbeing of the local community'. This co-production project commenced in June 2023.

2 The Oxfordshire Place Director of Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (BOB ICB) and Oxford Health NHS Foundation Trust confirmed at the outset that they have no plans to close Wantage Community Hospital and this commitment to keeping it open remains. Oxford University Hospitals NHS Foundation Trust also confirmed its commitment to continuing to provide maternity services at the hospital.

3 Initial work was facilitated by the consultation institute to agree the priority areas for consideration. During the development of the public engagement materials and approach it became evident that some additional time was required to refine the material and maximise the reach during the public engagement phase, such that a revised timeline was needed and agreed with HOSC in September 2023. As part of this it was agreed to bring in an independent organisation to facilitate and analyse the public engagement, to ensure there was sufficient resource to deliver the engagement.

4 The project has followed the below timeline (2023-24):



5 We have now completed the engagement process and the purpose of this report is to set out the co-production process that has taken place and detail the resulting recommendations to the Wantage Health Sub-committee and HOSC. This is to facilitate a decision as to whether the project has done enough to enable agreement of the long-term future service configuration to be provided from the community hospital.

Historical context

6 Wantage Community Hospital (WCH) is home to a range of health and care services. The Hospital is managed by Oxford Health NHS Foundation Trust (OHFT) and provides a range of NHS services from several healthcare providers. These include maternity services, community therapy services and specialist outpatient services, providing clinical assessment, tests, treatment and therapy for the local community. These include a mixture of one-off and repeat visits depending on the service.

7 Oxford Health NHS Foundation Trust is the main NHS provider of community healthcare services for the population of Wantage and Grove and manages the services provided by several providers (including the Trust) in Wantage Community Hospital.

8 Until 2016, Wantage Community Hospital provided inpatient beds, maternity care and a range of other NHS services from a single site over two floors. Following the detection of legionella in the hot water system in 2016 the inpatient facilities were temporarily closed and in 2020-21 all the old pipework was replaced, and this enabled all the clinical areas of the hospital building to reopen, although the inpatient beds have remained temporarily closed.

9 A trial of a number of different specialist outpatient clinics (clinic-based tests, treatment and therapy) have been running downstairs for the last 18 months, alongside the community therapies, with maternity services operating upstairs.

10 As of December 2023, the hospital premises are used to provide:

- On the ground floor - a range of services (clinical assessment, tests, treatment, therapy, follow ups) for the local community. A trial of a number of different specialist outpatient clinics have been running downstairs for the last 18 months, alongside these services. The hospital also serves as the local base for some outreach community services (e.g. school nurses and vaccination teams). See appendix A for a full list of the services.
- On the first floor – maternity services including a community delivery suite

11 The local community were previously asked for views about Wantage Community Hospital in what was called the "OX12 Project" between 2017 and 2019, which concluded without a decision. Over the past 6 months, a co-design process has been developed by the NHS with the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the Town Council Health Sub-committee with a commitment shared across the partnership to work together, which was agreed at an extraordinary JHOSC meeting on 11 May 2023.

See appendix C for the full HOSC history of Wantage community hospital

Governance and decision-making arrangements

12 Oxfordshire's Health Overview and Scrutiny Committee (HOSC) agreed a process of co-production at an extraordinary meeting on 11th May 2023 with Wantage Town Council Health sub-committee and key local stakeholders, in recognition of the need for the health and care system to work with the previously engaged community, with an aim to achieve a recommended way forward for the future type of services to be delivered from Wantage Community Hospital.

13 The NHS commissioning body responsible for the population, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), was formally established as a new statutory body on 1 July 2022, replacing the three former clinical commissioning groups. BOB ICB is the commissioner of community healthcare and NHS services provided at Wantage Community Hospital.

14 The stakeholder reference group for this project has the following representation who are committed to working in a co-productive way:

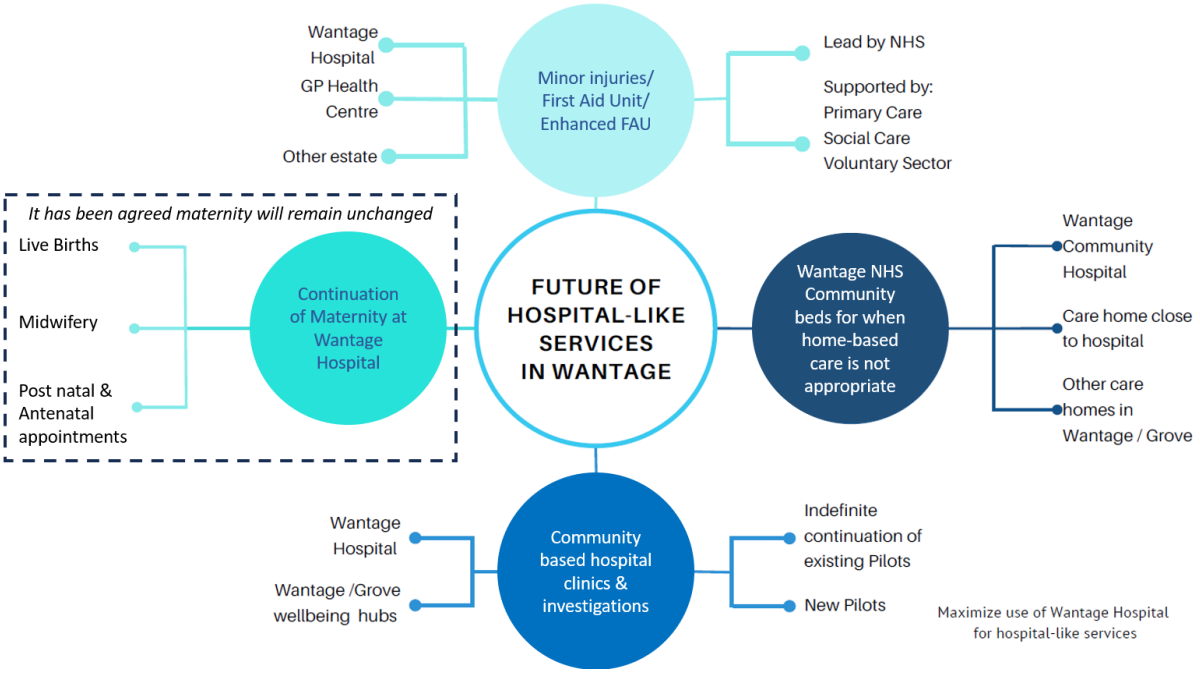
- Wantage Town Council
- Grove Parish Council
- Vale of White Horse District Council
- Wantage Hospital League of friends
- Wantage Patient Participation Groups
- OX12 Project representatives
- GrOW Families
- SUDEP Action
- Wantage Rural and OX12 Village

- Sanctuary Care
- Oxfordshire County Council
- BOB Integrated Care System & Board (ICS & ICB)
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Wantage Primary Care Network (PCN)
- Vale Community Impact
- Community First Oxfordshire
- Healthwatch Oxfordshire

15 From this wider stakeholder reference group a smaller working 'sub-group' was agreed to lead on the public engagement process. The sub-group consisted of local councillors, NHS representatives, Vale community impact and Wantage PCN.

16 Through our co-design process we also identified there may be a need for other types of health and care provision in other buildings and/or parts of the community to contribute to people's experiences and outcomes.

17 The below summary sets out, the co-produced summary of community needs for hospital-like services for the Wantage and Grove area:



Public Engagement process

18 A phase of public engagement was completed between October and November 2023. This was co-ordinated through the sub-group and built on input from residents, clinicians and NHS managers as well as learning from previous completed engagement. The engagement sought to understand the broader views of local people to help shape final proposals.

19 The engagement process used a blend of face-to-face and online approaches to gather suggestions and feedback from a wide range of participants representative of the local communities. By providing a range of opportunities through an array of channels the aim was to make it as easy as possible for people to have their say and shape the future of health and care services based in the Wantage and Grove area.

20 Focus groups and deliberative events were selected because they are a particularly good approach where plans are at an early stage and the user perspective can influence thinking significantly; there are

co-dependencies or trade-offs to consider; complex choices that require rich, well-informed discussion. In addition, a survey was used to understand the viewpoints of the wider population which received 285 responses (see appendix B).

21 The objectives for this engagement were to:

- provide scope and focus which will support the stakeholder reference group in the next stage of co-design.
- explore views on the three scenarios developed through the previously engaged community and stakeholder reference group and gather over-arching comments through a structured process.
- identify themes to inform decisions moving forward, avoiding repeating earlier research and engagement
- enlist the help of an independent organisation to facilitate the process and provide analysis of findings

Local population needs

22 This project has focused on developing the future role of WCH to ensure its long-term sustainability. In order to do this, consideration has been given to both existing and future needs of the local community alongside current and emerging models of health and care.

23 Wantage is located within Oxfordshire a county of around 725,300 residents, with a fast-growing population. Between the 2011 and 2021 census the population grew by 10.9% compared to 6.6% in England, and the number of people aged over 65 grew by 25%. Oxfordshire is the most rural county in the Southeast region but 60% of the population live in the city of Oxford or other main towns. Life expectancy and healthy life expectancy in Oxfordshire are each significantly higher than national and regional averages for both males and females. Oxfordshire is ranked the 10th least deprived of 151 upper-tier local authorities in England.

24 Wantage is a market town in Oxfordshire with just over 33,000 residents registered with local general practices. The area is within the local authority areas of Wantage Town Council, Vale of White Horse District Council and Oxfordshire County Council, and health services are within the purview of both the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the local Wantage Health Sub-committee of the Town Council.

25 For the purpose of this project, the Wantage and Grove local area has been identified through two measures, firstly the postcode area of OX12 and secondly the GP practices registration.

Wantage & Grove - OX12 postcode area

Newbury street practice boundary

Church street practice boundary

26 Within this geography which we have described as the Wantage & Grove area, there are a number of key trends which need to be considered.

27 **The population is growing, particularly within the Grove area**
In 2022, there were 33,179 patients registered with Wantage GP practices, this is an increase of nearly 10,000 since 2014 when it was 24,296. Based on housing growth trajectory, this is due to increase further to around 41,000 by 2030.

28 **The population is ageing, and more people are forecast to live longer**
As well as increasing in number, the population of the Wantage area is also getting older. Census data shows that between 2011 and 2021, the proportion of the population aged over 65 increased in both the Wantage and Grove areas.

	Grove (% over 65)	Wantage (% over 65)
2011 census data	17.0	19.6
2021 census data	18.0	22.0

Oxfordshire insights, Wantage & Grove profile 2018

29 ONS population estimates show that the number of people aged 75+ in Oxfordshire increased by 22,600 over the 20 years from 2001 to 2021. In the 20-year period between 2021 and 2041, this age group is expected to increase by 40,200 residents, almost double the number added in the previous 20 years (2001 to 2021). Both the ONS and Council's Housing-led forecasts predict a significant increase in people over the age of 65.

30 **More people both young and old are living with more complex needs**

According to Age UK, as we get older there are some conditions and illnesses that we are more likely to develop (*https://www.ageuk.org.uk/information-advice/health-wellbeing/conditions-illnesses/)*. Applying the prevalence of long-term health conditions in 2011 to the actual and predicted growth in the older population, suggests that there could be 80,200 people aged 65+ living with a life limiting long term health condition or disability in Oxfordshire by 2031, an increase of 32,600 (+68%) (*Oxfordshire Older people's strategy 2019-24*). As a result, this population require an increase in planned care services often with regular appointments and more integrated care as identified in the ambitions of the NHS Long Term Plan[1] and recently published guidance on Proactive Care[2].

Case for Change

31 The co-design project is now seeking to agree the long-term future of the hospital and confirm whether the inpatient beds should re-open or be permanently closed. There are a number of changes to the community and NHS best practice which have occurred since 2016, which impact on the way in which the hospital might be best used, and potential opportunities to fund new primary care developments in the Wantage area:

Temporary closure of the inpatient beds

32 Inpatient beds on the ground floor of the community hospital have been temporarily closed in 2016, following the detection of legionella in the hot water system. In 2020-21 all the old pipework was replaced, and this enabled all the clinical areas of the hospital building to reopen, although the inpatient beds have remained temporarily closed. A trial of a number of different specialist outpatient clinics (clinic-based tests, treatment and therapy) have been running downstairs for the last 18 months, alongside the community therapies, with maternity services operating upstairs.

Home First

33 Home First is the national NHS policy ambition to help older people receive care in their own homes wherever possible. NHS Reducing length of stay guidance describes taking a 'Home First' approach, providing patients with support at home or intermediate care. Home First requirements are that we should always seek to support people at home; assessing and intervening without a hospital admission wherever possible and getting people back to their own home before we assess their needs and plan their care [3].

34 A study carried out by the Better care support programme (available at reducingdtoc.com) found that on average, 27% (a range of between 19% and 35% across the areas) of the 10,400 individuals studied were declared to be medically fit for discharge yet remained in hospital. This study and other evidence support that an extended stay in a hospital bed is not good for vulnerable frail patient who is ready to go home, it can lead to disorientation, loss of physical conditioning and risk the person's future independence.

Discharge to assess model

35 It is widely accepted that the vast majority of people admitted to hospital want to leave as quickly as possible and that almost everyone wants to return to the living arrangements they enjoyed prior to their admission with the highest level of independence, wellbeing and quality of life possible, given their

[1] NHS Long Term Plan » Ageing well
[2] NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty
[3] NHS England » Principle 5: Encourage a supported 'Home First' approach

circumstances. Staff caring for people also want them to be discharged to the right place, in the right way, at the right time[4].

36 Oxfordshire health and care system is committed to the discharge to assess model which sets out principles around the number of patients who should be supported to return home following an acute hospital admission[5]. The Oxfordshire Way is the vision for Adult Social care to support people to live happy, healthy lives here in Oxfordshire. It brings together the council, health and care organisations and voluntary sector groups and is focused on 'what's strong rather than what's wrong'. You can see a video about the Oxfordshire Way in practice here: https://player.vimeo.com/video/842913641?h=9bcf384398&app_id=122963

37 Oxfordshire has been piloting a discharge to assess home first model since July 2023. In the pilot, we took people home with support and assessed them at 72 hours after their discharge. All of the patients in the pilot had been assessed in hospital as needing *long-term care*. In the pilot we found that

A. 24% were fully independent at 72h
B. 32% were able to engage in reablement at 72h
C. 33% were for long-term care support at home

38 Although many patients benefit from an admission to hospital, this can also bring its own risks. For the more vulnerable, being in a hospital bed can mean:

- losing confidence in the ability to live independently
- losing the continuity of whatever care packages are in place
- losing mobility
- a risk of secondary health complications (e.g. higher risk of picking up an infection)

39 In addition, older patients can often experience confusion and disorientation in an unfamiliar environment and daily routine. As a result, the home first approach proposes that where an individual is able to return home safely, they should be supported to do this rather than remaining in a hospital bed. In the discharge to assess pilot above 56% of patients supported to go home would have otherwise been waiting in hospital for the Council to arrange long-term care at home with all these risks to their health, wellbeing and independence.

40 Aligned to The Oxfordshire Way, the NHS Hospital Discharge Policy requires all health and care systems to discharge 95% of people from acute beds directly home or to their normal place of residence, whether independently or with support. Currently in Oxfordshire and prior to the Discharge to Assess pilot we have been achieving about 91%. That amounts to approximately 20 people a week who will have been placed in a step-down bed rather than their own bed and who will probably have been unnecessarily delayed in hospital. When a person does not need bed-based care, admitting them to hospital unnecessarily may compromise their reablement, reduce independence and can cause harm. As learning from the discharge to assess pilot embeds, the number of people who return home directly and earlier is anticipated to increase. The Oxfordshire health and care system is committed to discharge to assess and has been rolling out a County-wide 7-day service from November 2023. This has involved a reorganisation of social work teams working into and out from hospital sites which will be completed in January 2024.

Specialist bed provision

41 In recent years within the NHS, there has been a shift in approach to rehabilitation, to develop specialist centres of expertise which bring together staff with a specific skill set on one site, to better meet the needs of a particular cohort of patients. Although the majority of community hospital inpatient beds

[4] People-first-manage-what-matters.pdf (reducingdtoc.com)
[5] https://www.local.gov.uk/publications/developing-capacity-and-demand-model-out-hospital-care

continue to offer general rehabilitation, there has been a shift towards the development of specialist wards. Within Oxfordshire, as well as rehabilitation beds, there are also the following specialist beds:

- Oxfordshire Stroke Rehabilitation Unit (Abingdon)
- End of Life beds (Wallingford)
- Bariatric beds (Witney)
- Short-stay medical step-up beds for people with acute health problems (Abingdon & Witney)

42 Three community hospitals also provide an ambulatory care model, where the patient attends for treatment during the day and returns to their own home overnight (Henley, Abingdon & Witney).

43 This move towards more specialist provision means that where a patient has additional needs requiring inpatient care, they may be admitted to a specialist bed rather than to a general rehabilitation ward.

Urgent community response (UCR)

44 With increases in the older population, more people in the community are living with one or more long-term health conditions. Many services were commissioned to manage specific illnesses rather than the whole person. This means that people with multiple conditions can experience disjointed care which can result in an individual having to have contact with multiple different services. People with one or more long-term condition need high quality, consistent and integrated health and social care. People with more than one condition, or who have a long-term condition when something else happens to impact on their health (such as having a fall), often require more complex support. Health and social care services need to be designed differently to respond to these needs.

45 In response to this and in accordance with the national standard for community health services to deliver two-hour urgent community response, we have developed Oxfordshire's Urgent Community Response service which is focused on reducing avoidable admissions (Further details are available on the NHS England website https://www.england.nhs.uk/community-health-services/community-crisis-response-services/).

Preventative care to support sustainability

46 Preventing admissions and providing care at home is critical to managing hospital capacity. Many people with frailty currently admitted to hospital through A&E don't need inpatient care – estimates range up to 30%. Care Quality Commission (CQC) research (2018) has shown that investment in preventative services can lead to a reduced need for care and support and cost saving equivalent to £880 per person. Therapy-led reablement is proven to reduce need[6]. In order to increase the financial sustainability of community services it is therefore necessary to review the way in which we deliver services to ensure we are achieving the best patient outcomes within the financial resources available to the NHS. In general this would move from bed-based crisis care towards a more preventative approach based within the community. There is an opportunity to support this approach directly for local residents through the development of planned and preventative outpatient care in local community hospitals.

Workforce sustainability

47 Like many other parts of the NHS, community services are facing significant challenges in recruiting and retaining sufficient staff to meet the needs of the population. Central to addressing this challenge is ensuring that staff teams are supported to have an appropriate workload and mix of skills to be able to meet patient needs. Over the past 2 years Oxford Health NHS Foundation Trust has invested in both community urgent community response and community hospital staffing teams to increase their capacity and resilience. As part of this, a project to reduce use of agency staff has developed an

[6] Evidence review for adult social care reform (publishing.service.gov.uk)

international nursing recruitment campaign which has enabled the Trust to reduce vacancy rates within staff teams. In order to maintain staff retention however it is necessary to ensure services are both financially sustainable and there is sufficient capacity to meet the demand for services. This means that whichever services are agreed to be provided within Wantage community hospital there will need to be a sustainable approach to staffing them, including consideration of how these plans will impact on teams across other sites. Once the future of the community hospital is confirmed we would be looking to work with the local community to explore options to support recruitment within the local community.

48 Nationally the NHS has committed to the ambition of delivering seven-day services to ensure that patients receive consistent high quality safe care every day of the week. This has been shown to have significant patient benefits and reduce variation in patient care. However, in order to move to this model, services need to either change how they provide services or increase staffing by nearly 30%. In order to deliver this model sustainably it is necessary therefore to review how services are provided and identify opportunities to align services better to meet patient needs every day of the week.

Estates considerations

49 The buildings in which community inpatient services are provided are no longer cost effective or best suited to the needs of patients. A report produced in 2021 by NHS Benchmarking showed that Oxfordshire community hospitals are relatively inefficient to run compared to the hospitals in Buckinghamshire and Berkshire. This is due to the limited number of beds operating at each site and the old design of the buildings, requiring proportionately higher staffing numbers to deliver the same safety and quality of care as in larger bedded units. Within BOB ICS, Oxfordshire operates nine community hospitals of which six have inpatient wards; in contrast, Berkshire West has consolidated its provision to three, larger inpatient units; Buckinghamshire has closed its community hospital wards at Thame and Marlow and co-located its inpatient rehabilitation with its acute hospital care.

50 In addition, Wantage Community hospital site has particular limitations relating to the physical estate including parking, building size, design and age, and requirements to share space with other services.

51 Having reviewed the site, the Oxford Health estate team are of the view there is no opportunity to expand the ground-level footprint of the hospital. There is potential to look at what development could be done on the upper floor, but careful consideration would need to be given to the business case as it is anticipated this would have a significant cost. It is also important to assess the staffing implications and restrictions on parking space associated with expanding the space within the hospital.

NHS capital constraints

52 OHFT have already invested capital funds into Wantage Community Hospital since 2020/21 to rectify the old pipework and provide the clinical accommodation for the pilot outpatient/clinic/therapy services on the ground floor. Any funding for further estate refurbishment works to create space for additional clinical space (i.e. to enable expansion of services beyond the current pilot services) must be classed as NHS capital spend under the NHS finance regime (annual revenue funds cannot be used). There are nationally set constraints on how this is funded. Unless funded via NHS England under a national capital framework, such as the new hospitals programme, this must be funded via provider capital funds. This amount must be affordable for providers, in having available cash in the bank, and fit within their capital department resource limit (CDEL), which is a fixed amount and has not increased in line with population changes. For OHFT the majority of its capital funding for next year is pre-committed against existing multi-year programmes. Additionally, there are a number of urgent maintenance programmes requiring funding meaning there are pre-commitments against new CDEL allocation where the Trust has a continuing ageing estate. This means that any hospital site requiring new refurbishment

will require an external funding source and use of Local Authority community infrastructure level (CIL) funds would support this.

CIL funding

53 Following the May 2023 JHOSC meeting, a meeting was held with the District Council Infrastructure and Development Team Lead who is responsible for CIL funding, which identified that there is £2,503,892 of funding for CIL allocated for Health within the Vale area. It is understood that of this, approximately £2m has been identified as required for primary care developments which are currently at the early phases of development. An update on this funding opportunity was brought to the July Reference group session and a discussion took place to explore how this funding might be used in reference to this project.

54 It is understood from our liaison with the District Council that a CIL funding application would be supported through its demonstration of meeting the changing healthcare needs of the community as a result of local housing related growth and developments. The co-production process has generated significant enthusiasm and confidence of being able to describe a long-term future plan for Wantage Community Hospital that meets these requirements to enable a strong application.

Community hospital inpatient beds and the alternatives

55 In the period prior to their closure in 2016, 12 general inpatient rehabilitation beds were being provided within Wantage Community Hospital. Following their temporary closure due to the replacement of the plumbing system in the community hospital, this inpatient care has been provided at other community hospitals in Oxfordshire. Any long-term decision on the services to be provided at Wantage Community Hospital needs to address whether or not these beds should be reopened at that site, not least as this determines the facilities and space available at the hospital for other services.

56 As described within the case for change above (paragraphs 33-54), there are a number of changes in policy and approach which have taken place since 2016, in particular the focus on reducing length of stay within a hospital[7] and providing more care at home, both to reduce admissions to hospital and to support individuals to return home sooner. As such the consideration of the role of these beds and the option to reinstate them also considers the alternatives to bed-based provision, what services are available to individuals as well as the impact of reopening a ward within the community hospital on the currently available services.

The current service offer

Inpatient beds

57 The following types of inpatient beds are currently provided within Oxfordshire:

A. Community hospital inpatient beds

58 Community hospital inpatient beds provide rehabilitation following an admission to an acute hospital for those who are not able to return home. Within Oxfordshire, there are currently 8 community hospital inpatient wards open across 6 sites (see appendix D). These provide a mixture of general rehabilitation and specialist care (including Stroke, end of life, medical and bariatric care).

[7] NHS England » Reducing length of stay

59 Each month around 5 people from the Wantage and Grove area are admitted to a community inpatient bed. Despite the ageing population it is not anticipated that this will change because of the growing number of alternative health and care pathways to avoid hospital admissions.

60 Most people from the Wantage and Grove area (55%) currently go to either Abingdon (10 miles from Wantage) or Didcot (8 miles from Wantage) community hospitals. Of those that don't go to these hospitals (45%) the median distance travel from Wantage is 20 miles to other community hospitals. The average (median) length of stay in a community hospital bed is around 34 days.

B. Short Stay Hub Beds

61 In addition to community hospital beds, bedded care is also provided within care homes as part of the short stay hub bed model. This model was developed by Oxford University Hospital NHSFT in the winter of 2015-16 as what was planned to be a short-term provision to create the capacity to maintain hospital flow where there was not sufficient home-care capacity for the patient to go home. At that time, Oxfordshire had one of the worst performances in terms of delayed transfer of care ("bed-blocking") in the country. The model was retained over succeeding winters and then was integrated with the Council's intermediate care model in 2019. The current "short-stay hub beds" were recommissioned and contracted by the Council from November 2019 and the model is currently under review.

62 The short-stay hub beds are supported by a dedicated team of nurses, social workers, and therapists (the "Hub team") that is hosted by OUH. Medical cover is provided by local GP practices under an additional contract which reflects the fact that patients are not registered permanently with the practice. The average length of stay is intended to be relatively short at 14 to 21 days at which point the individual is then discharged home (in 70-80% of cases).

63 Each month, approximately 2 people from the Wantage and Grove area require either bed-based reablement or a period of bed-based assessment and are admitted to short stay hub beds in care homes (mainly to The Close in Burcot, 15 miles from Wantage) where they are supported by the Hub team and local GP practice as set out above.

C. Winter/ surge beds

64 As part of the approach to managing capacity over the winter or in times of increased demand, additional beds may be purchased within care homes normally to support further assessment outside of hospital for people who are likely to need Council or NHS Continuing Healthcare funded residential care in the longer term. The Oxfordshire health and care system currently has no plans to purchase any additional capacity for 2023/24 but if required would go to the care market to ascertain what could be made available for short periods of stay, typically 1 – 2 weeks per stay for a few months of the year. When this capacity is purchased, we also need to fund additional therapy in-reach and dedicated GP cover from the GP practice local to the home. This is in line with the system's ability to flex beds up or down as required.

D. Palliative and end of life care (EOLC) (outside of the individual's home)

65 Most people wish to receive a package of care to pass away in their own home, but sometimes alternatives are needed, particularly at times of crisis. Specialist end of life beds are currently provided at Wallingford Community Hospital (16 miles from Wantage) and within the Sobell House hospice in Oxford (20 miles from Wantage).

Home-based services

66 In addition to inpatient beds, as described within the case for change, there has been a significant increase in recent years in the number of services provided in an individual's home. Within Oxfordshire this includes:

A. Admission avoidance services (Hospital@Home & Urgent community response)

67 Provide healthcare in your own home and facilitate earlier discharges from hospital. Oxfordshire has both children & young people and adults Hospital@Home services. Around 45 people from the Wantage and Grove area currently access the service per month with the service continuing to expand over the coming 6 months to provide 40 places per 100,000 population by April 24. In addition, around 150 people from the Wantage and Grove area access the urgent community response service per month. In the past, many of these patients would have been admitted to a hospital bed as there was not the ability to diagnose the cause of the health crisis or offer the care to enable them to remain at home.

B. Discharge to Assess

68 The Oxfordshire health and care system is committed to discharge to assess and has been piloting a discharge to assess "home first" model since July 2023. The County-wide 7-day service has been operational from November 2023 including covering the Wantage and Grove area. This has involved a reorganisation of social work teams working into and out from hospital sites which will be fully completed in January 2024.

69 Discharge to assess is also a new service for people who are clinically optimised for discharge (i.e. considered medically well enough to return to their home or usual place of residence) and do not require an acute hospital bed, but may still require care services. They are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting where a package of care is provided whilst an assessment for longer-term care and support needs is then undertaken.

C. Reablement services

70 Reablement is a type of care that helps someone to relearn how to do daily activities. Most people who receive this type of care do so for 1 or 2 weeks after they have been discharged from an acute hospital. This service is commissioned by the Council and is in place across Oxfordshire including to Wantage and Grove residents. This has been a priority area for increased capacity and in November 2023, 91% of patients from this service (137 people) were discharged independent or with reduced dependency. Going forwards we understand this service may be wrapped into the Discharge to Assess model as this works by taking people directly home and then determining whether the person needs reablement.

Engagement feedback on inpatients and the alternatives (see appendix B for further details)

71 Within the inpatient services considered, rehabilitation beds were the clear priority over the other kinds of inpatient services with the view that other beds might be better provided less locally.

72 The rationale behind support for these services, as with other services, related to the ease of travel. If visiting a loved one recovering in hospital involves a long, difficult and expensive journey, that is good for neither patient nor visitor. Having patients return closer to home to recover enables them to receive greater social support, which has been shown to speed up recovery, something from which all parties gain, including the NHS as it frees up a bed earlier.

73 There was significant support for having more local beds within Wantage; when looking at the bigger picture, more people felt that if the price of providing rehabilitation beds is the loss of outpatient clinics, then the latter should be the priority - especially when looking at the relative demand for each service (based on the presentation handout made available during the focus groups).

74 Other inpatient possibilities – palliative care and specialist stroke rehabilitation beds – were felt to be best offered regionally rather than necessarily locally and, though it is difficult to find places, palliative care can be offered though care homes.

75 Home based services were seen as a high priority and provide a really good alternative to admission as an inpatient at a regional hospital, with consequent travel issues for visitors. However, the importance of having sufficient capacity and a joined-up approach were highlighted and feedback reflected a mixed experience of these services currently.

Options identified

76 Were inpatient beds to be reinstated within Wantage community hospital, the following options have been identified:

A. Re-open an inpatient ward of around 20 inpatient beds within the community hospital

- General rehabilitation
- Mixture of specialist (e.g. EOLC beds) and general rehabilitation

As part of this work, the sustainable staffing models for community hospital inpatient units have been reviewed. The Lord Carter review (2018) noted that *"…one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure"*[8]. In order to provide a safe and sustainable service, it is recommended that a minimum staffing level (equivalent to 15-20 general beds) should be maintained on each site. It is neither clinically safe nor sustainable from a workforce perspective to operate a smaller number of beds at Wantage nor to shift resources to Wantage from other community hospital inpatient units to reduce their bed numbers further.

77 Based on an assessment of the building layout of Wantage Community Hospital, and on the advice of local hospital clinicians, it is recommended that any inpatient unit operated at the hospital should consist of a minimum of 18-20[9] beds; this would ensure that there is sufficient staffing and expertise available on the ward to cover the 24-hour rotas and manage sickness and other absences sustainably, to ensure safe care can be reliably maintained.

78 If a higher number of specialist beds are provided, with a higher workforce to patient ratio than the 1:6 nursing ratio used for generic rehabilitation beds, the total number of beds on the inpatient unit could be slightly lower than 18-20 due to the proportionately larger staffing team required for each of the more complex patients, although this would not reduce the size of the overall workforce requirement of the unit.

79 Throughout this work the focus agreed by the stakeholder group has been on ensuring that all options identified for the hospital must be safe and sustainable; an option to operate fewer than 18 generic inpatient beds within the hospital is not recommended on this basis.

Enabler considerations

Estates implications

80 To deliver this option it would be necessary to modernise and refurbish the whole ground floor of the community hospital to an inpatient ward with 18-20 beds in line with current infection prevention and control standards. It would be necessary to upgrade the kitchen facilities**.**

81 If Community hospital beds were provided in Wantage there would be no space for any outpatient (tests, treatment and therapy) services or potential urgent care type service. Wantage and Grove residents would need to access these at other hospital and health and care locations (e.g. Oxford).

[8] Lord Carter review (2018)https://www.england.nhs.uk/wp-content/uploads/2019/09/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental_....pdf p3

[9] Productivity in NHS hospitals - GOV.UK (www.gov.uk)

82 Were this option to be taken forward it would be necessary to review the location and configuration of community hospital beds across the County as a whole, in order to redistribute the available NHS staffing expertise and resources. Additional investment in staff recruitment, staff consultation and training programmes would be required to develop the required ward workforce.

Workforce implications

83 The cost would be dependent on number of beds and type of care interventions provided. A ward would be typically staffed for an equivalent size ward with nursing ratio 1:6 (24 hours per day), Therapy ratio 1:8 (7.5 hours per day) Occupational Therapy, Physiotherapy, Dietetics and Rehab Assistants, ward medical input and on-call cover (GP and Advanced Care Practitioners), and ward discharge support by a patient flow team.

84 Where a ward and overall hospital site has only a small number of beds, and a correspondingly smaller expenditure budget, it is much harder to maintain a core team with the headcount, skill mix and expertise to provide sustainable staffing, which can impact on the ability of that environment to provide optimal care. To ensure wards can be staffed appropriately to meet patient needs, consideration needs to be given to a viable ward size and smaller units have higher running costs on average where they have limited opportunities to share resource across multiple wards including the more specialist workforce.

Wider dependencies within the Wantage & Grove area

85 The following were identified as dependencies relating to the provision of inpatient beds within the community hospital:

Local short stay hub beds for reablement care

86 Most reablement care is provided in the person's own home. Some people, however, require a short period of reablement in a bedded care facility, such as a care home. We understand the profile of this demand may change with the adoption of the discharge to assess model set out above and the need to divert more people home to meet the NHS policy requirement of 95% of people going home from hospital. Using the *current* model, the need to provide short stay bedded reablement care to Wantage and Grove area residents has been considered during this work, including the option to provide this care in local care homes. However, the demand data suggests, only 2-3 Wantage and Grove residents require this type of bed at any one time in the current model.

87 As noted within the case for change, there is a national focus on moving to provide as much care as possible at home, as part of the 'discharge to assess' and 'home first' approach. Oxfordshire has only ever achieved c 90-91% of people going directly home. This amounts to 20-25 people per week who go into a bed who should not need one and could instead be diverted to Home First. To address this, an extended reablement service is currently being developed to offer additional assessment, reablement and long-term care in people's homes together with any equipment and/or assistive technology. As part of this work it was agreed in May by Oxfordshire County Council and the ICB that the number of short stay hub beds should be reduced from the current 94 to 40-45 over time. The impact of discharge to assess and the implications for the step-down bed provision in the County will be considered at the January 2024 extraordinary JHOSC meeting.

Local end of life care home beds

88 A second area identified for review was the need for local specialist beds to support people receiving care at the end of life.

89 Members of the stakeholder group expressed the view that more resilient and responsive EOLC should be provided in the person's home or usual place of residence, if this is their choice, and this should be priority area of focus for the future development of the end-of-life care pathway in Oxfordshire.

90 End-of-life care is not ideally provided in a busy acute hospital or inpatient rehabilitation ward optimised for the delivery of strengths-based therapy, due to the different nature of the care environment, therapy facilities, clinical expertise and skill-mix required for this cohort of patients.

91 Two areas of end-of-life care identified for possible development in Wantage are:

- Enhancing end-of-life care support for local residents at the end-of-life whose usual place of residence is a local care home, enabling more people to die in the place of their own choice
- Developing end-of-life care 'crisis beds' (24-48 hours stay) in local care homes - this was seen to be particularly relevant where the families and carers of people at the End of Life may need a brief period of additional end-of-life nursing support in a community setting, if the dying person is temporarily not able to remain at home but does not require admission to an acute hospital.

92 It is agreed this is an important area to get right for people and is therefore recommended that these proposals are taken forward as part of the End-of-Life care pathway development work being progressed by the Oxfordshire system.

Summary & recommendations

93 There have been a number of changes to the role of community hospital beds since the Wantage community hospital inpatient beds were temporarily closed in 2016. Recently, there has been an increase in the amount and complexity of care which can be provided at home. This means that more people are able to return home quickly after a stay in hospital and fewer people are admitted in the first place.

94 It has been widely recognised that preventative care, and providing more care in the patient's home, leads to better outcomes for them, their families and carers, and reduces pressures on the health and care system. This also means that, despite a growing and ageing population, there is less need for inpatient beds than there was in the past. In addition, there have been changes to the needs of the local population which mean that it is important to focus more on the older population and those with complex care needs. All of these factors have impacted on the way in which we have approached determining the role of the hospital moving forward.

95 In order to be sustainable from a staffing perspective a ward needs to have between 18-20 beds. To open a ward of this size in Wantage would require an equivalent number of beds to be closed within other community hospitals within the county, and these beds would not be efficiently scaled to the needs of the local community. Moreover, due to the space required, difficult choices would then need to be taken on which of the current planned care pilot services currently provided in WCH would need to be downgraded or removed to make room.

96 When considered against all the options within the engagement process, although there was a significant level of support for the future role of the hospital being to provide inpatient beds within the survey, this view was expressed by significantly fewer people than the number who supported both outpatient and same day services. Taking the evidence, the costing and service implications, in conjunction with the stakeholder views, into consideration, it is therefore recommended that the inpatient beds are not reopened.

97 However, this is not the only way to provide beds in the local community. The role of local care home beds and end of life specialist beds were identified as areas for consideration by the local community. It is recommended that the work to review the local offer for these alternative beds options should be taken forward alongside discussions with local care homes, in line with the countywide approach to strengthening reablement and end of life care.

98 If inpatient beds are not re-opened within the hospital, a strong alternative identified as part of this project is to use the hospital to provide clinic space. Two types of clinic services have been considered, planned care and urgent care. Both types of clinics would require the ground floor to be redeveloped to maximise clinic space and remove remaining inpatient infrastructure.

99 **In relation to inpatient beds and the alternatives it is therefore recommended that:**

- **Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage community hospital are permanently closed.**
- **In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.**

Clinic-based services

100 If the ground floor of the community hospital were not to be used to provide an inpatient ward, then it could be redeveloped to provide an expanded range of clinic-based services. There are two types of clinic-based service which we have considered as part of this work:

- Planned care (tests, treatment and therapy for planned care appointments) – booked in advance
- Urgent care (minor injury, common illness and mental health issues) – accessed on the same day

A: Planned care (tests, treatment and therapy for planned care appointments)

101 Planned care refers to care or treatment that is scheduled in advance, most commonly for a long-term health condition or a problem which is not deemed to be urgent. This may be accessed directly by a patient or may follow a referral to a specialist service by a GP or other primary care practitioner or by another specialist team. Planned care tends to be preventative in nature and is focused on maintaining health and wellbeing as well as treating chronic injury or illness.

102 A range of these types of services is currently being piloted within the hospital (see appendix A). These services have been operating at the hospital since the inpatient space was refurbished in 2020-21 and have received positive feedback from patients overall.

Securing and extending the current service offer

103 The types of services required by the local population vary significantly based on age, socioeconomic factors and demographic characteristics. This could include therapy, specialist appointments or diagnostic services for example. Currently, the specialist outpatient service most needed by residents from the Wantage and Grove area is Ophthalmology (specialist eye appointments). This is the outpatient clinic that people attend most often. Between April 22 and April 23 an average of 299 patients per month used ophthalmology outpatient services from the Wantage and Grove area.

104 The mental health service within the Wantage & Grove area with the highest number of referrals between April 2021 and August 2022 was the Children and Adolescent Mental Health Services (CAMHS) Team followed by Adult Mental Health team. Outpatient appointments for both these services have been provided as part of the outpatient pilot within the community hospital.

105 Clinic-based planned care services are currently available at the below locations:

A. Wantage community hospital pilots

106 An initial review of these pilot services identified that, 1,445 patients came to an outpatient clinic as part of the pilot services being provided on the ground floor of Wantage Community Hospital between

November 2021-22. Most of these patients were seen by Ophthalmology and they mainly (57%) came from an OX12 postcode. On average 120 people per month come to Wantage Community Hospital to access the range of clinic-services currently provided.

B. Outpatients within John Radcliffe/Great Western hospitals

107 A wide range of clinic-services are available within acute hospitals, for most people in Wantage this would either be the John Radcliffe hospital in Oxford (23 miles from Wantage) or Great Western in Swindon (34 miles from Wantage).

C. Oxford city clinic bases

108 Clinics can also be accessed at the Churchill hospital site in Oxford (20 miles from Wantage) or at one of the other clinic bases within Oxford.

D. Other community hospitals

109 Most other community hospitals also have some clinic-based appointments providing community clinics with outreach from Oxford University Hospital specialists, community teams and mental health teams.

Engagement feedback on planned care (see appendix B for further details)

110 Residents are aware of many of these services currently offered at the Wantage Community Hospital, many of which are well used, such as podiatry and ophthalmology. People want these existing services to remain now that they have become accustomed to having them and are loath to lose them.

111 Ease of access that comes with a locally-based service is seen as the key benefit, especially when considering the alternative of having to travel to regional hospitals. The inconvenience involved in having to travel to the John Radcliffe in Oxford (especially) clearly weighs heavily on residents, and having appointments in Wantage is welcomed even by those able to travel further. Those who reported driving to the John Radcliffe cited frequent holdups on the A34, heavy traffic and the difficulty and high price of parking once there, and travel issues are significantly worse for people reliant on public transport. Outpatient clinics, especially those which might require frequent visits, mean that the inconvenience and cost pile up to an extent that would cause real stress to patients and carers alike.

112 It is worth noting that in workshop introductions, the frame was “hospital-like” services. Services like podiatry and physiotherapy may have felt to participants very much like hospital outpatient services and hence seen to provide a coherent and consistent service offer. The feeling is that what is offered at Wantage Community Hospital Community Hospital needs to be well defined, with clear demand and avoid replicating services covered elsewhere. Views were also more mixed on children’s and mental health services.

Options identified

113 If the decision were taken to focus on clinic-based services within the community hospital rather than inpatient beds, then there would be an opportunity to both confirm the current pilot services and look to increase the number of clinics available.

A vision for outpatient care at Wantage Community Hospital

114 There is considerable support in the stakeholder group to develop additional clinics within the community hospital to deliver more planned and preventative care locally and reduce the number of people who need to travel to acute hospital sites, such as the John Radcliffe.

115 There is potential to secure the existing outpatient and therapy clinics at the hospital and also to expand the space available for additional clinics and outpatient services. This potential has been confirmed by the ICB Place Team, the Community Hospital Estates Team and by the clinical and

operational leads at Oxford Health NHS Foundation Trust (OHFT) and Oxford University Hospitals NHS Foundation Trust (OUH). This approach of providing more clinics and outpatient services (planned care) out into local community sites and through greater service integration is a key objective of both OHFTs Community Strategy[10] and OUH Clinical Strategy[11].

116 This development of the hospital would enable additional clinic-based services to be provided to local residents. A number of new services have been proposed, based on three main sources:

A. The health needs data for the local population
B. Service data and operational information from the NHS providers
C. Experience from local residents and other local stakeholders through the engagement work

117 If this option were taken forward, examples of the types of services could include:

- Community gynaecology and menopause services
- Community Urology and men's health services
- Specialist planned and outpatient services
- Services supporting people with epilepsy and other neurological conditions
- Children's mental health services
- Art therapy services at the hospital, particular for people with long-term health issues and mental health conditions
- Facilities for digital health and multi-disciplinary team working

If this option were taken forward the lead partners (Wantage Town Council health subcommittee, BOB ICB and Oxford Health NHS Foundation Trust are committed to continue to work within the local community and with its provider NHS partners to identify which clinics can be provided.

Enabler considerations

Estates implications

118 As mentioned above, if the option to develop additional clinical space were to be taken forward, then NHS partners would be looking to access local CIL monies to fund the development of the new rooms. Consideration would also need to be given to improving transport and accessibility to the hospital for those using the additional outpatient services.

119 OHFT Estates have undertaken an indicative assessment of refurbishment of the ground floor space of Wantage Community Hospital not currently used for clinical activity, in order to convert it to general/flexible clinical space. This could realise up to approximately 12 additional clinical rooms, which could be used to support an expanded range of services available at the hospital (the exact number of additional clinical rooms would depend on service and clinical design requirements).

120 Redevelopment of the whole ground floor would involve removing the currently unused kitchen space to maximise clinic room provision and to improve waiting areas. There would also be an opportunity to consider the relocation of non-clinic-based services currently hosted within the hospital to maximise clinic space. Due to space restrictions, it is not possible to provide both the inpatient and outpatient options on the ground floor of the hospital.

Workforce implications

121 If this option is preferred, further work would be required to determine the workforce requirements for the type of clinic-based service to ensure viability.

[10] Community Services strategy - Oxford Health NHS Foundation Trust

[11] Our Clinical Strategy 2023-2028 (ouh.nhs.uk)

122 As existing NHS providers of clinic-based services at Wantage Community Hospital Oxford University Hospitals NHS Foundation Trust (OUH) and OHFT have committed to identify the services which could be sustainably staffed to provide expanded outpatient services should this be the preferred option. Consideration would need to be given to both the size, specialities and skill mixed needs of a service offer to ensure that these services remain sustainable. Other local NHS providers of clinic-based services would also be approached.

123 This option could be delivered through the reallocation of existing resources to focus on the provision of more community-based specialist services. This means that substantial additional funding would not be required to support these services; instead this could be delivered from within existing system resources.

Wider dependencies within the Wantage & Grove area

124 The following were identified as dependencies relating to the provision of clinic-based planned care services within the community hospital:

Role of the GP health centre

125 Some planned care services are currently provided at the health centre alongside GP services. Currently this includes District Nursing, Health visiting and community dentistry. As part of any considerations around services to be located within the community hospital, there is an opportunity to review the services within the health centre and also whether some of the services currently provided within the community hospital would better be provided from the health centre.

126 As part of this work it was also considered whether there is any opportunity to expand the number of services provided at the health centre, however, it has been advised that there is no additional capacity within the building to increase the number of clinics provided there. Consideration could be given to deliver services at alternative times outside of current health centre operating hours, subject to resource requirements and appropriate measures being able to be put in place.

Kingsgrove & Grove community hubs

127 Other local sites have also been considered as dependencies within this type of service provision. In particular, the development of additional community sites within the local area including community hubs at:

- Kingsgrove (due to be completed in Summer 2025)
- Grove (timeline still under development)

128 As part of any future discussions these options should be considered to identify any services which would better be located at sites other than the community hospital.

Summary & Recommendations

129 Since 2021, a pilot of outpatient clinics made up of a range of service types has been offered at the hospital. These services have been largely well received by the local community and were positively reported on as part of the engagement work. In particular, respondents highlighted the benefits of not having to travel to access regular appointments. The data shows that these types of services are the ones needed most frequently by the majority of patients. Should the decision be made to not reopen the inpatient beds there would be an opportunity to significantly increase the number of these clinics available within the hospital

130 In this eventuality, the NHS partners are committed to dedicate appropriate additional resource to co-produce the business case for expansion of the services offered from the hospital, complete the work to redevelop the hospital and to work with OUH specialty departments, NHS partners and other planned care providers to deliver these.

131 **In relation to planned care clinic-based services it is therefore recommended that:**

- **ICB, OHFT and OUHFT work to confirm the existing outpatient services currently being delivered in Wantage Community Hospital.**
- **ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

B: Urgent care (minor injury, illness and mental health issues)

132 Alongside planned care services within a clinic, consideration has also been given to services which people need urgently. A range of these services have been reviewed as part of this project which include unplanned services including minor illnesses, injuries and mental health crisis.

The current service offer

133 There are many reasons why someone might need an appointment on the same day. As noted within the case for change, the local population is ageing, and there is an increased complexity of care needs. This means that it is important to consider the different types of urgent care needs that are required currently and in the future.

A. 111 service

134 The 111 service provides an initial assessment, and signposting to same-day healthcare services; this includes 'option 2' to seek mental health support on the same day.

B. Minor Injuries Units (MIUs)

135 MIUs are for injuries, such as deep cuts, eye injuries, broken bones, severe sprains, minor head injury, minor burns and scalds. There are currently two MIUs in Oxfordshire, one in Abingdon and one in Witney.

136 On average a resident of Oxfordshire visits an MIU once every 7 years. The most recent data available tell us that the Wantage & Grove population made 1361 visits to an MIU over one year, which equates to an average of 3.7 total visits from this area to an MIU a day. (164 visits a month to Abingdon MIU).

137 When considering forecast population growth and assuming similar demand patterns, the average number of visits from Wantage and Grove area could increase to 4.8 visits a day to an MIU (1745 visits per year).

C. Emergency Department (A&E)

138 If you have had an accident and contacted the 111 service, you would usually be recommended to go to a Minor Injuries Unit (MIU) or the Emergency Department (ED). From Wantage the majority of patients go to the John Radcliffe (23 miles from Wantage) or the Great Western in Swindon (34 miles from Wantage). Between 2017 and June 2023, 53% of patients attended an OUH site, 36% an Oxford Health MIU and nearly 5% the Great Western hospital site.

D. Ambulatory Assessment Unit or Emergency Multidisciplinary Unit (EMU)

139 Where an older person needs additional assessment which cannot be provided at home then they may be referred to an ambulatory care service. Within the community this would usually be to either Abingdon or Witney Emergency Multidisciplinary Unit (EMU) or the John Radcliffe Ambulatory Assessment Unit (AAU).

140 Between April 2021 and August 2022, the vast majority of patients from the Wantage area who required these services, were usually referred to Abingdon EMU (387 patients) or the John Radcliffe AAU (847 patients) rather than Witney EMU (only 18 patients).

E. GP same day appointment

141 In addition, people can also contact their GP to access a same day appointment. This is a key part of the same day care offer for minor illnesses. Across the two Wantage and Grove GP practices an average of around 800 same day appointments are offered each week.

F. GP Out of hours

142 Outside of GP practice hours, patient support is provided by the out-of-hours GP service. Where a patient needs to be seen they can either attend an out-of-hours base or can be seen at home. Where a patient from the Wantage and Grove area requires a base visit they nearly always go to Abingdon. On average over the period of April 2019 – March 22, this equated to 83 patients per month. In addition, when a patient needed to be seen at home there were, on average a further 35 home visits per month by the out of hours GP team over the same period.

G. Mental health crisis support hubs

143 Mental health access on the same day is through the 24/7 Mental Health Helpline (via 111) or through referral to a crisis support hub.

Engagement feedback on urgent care (see appendix B for further details)

144 Suddenly being presented with the need to seek urgent treatment can be stressful and people reported sometimes being at a loss around the most appropriate first port of call. This was reflected both in responses in the focus groups and the multiple options quoted in the wider survey when people are asked where they would turn in such circumstances.

145 With the A&E department at the John Radcliffe hospital seeming so far away and feeling quite inaccessible, people feel that only the most serious injuries merit seeking help there. Although some cited Abingdon as an alternative, getting there can also pose a challenge.

146 When asked specifically how urgent care can be made more accessible, the clear response is the provision of a minor injuries unit (MIU) as well as clearer information around the options available to deal with these cases. Many residents were keen to see such a unit provided locally and see Wantage Community Hospital Community Hospital an ideal site. Some remember fondly a similar service provided locally and would like to see it return.

147 Jargon is an issue here. It is important to note that due to the large number of clinical terms used to refer to urgent care services, there may be some confusion among members of the public about which services would meet a specific need. An MIU for example, has a specific meaning within healthcare management, but may be used by a non-specialist to cover a broader range of services.

Options identified

148 There are a range of types of same day care which could be provided within the community hospital which have been considered within this project:

Whole population services

149 There are a range of similar urgent care services open to the whole population, of these three have been identified which could be provided at Wantage community hospital:

A. Nurse/AHP led first aid service

Like a MIU but with narrower criteria, run by a team of highly qualified nurse practitioners with a lot of experience and expertise in the treatment of minor injuries. Does not have access to x-ray facilities https://www.oxfordhealth.nhs.uk/service_description/minor-injuries-units/

B. Nurse/AHP led minor injuries unit with x-ray on site
See above, an urgent service for those who have had an accident but do not need to go to an emergency department (A&E).

C. GP led urgent treatment centre with x-ray on site
Urgent treatment centres provide medical help when it's not a life-threatening emergency. They can diagnose and deal with many of the common problems people go to A&E for. Unlike MIUs they are overseen by GPs.

Specialist urgent care response for those with long term conditions

150 Based on public feedback and stakeholder discussions, one urgent care service that has been proposed for development at the hospital is an urgent care service for people experiencing a worsening of their long-term health condition(s) that requires a prompt review by a multi-professional expert team, avoiding the need for an acute hospital attendance or outpatient referral.

151 This service would focus on providing a rapid response to local residents with complex health needs, including people who live with multiple long-term health conditions (LTCs) and older people with frailty. It would provide rapid access to nurse- and therapist-led assessments, therapies and treatment interventions at the hospital for people identified by a suitable healthcare professional as needing same-day/next-day care to manage a flare up of a known long-term health condition, in order to prevent this from further deteriorating.

152 The service would integrate closely with the planned care Integrated Neighbourhood Team being developed in Wantage between the GP practices (Primary Care Network) and the community services (District and Community Specialist Nursing teams). It would also link closely with the relevant consultant-led specialist services, such as the diabetes, cardiology/heart failure, respiratory, geriatric medicine and neurology teams in secondary care.

Enabler considerations

Estates implications

153 If it were decided to develop a same day offer at the hospital this would align with the redevelopment of the ground floor as clinic spaces. This could be offered alongside planned care clinic spaces. The capital considerations to do this are therefore as above to develop clinic space.

154 If the decision were taken to install x-ray services at the hospital, this would have significant additional costs made up of a one-off capital investment for the estates works as well as equipment and ongoing maintenance costs. However, consideration will be given moving forward to the diagnostic options that could be included within any future provision.

Workforce implications

155 There are significant workforce pressures associated with the specialists needed to run urgent-care services so consideration would need to be given to the impact this would have on other local services and challenges associated with recruitment. In particular, were a GP led unit to be developed this **c**ould impact on the local GP services recruitment. Radiographers are also very hard to recruit so if an x-ray service were to be developed consideration would need to be given to the impact this might have on other local services and the sustainability of the service offer.

156 In contrast, the multi-disciplinary team needed to provide specialist urgent care could be brought together through improved co-location and collaboration between existing teams. This would therefore be a more sustainable offer.

Wider dependencies within the Wantage & Grove area

157 The following were identified as dependencies relating to the provision of same day care services with the community hospital:

Walk in minor injuries at the health centre

158 Alignment with services at the health centre is important as highlighted within the enablers around managing workforce pressures. Consideration has been given to whether urgent care could be provided within the health centre in line with the expanded GP offer, however as highlighted earlier there is very limited space at the health centre and concerns have been expressed around how this would be staffed so any proposal would need to address these issues.

Alignment with the Primary Care Network (PCN) frailty service

159 Work is currently in progress to develop same day services to patients with long-term conditions and frailty, who may have more complex health needs. The integrated neighbourhood teams within the GP practices to support patients with identified long-term conditions. Clinicians from the PCN have been involved throughout the discussions to date and are supportive of working alongside this project to support development of preventative care within the local area.

Summary & Recommendations

160 There are a range of urgent care services currently available to residents of Wantage including an MIU in Abingdon and A&E departments in Oxford and Swindon. The type of service required for this type of care and the frequency with which it is needed is much more varied. Within the engagement work, local access to these services was identified as a priority by many respondents, although not all felt this needed to be within Wantage, particularly if it conflicted with the planned care services that could be provided from the WCH site. The most popular services identified were those with an x-ray service, either an MIU or a UTC. However the cost and challenges associated with staffing this are significant. Therefore, although this option was preferred by many, it is not considered to be affordable or sustainable within the current service model.

161 The other area within urgent care which was identified relates to the complexity of patient needs which is increasing alongside the ageing population. Looking to the future, it is important that services address this challenge. In this regard, we will develop clinics to bring together a range of specialist clinicians to provide urgent care for those with identified conditions who are experiencing a health crisis. These clinics would help avoid unnecessary hospital attendances and admissions and ensure that they are given a holistic care offer. These clinics could be provided within the same space as outpatient clinics. It is therefore recommended that we include specialist same day care within the development of a business case for clinic-based services in Wantage.

162 **In relation to clinic based urgent care services it is therefore recommended that:**

- **Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.**

- **Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

Summary of project outcomes and next steps

163 To summarise the above, the following recommendations are made on the basis of this report:

164 **In relation to inpatient beds and the alternatives:**

- **Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage Community Hospital are permanently closed.**
- **In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.**

165 **In relation to planned care services:**

- **ICB, OHFT and OUHFT work to confirm the outpatient services currently being delivered in Wantage Community Hospital.**
- **ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

166 **In relation to urgent care:**

- **Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.**
- **Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

167 Therefore on the basis of the work done to date through the co-production with local stakeholders and the feedback from the local community as reflected above, it is recommended that the closure of the community inpatient beds is made permanent.

168 If the above is confirmed, then our preferred option for the ground floor is to continue to work collaboratively with local stakeholders to:

- NHS partners to work with local community to progress with an application in 2024 to The Vale District Council Community Infrastructure Levy (CIL) fund to provide necessary capital to support a sustainable range of outpatient and community clinics to be delivered from the ground floor of the community hospital building.
- Continue to work with the countywide end of life project and with local care homes to strengthen the local palliative and end of life care offer.

- Agree to further develop and confirm a range of outpatient services and community clinics through a detailed proposal of which services, operating hours, estimated activity will be delivered from within the community hospital.
- Develop urgent care offer including consideration or diagnostics for those with long term conditions and work with GP practice to support local urgent care for the wider population.

Proposed Future Project Delivery Plan

169 If the recommendations described in this co-produced report are endorsed and accepted following consideration through the governance framework of BOB ICB, OHFT, Wantage Town Council Health Sub-committee and Oxfordshire's HOSC, then the following proposed project delivery plan would realise the ambitions described in the report and secure a sustainable future for Wantage Community Hospital.

170 OHFT Estates and Facilities are a dedicated specialist team that manage and operate the estates infrastructure for the Trust across its entire operating footprint that encompasses Oxfordshire as well as Buckinghamshire, Bath, Swindon and Wiltshire. The specialist team have been engaged throughout the co-production process and have provided advice and guidance to help inform the final options and recommendations in this report. The team have a track record of delivering significant estate refurbishment and reconfiguration works working closely with services, community partners and other key stakeholders. If the report recommendations are agreed, the Estates Team would directly support delivery of the refurbishment works at Wantage Community Hospital by assisting with architectural design through to required NHS building design specification to meet such things as infection prevention and control through to informing procurement of contractors and fit out stage to works completion. Alongside, OHFTs Transformation Team would provide the required project support and co-ordination with the sub-group formed from the stakeholder reference group (the sub-group) and the other NHS provider partners.

Date	Action
Jan 24	Wantage Community Hospital report recommendations agreed.
Jan-Feb 24	Notification to Vale District Council by NHS partners to apply for £600k CIL funding for Wantage Community Hospital and provisional allocation confirmed.
Feb 24	Small proportion of provisional CIL funding allocation confirmed to enable appointment of Project Team to work alongside OHFT Estates and Sub-Group
Feb 24	Long Term Condition (LTC) and frailty Wantage pilot commences through Integrated Neighbourhood Teams (INTs) Oxfordshire Improvement Programme and Oxfordshire's Primary Care Strategy
March 24	Project Team commence
March-May 24	Project Team alongside sub-group work with NHS providers including OH, OUH, local PCN, MSK and GP feds to confirm which clinics/therapy/assessment type services for the ground floor. Estates design and costings finalised. Art therapy plan confirmed. Re-establish activities through Wantage Community Hospital League of Friends
Jun 24	Business Case and full CIL application submitted to Vale District Council.
Jul/Aug 24	CIL decision confirmed (estimated awaiting Vale confirmation of likely decision timeline)
Sept-Oct 24	Procurement of contractors for refurbishment and fit out.
Nov 24	Estates improvement works commence and any temporary relocation of services whilst works takes place put in place
Jan/Feb 25	Works complete. CIL project work concludes.

Feb -June 25	Service configurations confirmed and transfers take place.
Summer 25	Wantage Community Hospital service portfolio is managed through usual NHS system mechanisms.

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Appendices

Appendix A: List of outpatient services

The following outpatient services are currently being piloted within the community hospital:

- Ophthalmology, including intravitreal (eye) injections
- Audiology & Ear, Nose & Throat (ENT)
- Mental health services (Adult mental health, psychological therapies Oxfordshire Talking Therapies, neuro-developmental)
- Learning disabilities care
- Diabetes screening
- Health visiting clinics including group sessions
- GP clinics
- Expansion of MSK/physiotherapy by Connect Health
- Health Share providing ultrasound clinics

In addition, the following services have been established at the hospital for a longer period of time (with a temporary suspension during the early part of the COVID-19 pandemic):

- Podiatry
- Adult & children's speech and language therapy
- Children's Integrated Therapy Services (e.g. speech and language, occupational therapy, SEND)
- MSK/Physiotherapy
- Maternity Unit (upstairs)
- School Nursing Team (not clinic-based)

Appendix B: Full engagement report

See attached document

Appendix C: HOSC history of wantage community hospital

https://mycouncil.oxfordshire.gov.uk/documents/s66454/Annex%201%20-%20Wantage%20Community%20Hospital%20Timeline.pdf

Appendix D: Map of community hospital inpatient locations

Appendix E: Statements of support from Partner organisations

Oxford University Hospitals NHS Foundation Trust statement of support:

See attached document

Oxfordshire County Council statement of support:

This approach aligns with and is supported by Oxfordshire County Council whose strategic vision is to support people to live happy, healthy lives here in Oxfordshire achieving this by supporting people to live well and independently within their communities, remaining fit and healthy for as long as possible which they refer to as the Oxfordshire Way. It is important that we work together as system partners to achieve better outcomes for the residents of Oxfordshire.

Karen Fuller (Corporate Director Adult social care)

Partner statements of support:

Further statements of support to follow week commencing 8th January

verve

REPORT

Wantage Community Hospital Public and Stakeholder Engagement

Author: Clive Caseley and Sue Clegg
Date: 01 December 2023

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1. EXECUTIVE SUMMARY

1.1 OVERVIEW

This report collates and presents an analysis of residents' views heard during public engagement on community healthcare services in the Wantage and Grove area. It has been independently written by Verve Communications, and our team facilitated a series of events during the engagement period to complement a survey conducted by the NHS team which was open from 11 October to 06 November 2023.

Our brief for the project was to explore the types of services residents would like to be provided locally, including those services which might be provide from Wantage Community Hospital. In analysing both the survey, meeting notes and other feedback, we were asked to focus on three specific alternatives (referred to throughout this report as "scenarios"):

1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.

1.2 FACTORS DRIVING PREFERENCES

- Travel and convenience. The major benefit of outpatient services provided locally is accessibility and convenience, and this is the same for local provision of a Minor Injuries Unit (MIU) for Wantage residents. Having to travel to and find parking at the John Radcliffe in Oxford or to the MIU at Abingdon is seen as a major inconvenience, especially when these journeys need to be made frequently or when already in some distress. This is compounded for those without cars.

- Filling a genuine gap. Residents took a generally pragmatic approach in prioritising the services they wanted to see. While it would be nice to have everything locally, people do realise that this is not possible and only want to see services made local that fill a genuine need or at least optimise added value (as with eliminating travel time above).

- Familiarity and stability. Those who are aware of and have used some of the existing piloted outpatient clinics at the hospital are reluctant to see them removed. In the focus groups every individual cited these outpatient services as something they felt it was important to be offered locally with many also feeling that the Wantage Community Hospital was the best site from which to provide these services.

- Services that people need regularly. The feeling was that clinic service provision should prioritise the kinds of tests and clinics that require people to go on a regular basis, rather than focus on services that someone might need on, say an annual basis. This makes sense on an individual level - however not everyone will need the same services at the same frequency.

- Whatever is provided, it must be done well. Not unreasonably, residents seek reassurance that any services that are provided will be adequately resourced and fully functional. Thus, they qualify preferences with questions such as whether a Minor Injuries Unit (MIU) would be equipped with an X-ray machine and whether it will be open outside 'office hours', or whether the capacity for nursing support will be available at any inpatient facility.

1.3 WHAT IS IMPORTANT TO PEOPLE?

Within Scenario 1 (Clinic Based Services and Planned Care Appointments), the retention and expansion of outpatient services currently being piloted at the Wantage Community Hospital are strongly supported. Those who are aware that these services are currently being provided are loath to see them disappear, especially if they or someone they know has used them.

If not provided at Wantage Community Hospital, then the clear feeling is that these services should be retained locally. Thus, there will be a cohort of the local population who will feel that they have lost something if this is not part of what is offered either at best at the hospital or at worst elsewhere locally.

Within Scenario 2 (Community In-patient Beds and Alternatives), calls for some form of rehabilitation bed provision strongest. Here too, if this is not provided at the hospital it is acceptable that it is at least provided locally. Although not a statistically valid exercise, the data suggests that overall inpatient beds are seen as less of a priority than other services.

Servies within Scenario 2 delivered at home seem to be less of a priority, although they are clearly seen as eliminating the inconvenience of travelling to visit patients at regional hospitals and supporting carers. Views from those with experience of these services were mixed – some had a positive experience, while others were less positive, citing the level of support available and examples of poor communication, and rushed provision.

Within Scenario 3 (Urgent care), the strongest call was for a minor injuries unit (MIU) which people feel would be a valuable addition to the healthcare services provided locally, and for which Wantage Community Hospital would be an ideal location. This is the only service within Scenario 3 that gets much traction, with others felt to be well covered already elsewhere.

It was felt important by some that, if provided, this must provide a comprehensive urgent care offer e.g. X-ray with capacity for reasonable opening hours.

1.4 NEXT STEPS

We understand that this engagement was undertaken at one point in time in a longer-term process. From everything we heard during the project, some strategic next steps suggest themselves, and we set out some high-level questions for next steps relating to these:

- How to focus dialogue about needs and services from the 'place' perspective
  Wantage Community Hospital – and its history – represents more than a 'bricks and mortar' health facility. The pride, sense of ownership, and local identity are palpable, and could play a hugely valuable role in making community healthcare services in Wantage and Grove successful - and a real asset for this growing community in future.

- How to manage expectations around choices and trade-offs
  Whatever decisions are reached, it will be important for both the Stakeholder Reference Group (SRG) and the NHS to avoid giving the impression there are "winners and losers".

- What might future co-design look like?
  The involvement and commitment across agencies and institutions within (and beyond) the public sector stands out. Under the auspices of the SRG, a robust, inclusive process has been developed - arguably ahead of the curve in the design and commissioning of healthcare in partnership with communities.

2. BACKGROUND AND INTRODUCTION

2.1 CONTEXT

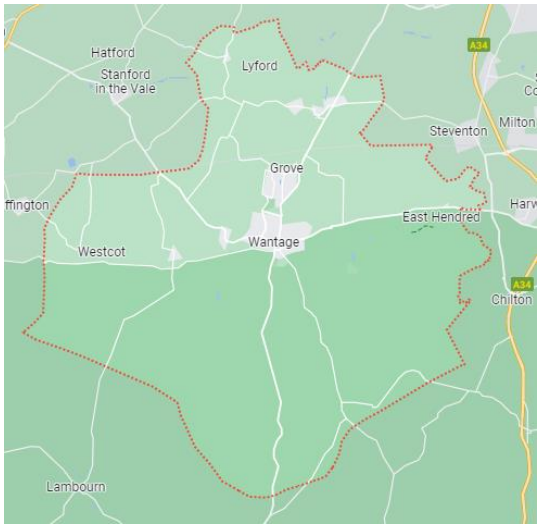
2.1.1 ABOUT WANTAGE AND GROVE

Wantage is a market town in Oxfordshire with just over 33,000 residents registered with local general practices. It has a population which is ageing and growing, largely within the Grove area. The total local population is forecast to grow to around 41,000 by 2030, and the proportion over 65 years increased in both the Wantage and Grove areas between 2011 and 2021.

As a result, the health needs of the local population are also changing, with both younger and older people living with more complex needs.

The area is within the local authority areas of Wantage Town Council, Vale of White Horse District Council and Oxfordshire County Council, and health services are within the purview of both the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the local Wantage Health Sub-committee of the Town Council.

The NHS commissioning body responsible for the population, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), was formally established as a new statutory body on 1 July 2022, replacing the three former clinical commissioning groups. BOB ICB is the commissioner of community healthcare and NHS services provided at Wantage Community Hospital.



OX12 boundary *Source: Fact*

2.1.2 ABOUT WANTAGE COMMUNITY HOSPITAL

Oxford Health NHS Foundation Trust provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset.

The Trust is the NHS provider of community healthcare services for the population of Wantage and Grove and manages the services provided by several providers (including the Trust) in Wantage Community Hospital.

Until 2016, Wantage Community Hospital provided inpatient beds, maternity care and a range of other NHS services from a single site over two floors. Due to Legionella risk, inpatient services were closed temporarily and, although remedial works to address this were completed in 2020, inpatient beds have remained temporarily closed.

Since 2020-21, the hospital could be re-opened fully, and is currently used to provide:

- On the ground floor - a range of services (clinical assessment, tests, treatment, therapy, follow ups) for the local community. A trial of a number of different specialist outpatient clinics have been running downstairs for the last 18 months, alongside these services.
- On the first floor – maternity services.

2.1.3 ENGAGEMENT ABOUT COMMUNITY HEALTHCARE SERVICES FOR WANTAGE AND GROVE

The community hospital inpatient ward has now been temporarily closed for almost eight years, and a partnership project has been established to consider the right mix of services for the future - with a focus on "hospital-like" services at Wantage Community Hospital in the context of local needs and other community health services available.

A co-design process has been developed by the NHS with the Oxfordshire JHOSC and the Town Council Health Sub-committee with a commitment shared across the partnership to work together, which was agreed at an extraordinary JHOSC meeting on 11 May 2023.

A Stakeholder Reference Group (SRG) has been appointed to shape this work (see Appendix 2 for membership of the SRG) and, from among its members, a smaller Sub-Group leads on engagement and has commissioned this exercise which reports to the SRG in the first instance.

The local community were previously asked for views about Wantage Community Hospital in what was called the "OX12 Project" between 2017 and 2019. However, this concluded without a decision and we heard prompted widespread community dissatisfaction. In addition, there have been stakeholder workshops over the course of 2023.

2.1.4 ABOUT THIS ENGAGEMENT EXERCISE

The starting points for this engagement exercise were:

- A shared commitment among NHS organisations and partners to retaining services in Wantage Community Hospital that are sustainable and best meet the needs of the local community (confirmed by the BOB ICB Place Director for Oxfordshire on 11 May 2023)
- No changes proposed to the current maternity services which are located upstairs in the hospital – and consideration of these is out of scope for this engagement.
- For use of the ground floor, a recognition that there is an opportunity to consider the service mix at an early stage and before proposals are finalised.

The SRG Sub-Group has developed three scenarios for services for consideration developed through a process of co-design informed by previous engagement and with input from residents, clinicians and NHS managers, and the SRG now seeks broader views from local people to help shape final proposals.

The central frame of reference for the project was therefore these three scenarios to explore the types of services to be provided from the hospital:

1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.

Through the co-design process, it was also identified that there may be needs for other types of healthcare provision locally to complement effective healthcare pathways, and the SRG also seek to understand residents' views on these links and co-dependencies.

2.2 OBJECTIVES

2.2.1 THE OBJECTIVE OF THE SRG

The stated objective pursued by the SRG is to provide sustainable "hospital-like" services from Wantage Community Hospital for the longer term to meet the needs of the local population now and in the future that maximises use of the available space. This is articulated in discussion by the Oxfordshire JHOSC (11 May) in the question:

> *How can we use space in Wantage Community Hospital to benefit the health and wellbeing of the local community?*

Within this, the objectives for community involvement set out in the specification for this project are to ensure that public, patients, and stakeholders have an opportunity to:

A. Receive clear and accessible information about the options for future delivery of services at Wantage Community Hospital (and potentially other local health sites in Wantage)
B. Provide input to the development of local plans for the hospital, through a process of meaningful community co-production.
C. Demonstrate their support for these plans, once developed.

This engagement exercise therefore helps to meet objectives A and B.

2.2.2 THE BRIEF FOR THIS ENGAGEMENT

The brief for this work was therefore set out:
The Wantage Community hospital engagement programme will use a blend of face-to-face and online approaches to gather as representative as possible suggestions and feedback from a wide range of participants. This will inform current and future decision making.

By providing a range of opportunities through an array of channels we will seek to make it as easy as possible for people to have their say and shape the future of health services based in the Wantage and Grove area.

Focus groups and deliberative events were selected because they are a particularly good approach where:

- Plans are at an early stage and the user perspective can influence thinking significantly.
- There are co-dependencies or trade-offs to consider.
- Complex choices require rich, well-informed discussion.

The objectives for this engagement are therefore:

- To provide scope and focus which will support the SRG and partners in the next stage of co-design.
- To explore views on the three scenarios and over-arching comments through a structured process.
- Identify themes which inform decisions moving forward, avoiding repeating earlier research and engagement.

2.3 ABOUT VERVE COMMUNICATIONS

Verve Communications was commissioned to conduct the engagement exercise and produce this independent report to inform the co-design process. We use social research methodologies to support transformation and change in health services, including with patients at the early stage of developing a vision for clinical pathways and new models of care.

We bring experience supporting NHS clinical programmes, service reconfigurations, mergers/acquisitions and spinouts, and workforce engagement, as part of which we specialise in independently conducting engagement and evaluation of consultation.

We are a values-led company, and our focus is involving patients, service users and communities in developing vision and plans for their care.

Our role in this project was to work with the SRG Sub-Group to develop and conduct the engagement exercise using a range of methods and to produce this independent report summarising the views of participants and making relevant recommendations.

We would like to put on record our grateful thanks to the Sub-Group and NHS staff for their patience and all their support during the project.

3. METHODOLOGY

3.1 OVERVIEW OF ENGAGEMENT ACTIVITIES

The engagement ran from 11 October to 06 November 2023. In conducting this engagement, a range of opportunities was provided for people to participate:

- Public workshops
  Two workshops were held in person at The Beacon Centre in Wantage. These were open to all - however participants were invited to register using the Eventbrite platform.

  The events were independently facilitated by Verve with a structured agenda which is described in this section.

- Focus groups
  An invitation event was held for patients or carers of people with long-term health conditions, held in person at The Beacon Centre, independently facilitated by Verve.

  Two online focus groups were also scheduled, with the aim of engaging people with an interest in community health services for families, and to provide an additional opportunity for those who are not confident with technology or were unable to attend one of the in-person events.

  Although a significant number of people signed up for the online events, across both events only a small minority turned on their camera and actively participated. This was obviously disappointing – however, facilitators noted all comments made by those who contributed, and their views are incorporated into this report.

- Community engagement
  Members of the SRG Sub-Group and NHS staff engaged actively with local people to provide information about the engagement, encourage completion of the questionnaire and to collect information.

  For example, the team went out and about in the Market Square, Wantage on Saturday 28 October and held a drop-in session at the Beacon Centre to answer questions and promote the questionnaire. The notes of comments and questions raised during this activity, as well as any relevant correspondence received, were also included in this analysis.

- Online and printed copy questionnaires
  The questionnaire was hosted on the ICB's Your Voice engagement portal and open throughout the engagement period.

  Printed copies returned during the engagement period were added to the online response to enable analysis of a single quantitative data set.

  The client team undertook quantitative analysis, producing tables and coding free text comments. As described in the approach to analysis section, the code frame was designed in collaboration with the Verve team, to enable comments from workshops, focus groups and questionnaire to be considered in this single integrated report.

3.2 GATHERING DATA

3.2.1 ABOUT THE QUALITATIVE APPROACH

This engagement used qualitative methods to ensure that people's views and experiences could be explored in detail.

As feedback was received through a variety of channels, we have aimed in this report to ensure that comments gathered are analysed to provide insight which will inform commissioning decisions as fully as possible:

- Feedback from all channels integrated into a single set of conclusions.
- Analysis of comments reported thematically, with the aim of understanding the reasons behind participants' views and priorities.
- Although this is a qualitative exercise, we will aim to comment on commonly emerging themes and/or where high levels of agreement are suggested by the data.

The aim of qualitative research is to define and describe the range of comments and emerging issues and to explore linkages, rather than to measure their extent. The use of qualitative methods means that this report is not based on collecting, or reporting, on the numbers of people holding particular views or experiences.

Please note that caution should be exercised in considering majority opinions suggested by the data:

- The research received views from a relatively small number of respondents in comparison with the population of Wantage and Grove; they were not selected randomly to participate; nor do they comprise a representative sample of residents.
- For these reasons we cannot assume that the proportion of people holding any particular views reflect those of the population at large.
- While we asked questions to explore preferences, it was made clear to participants that primarily the aim was to understand their priorities and inform complex decisions about future services – and it was emphasised that this did not represent a referendum or "voting" for any specific service.

3.2.2 RESEARCH CO-DESIGN

The public workshops and focus groups were designed to enable a single integrated report, and the discussion guide was developed using the same themes as the questionnaire with prompts designed to explore these questions in more depth. While we would expect the response to differ between cohorts of patients or different groups within the community, we are aiming to collect views around a consistent set of topics.

The central principle of co-design was incorporated into the methodology. The purpose of this engagement is to support the SRG and NHS clinicians and managers to make decisions about services for the future. It was designed to:

- Enable the SRG to take stock, having developed some over-arching service models.
- Hear the views of patients and public at this key stage in the process.
- Ensure that views are independently analysed to inform next steps.
- Produce a report to support and build on the co-design process.

The engagement was therefore shaped to explore views about the models ("scenarios") developed on behalf of the SRG, and this was the key focus for the process. We were seeking insights which, over the coming months and years, will inform:

- Thinking about current services and needs and local priorities for future services
- Understanding about how services are, or should be, integrated and joined up into a single local system.
- Focus on local health and care.
- Commissioning decisions about the future of Wantage Community Hospital and (potentially) other community health services.

While qualitative research allows deeper exploration of people's experiences and allows them to tell their stories in their own way, the addition of a questionnaire also enables the measurement of variables and comparison of data from different types of respondents – where justified in the data.

As ever, our aim is to create a clear, positive report focused on supporting effective decisions and implementation. This means:

- Seeking to understand not only the views people hold, but also the rationale and drivers behind views.
- Exploring priorities and indicating the most common theme and indicating likely majority views where these are suggested in the data.
- Picking up all substantive points made across the engagement, to enable a comprehensive and inclusive report.
- Covering the key elements of the scenarios, while also leaving open the opportunity for people to add relevant information, for example suggested alternatives.

3.2.3 FACILITATION

The workshop and focus group sessions were structured and facilitated by the Verve team of experienced engagement and research professionals, who used their notes and recordings to synthesise the material thematically under a set of headers relating to the scenarios under consideration; anything which was discussed which fell outside of the main themes was noted.

We created discussion guides (see Appendix 4) for facilitators to shape, stimulate and facilitate workshop and focus group discussions, as well as a simplified version for use during community outreach. We are grateful for the opportunity to attend meetings of the SRG Sub-Group as the three engagement scenarios were fleshed out which were especially helpful in preparing prompts for the discussions.

At the outset of each face-to-face session, facilitators sought permission to record the discussion to support accurate notetaking, and all sessions were conducted under Chatham House Rules (i.e. verbatim comments were not attributed to any individual).

At the end of the fieldwork debriefing discussions took place where all those involved in the fieldwork explored the main themes arising. The findings were then analysed, looking for major themes and identifying similarities and differences, where these exist.

3.2.4 PRIORITY-SETTING EXERCISE

To focus attention on people's priorities within the qualitative consultations, participants were asked to select the eight services across all three scenarios that they would like to see provided locally, though not necessarily at Wantage Community Hospital.

Respondents were given eight coloured stickers to distribute between the 20 service options set out in the questionnaire. These could be allocated singly to services, or multiple stickers could be allocated to higher priorities.

This was conducted as an individual exercise rather than a collective discussion, which was different from the rest of the workshop discussions and intended to provide a clearer steer on preferences with equal influence for each participant's opinions.

It is important to be clear, and it was explained to participants, that the exercise was neither in any sense a 'vote' or conducted on a large or representative enough scale to be statistically reliable. Nevertheless, with this proviso, a picture emerges of participants' priorities when responses are aggregated.

Once this first exercise was complete, respondents were given three further (differently coloured) stickers and asked to prioritise – again across all three scenarios – the three services they felt it was most desirable to be provided at Wantage Community Hospital.

3.2.5 RECRUITMENT

The engagement was publicised by the NHS team and a leaflet was distributed with QR code and URL link to the questionnaire as well as promoting participation at the events (see Appendix 3). Participants were invited to register in advance using Eventbrite. The promotional activity has been summarised and reported separately to the SRG Sub-Group (07 November 2023).

We are also grateful to the SRG Sub-Group for distributing material through their networks and via community locations.

4. SUMMARY OF PARTICIPATION

4.1 EVENTS AND SURVEY

	Participation
Public Workshop 1 11 October – 12.00 – 2.00pm	8
Public Workshop 2 17 October – 12.00 – 2.00pm	9
Focus Group 1 - People living with long term/chronic health conditions (in person) 11 October - 2.30 - 4.30pm	7
Focus Group 2 – Services for families and people aged 18-40 years (online) 19 October – 7.00-8.00pm	1
Outreach – Drop-in at the Beacon Centre and Market Square, Wantage 28 October	Approximately 30 people attended the drop-in session 5 comments gathered in 1:1 conversations
Questionnaire survey	285

4.1.1 ATTENDANCE AT EVENTS

Overall, the events relied on individuals coming forward voluntarily and they participants were heavily skewed to an older demographic, with well over half of respondents over 60. Women also make up a clear majority, representing around three quarters of the total sample. The same pattern was also evident in the survey response.

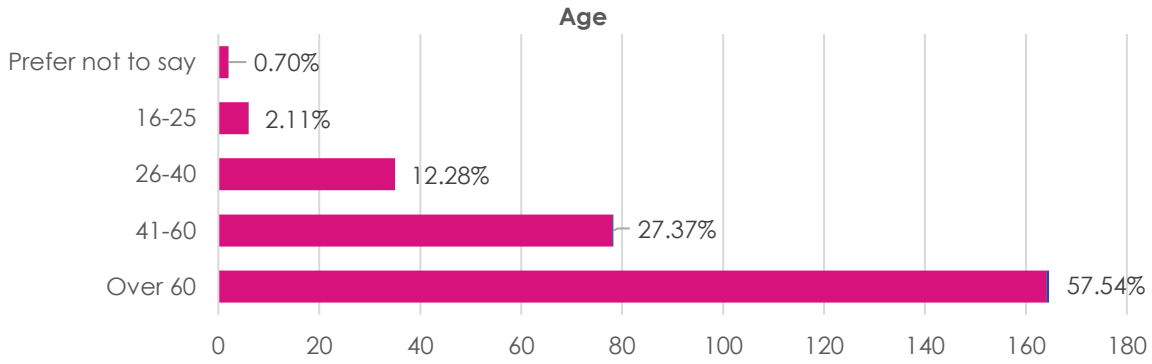
People serving as representatives or advocates for patient groups were well represented in the face-to-face focus group discussions. Nonetheless, residents' stated preferences and priorities in the focus groups are largely consistent with those that emerge from the wider survey exercise, suggesting a robust perspective has been gathered from the overall research study.

During the online sessions (in particular) it was clear that most of those on the calls were not from the Wantage area, but working with the client team we are confident that the contributions of the small number of local participants were recorded and kept separate and that views of non-participants were not taken into account.

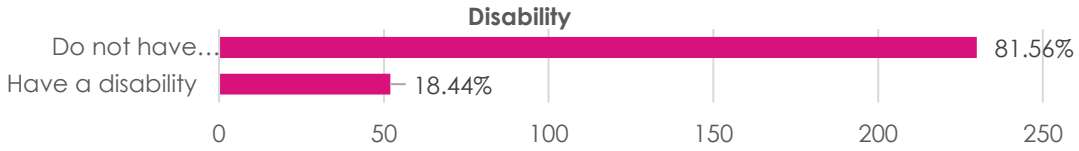
4.2 QUESTIONNAIRE

The questionnaire included demographic monitoring questions, and the profile of those responding was as follows.

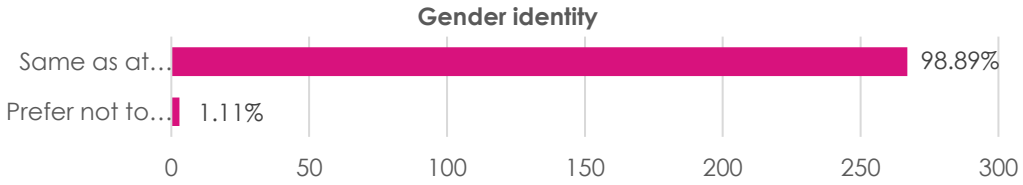
As accessibility and hence reach to individuals and groups experiencing health and other inequalities is an important element of this work, the background of those completing the survey is helpful to understand the perspectives and views we heard:



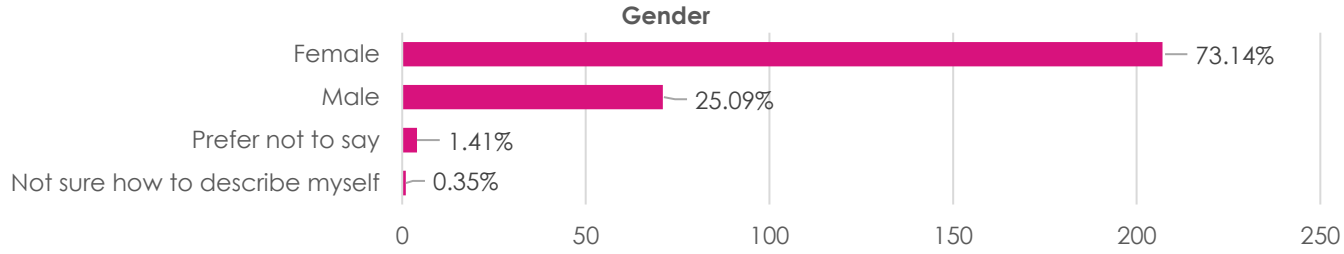
Base: All who responded = 283



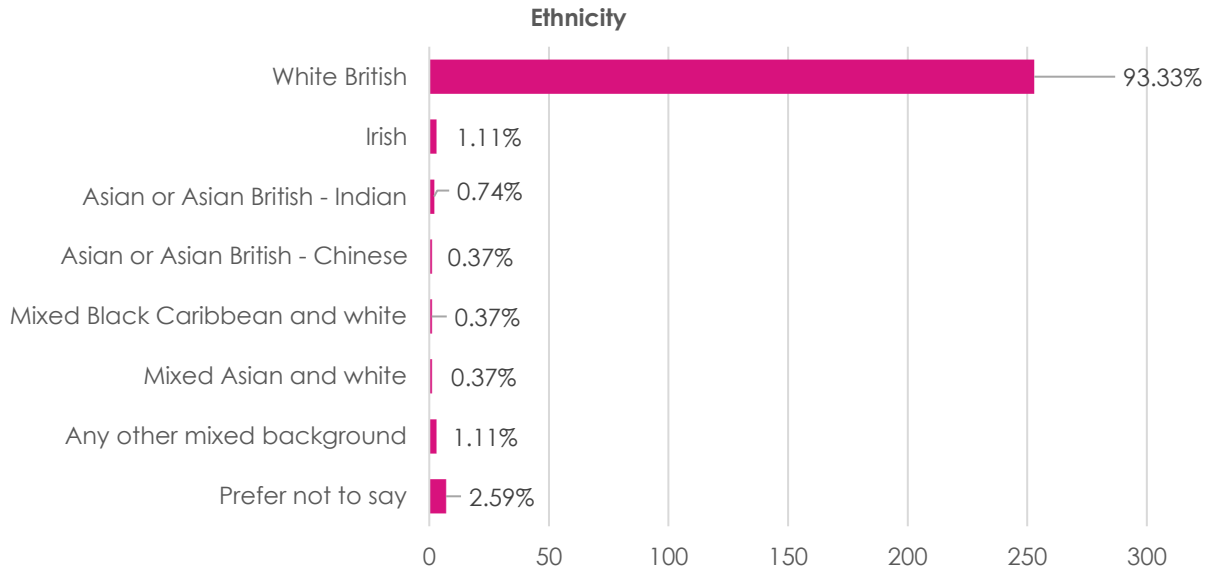
Base: All who expressed a view = 282



Base: All who completed question



Base: All who completed question = 283



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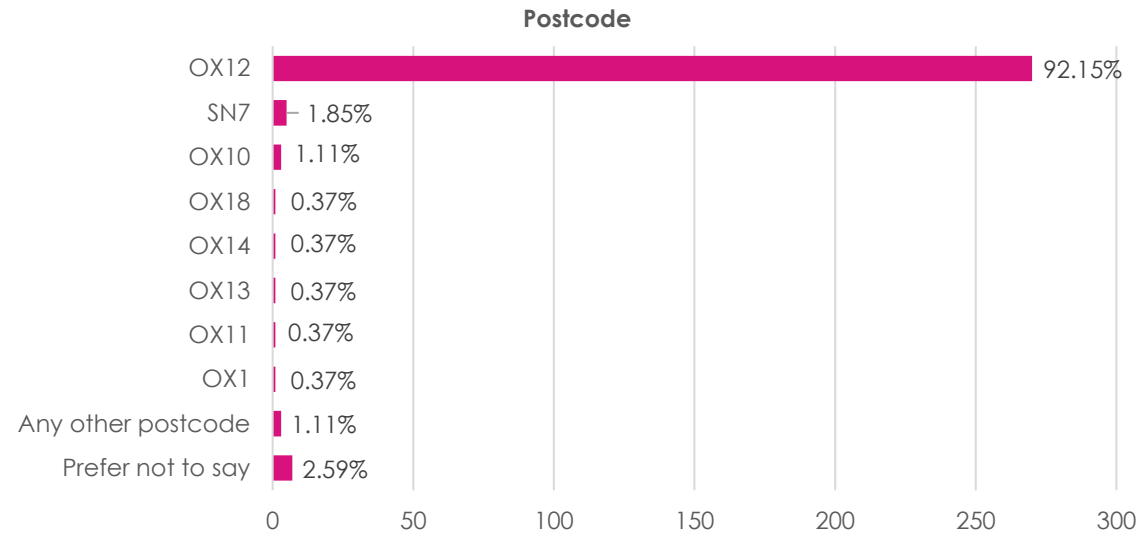


Base: All who completed question = 283

5. APPROACH TO ANALYSIS AND REPORTING

5.1 SUMMARY

The data collection approach for this project includes:

- Notes and recordings from public engagement workshops.
- Notes and recordings from face-to-face and online focus groups.
- Attendance at a local community festival (28 October) and other ad hoc comments received.
- An externally hosted survey, with questions developed by the SRG Sub-Group.

Analysis and reporting therefore incorporates a mix of qualitative comments and quantitative data, the latter derived from demographic monitoring survey questions.

Open questions with free text response in the survey and facilitated discussions at events were used to explore people's use of services, as well as their views on the scenarios and wider perceptions about local health and care.

Survey questions and prompts used at events were designed around the same topics in order to enable a single, consistent process for analysis. The discussion guide used at the workshops is attached for reference, along with the survey questionnaire.

5.2 IDENTIFYING THEMES

The central frame of reference for the whole project is the three scenarios developed through co-design by the SRG Sub-Group in light of previous engagement and with input from residents, clinicians and NHS managers:

1. Clinic based services (tests, treatment and therapy) for planned care appointments.
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate.
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day).

We therefore used these to structure discussion guides and the analysis. We should be clear that both development of the service model and NHS guidance around public engagement makes it inappropriate to regard this exercise too simplistically as a referendum between competing services.

Rather we are seeking to understand in more depth people's views and priorities to provide insight which will usefully complement clinical, financial and other data to inform commissioning decisions about future services.

5.3 INTEGRATING QUALITATIVE AND QUANTITATIVE DATA

5.3.1 QUALITATIVE ANALYSIS

In analysing qualitative comments, we aim to produce a comprehensive report which reflects all substantive points made and to explore the reasons behind people's priorities, especially where they may share the same or hold different views. These are reflected in the narrative report.

This report is set out thematic sections, and we aim to be clear where we are reporting:

- Individual comments (verbatims included to encapsulate key points)
- Inferences based on thematic analysis
- Our views and conclusions informed by comments received. These are based on Verve's experience and our understanding of the wider objectives of the engagement, and are set out in section 7.

The narrative report is complemented by an approach to "quantifying qualitative data". This is achieved by developing a coding frame in which similar answers are clustered together to develop categories.

This approach was used in the analysis of questionnaire free text comments by the NHS team. Each theme is given a numeric code (e.g. "I am concerned about xxxx" might be code 1, and "I am concerned about yyyy" might be code 2). The coding frame is constantly checked against new answers and modified if new categories were needed.

The advantage of this approach is that it provides an overview of the degree to which certain themes are raised more or less commonly, and also enables the analysis to "funnel" into more detailed comments on similar themes.

5.3.2 QUANTITATIVE ANALYSIS

Monitoring questions in the survey included five of the nine 'protected characteristics' identified in the Equality Act. Where survey respondents answered these, it is possible to produce a summary profile showing participation broken down by:

- Age
- Disability
- Gender
- Transgender
- Ethnicity.

6. REVIEW AND ANALYSIS

6.1 OVERVIEW

Residents' priorities around services that they want to see offered both locally and from the Wantage Community Hospital seem often to be strongly driven by prior experience, either personal or heard through word of mouth.

As for the priorities themselves, there are services participants valued across all three scenarios presented, though generally they understand that when opting for one type of provision, it means that other priorities may necessarily be excluded; that difficult choices need to be made.

6.2 SCENARIO 1 - CLINIC BASED SERVICES

Residents are aware of many of these services currently offered at the Wantage Community Hospital, many of which are "so well used", such as podiatry and ophthalmology. We understand that these are currently the most well-used services, and some of the participants had used these themselves.

People want existing services to remain now that they have become accustomed to having them and are loath to lose them. Because many of these services are located in Wantage Community Hospital, it seemed a reasonable proposition to participants to keep them there.

Ease of access that comes with a locally-based service is seen as the key benefit, especially when considering the alternative of having to travel to regional hospitals. The inconvenience involved in having to travel to the John Radcliffe in Oxford (especially) clearly weighs heavily on residents, and having appointments in Wantage is welcomed even by those able to travel further.

> *"Excellent, very well organised. When this appointment was made for me by my GP, I was expecting it to be at the JR, so was very surprised when I was told it was at Wantage. For such an appointment, I would have been quite happy to travel to the JR."*

For many people, however, travel and distance is a real issue. Those who drive cite frequent holdups on the main A34, heavy traffic and the difficulty and high price of parking once there, and we heard that travel issues are significantly worse for people reliant on public transport. Outpatient clinics, especially those which might require frequent visits, mean that the inconvenience and cost pile up to an extent that would cause real stress to patients and carers alike.

> *"It's so much easier than having to go to the John Radcliffe Hospital in Oxford which takes 90 minutes on the bus. It works very well. We used to go up to the JR and as you can imagine she's blind and very frail and for me it's an everyday trip but for her it's a trek and she's frightened of people bumping into her and you have the parking etc, so it's a godsend having it here".*

> *"Do not do away with the clinics now that they're there".*

The provision of local community healthcare clinics and therapies are relatively high on residents' priorities for what should be offered locally and, if possible, through the hospital. It is worth noting that in workshop introductions, the frame was "hospital-like" services. Services like podiatry and physiotherapy may have felt to participants very much like hospital outpatient services and hence seen to provide a coherent and consistent service offer.

Though 'nice to have', many question the need for a GP clinic at Wantage Community Hospital specifically. It was pointed out that there are several practices elsewhere in the area, though there were the complaints around the current availability of GP appointments and ease of communication with practices.

The feeling is that what is offered at Wantage Community Hospital Community Hospital needs to be well defined, with clear demand and avoid replicating services covered elsewhere.

> *"Most (if not all) of these outpatient clinics could be held upstairs at the Mably Way Health Centre"*

Two of the services considered drew a more polarised response. While many clearly value the provision of local children's services, others question provision through the Wantage Community Hospital. It seemed to some to be a specialism which would necessarily crowd out the more 'volume' outpatient and community services. This view was not shared by everyone, however, and – while the survey data suggests a relatively low priority for paediatric services – perhaps the older demographic profile of respondents explains this.

Similarly, while some stress the importance of mental health provision locally, others questioned why support for mental health should be offered at the hospital; they feel it is more of a specialised service and one that can be offered elsewhere – perhaps through specialist mental health facilities or primary care.

So we heard concerns to avoid spreading Wantage Community Hospital Community Hospital facilities too thinly and we heard the view that it is better to do a small number of things well.

Several questioned why online services were included in the list of potential services to consider as these can be located anywhere.

> *"You can do that out of an office block."*

Regarding digital services generally, participants have mixed views. Services such as eConsult and phone appointments were felt to be acceptable for relatively minor conditions, but if feeling really ill, filling out an eConsult can feel like too much.

Further, some elderly residents are either not online or find using digital services challenging without help: participants felt that those most in need of care often lack the digital skills necessary to negotiate the process.

There were criticisms of digital appointments in some instances. Some had themselves called on younger relatives to help them. If required, for instance, to post a photograph then a family member needs to be on hand, which is not always possible.

> *"There are areas on your body you can't photograph yourself". And "A lot relies of people's ability to negotiate the digital age, my husband is hopeless".*
>
> *"When you're my age it's not a good deal. When you're old you get very upset when things are not happening. You can't just phone up anymore and you get frustrated and bothered."*
>
> *"No amount of digital is going to substitute for face-to-face in any (minor injury) scenario."*
>
> *"If you're under stress it's very difficult to use the system even if you're a trained computer professional. I know from experience."*

Scenario 1 clinic-based services were the subject of most discussion during the focus group with people living with long-term and chronic health conditions, perhaps because these patients require frequent outpatient appointments and there were a mix of patients and carers in the group.

Their views were consistent with the wider groups and survey respondents, but the experiences we heard and the problems were more pressing, so views were strongly held.

Transport to appointments/services outside of Wantage is the main issue, and parking is often a problem – one person, caring for an elderly, visually impaired relative, said that it was difficult taking the person they care for to the John Radcliffe Hospital in Oxford:

> *"It isn't just that it's a long drive, but there are parking problems there too as there aren't enough Blue Badge spaces. So it's very traumatic."*

Travelling for appointments can also be difficult for people on the autistic spectrum, meaning that being able to be seen locally serves them better.

Many people are not eligible to use NHS transport services, and even when they are they sometimes have to wait hours for transport to take them home after appointments.

It was felt that some people simply do not attend appointments they find difficult to get to, for example those requiring eye treatments and people with mental health issues might find public transport daunting.

> *"So people just don't go"*

From an equalities perspective, given the local population demographics these patients probably face the greatest access challenges of any group.

6.3 SCENARIO 2 - COMMUNITY INPATIENT BEDS AND ALTERNATIVES

Across the range of inpatient beds, feelings were less strong and the consensus seemed to be that many of these services can be provided regionally rather than locally.

That said, thinking just about inpatient services, rehabilitation beds would be the clear priority over the other kinds of inpatient services discussed from the showcard - both locally and as something that could be provided through Wantage Community Hospital.

The rationale behind support for these services mirrors that behind support for local provision of outpatient clinics; the ease of travel. If visiting a loved one recovering in hospital involves a long, difficult and expensive journey, that is good for neither patient nor visitor.

We heard that having patients return closer to home to recover enables them to receive greater social support, which many believe helps to speed up their recovery, something from which all parties gain, including the NHS as it frees up a bed earlier.

Further, with care homes at full capacity, Wantage Community Hospital feels like a good place to provide these beds.

> *"My belief is that it's a very good step out from a major hospital to a community hospital."*

> *"Most of the care homes, to my knowledge are pretty well full up most of the time. There's no nursing home in Wantage that has any capacity at all."*

Some though, looking at the bigger picture, felt that if the price of providing rehabilitation beds is the loss of outpatient clinics, then the latter must be the priority - especially when looking at the relative demand for each service (based on the presentation handout made available during the focus groups).

Forcing a choice, participants tended to opt for retaining the outpatient clinics.

> *"I'd hate to have in-patient beds to the detriment of a lot of people losing out on all these outpatient clinics".*

Other inpatient possibilities – palliative care and specialist stroke rehabilitation beds – were felt to be best offered regionally rather than necessarily locally and, though it is difficult to find places, palliative care can be offered though care homes. These remain 'nice to have' options which are relegated down the order of priorities when residents are considering a range of alternatives and considering the trade-offs.

> *"I mean there's always give and take isn't there, and you've got to choose which beds you're going to provide."*

As an alternative to inpatient care, residents were asked to consider in-home care options: Hospital at Home, Urgent Community Response and Social Care Community Support for Reablement.

These services were seen as a high priority and provide a really good alternative to admission as an inpatient at a regional hospital, with consequent travel issues for visitors.

> *"Recently I needed Hospital at Home services which were excellent and saved me and my carer 3 weeks of daily visits to the John Radcliffe and got me well again without the need to be a hospital inpatient."*

Perhaps not surprisingly given its name, Urgent Community Response is seen as a priority for local provision, though not necessarily as something that should be offered through Wantage Community Hospital as it is, by definition, provided through home visits.

Collectively, these services are popular. Those with caring responsibilities reported feeling unsupported and would value being able to call on services like these to provide support and temporary respite from their caring duties.

> *"I'm unable to go on holiday".*

That said, knowledge of what help is available is patchy. Some reported that social services can be very helpful in providing funding for support, including home adaptations to help the carer and the patient cope better with their recovery.

Conversations around help at home highlight the importance of seamless communication between various healthcare strands.

Access to patient information is felt to be vital to be able to offer optimal care.

> *"With all medical records computerised there should be no reason for a paramedic arriving at your house without having a total history of the patient. There needs to be a one stop shop."*

The idea of Hospital at Home care was felt to sound good in that intuitively patients would be likely to recover better at home tended to by family in their own familiar environment.

> *"(My) mother in law had really excellent post hip op and stroke in-home care from specialist home teams for 6 weeks after. Without this she could not have come home."*

Contact with the Hospital at Home service by participants was limited, however some with experience of it reported being unsatisfied with the quality of delivery, with one describing it as "*absolutely appalling*".

We heard that poor communication was an issue, with carers unaware of the patient's circumstances and visits rushed, leaving carers, family and friends to fill in the gaps.

Reinforcing one of the key themes driving residents' views, this suggests that if a service is to be delivered, it has to be delivered well or not at all.

Just as both the focus groups and the wider survey highlight concerns around insufficient support for those undergoing rehabilitation at home, so we also heard a consistent list of what services residents feel might improve the situation.

GP support is key here as are sufficient availability of nurses, being able to access help and advice by phone and better interdisciplinary communications, so that any visiting healthcare professional will have a good knowledge of the patient's background.

6.4 SCENARIO 3 - URGENT CARE

Suddenly being presented with the need to seek urgent treatment can be stressful and people reported sometimes being at a loss around the most appropriate first port of call. Is it: 111; 999; visiting A&E (assuming there is one within reach and people have access to transport); MIU; calling their GP?

This is reflected both in responses in the focus groups and the multiple options quoted in the wider survey when people are asked where they would turn in such circumstances.

Clearly, the severity of the injury or condition can help drive people to a specific option, but we heard that this 'self-triage' can still be a challenge.

> *"Trying to negotiate which service you need and even getting a reply when you phone and when you're panicking".*

With the A&E department at the John Radcliffe hospital seeming so far away and feeling quite inaccessible, people feel that only the most serious injuries merit seeking help there.

Residents feel, though, that there is a range of relatively minor injuries which need medical attention, but which fall short of the threshold for A&E attendance.

Self-triaging these can be difficult. Some respondents gave example of experiences of this type of injury with relatives as evidence for the value of a local MIU. As well as the long journey to A&E – even by car – patients must often face many hours' wait to be seen.

However, though some cited Abingdon as an alternative, getting there can also pose a challenge.

> *"We want it brought back locally"*

> *"My husband drove to Abingdon with a very badly cut hand and didn't know if he'd get there."*

> *"Abingdon A&E is excellent, but it is difficult to get there so it would be good to have it available locally."*

> *"That 'urgent' bit, to have that more local is a huge reassuring factor, because you don't plan for it, do you?"*

When asked specifically how urgent care can be made more accessible, the clear response is the provision of a minor injuries unit (MIU) as well as clearer information around the options available to deal with these cases.

Many residents are keen to see such a unit provided locally and see Wantage Community Hospital Community Hospital an ideal site. Some remember fondly a similar service provided locally and would like to see it return.

While there is a MIU in Abingdon, this is ten miles away and for many, felt to be too far to travel Further. These views were justified by reference to the rising population in the area of both older

people and children – exactly the age groups expected to need such a service most and, for older people especially, the patients who might find mobility most challenging.

> *"They used to have the option of the nurse calling a GP if required. We've used that. Years back really. And it was very successful. We used it a number of times with our children . . . and it was very efficient and effective. I think it operated from about six in the morning until ten in the evening. That's quite good, isn't it? I thought it was excellent."*
>
> *"So as the population increases, you presume employment's going to increase. You could have quite a few people going into a minor injuries unit due to injuries at work, which wouldn't be picked up in this sort of survey."*
>
> *"if you could fit an X-ray service in as well, I mean that seems like a logical extension of a minor injury unit".*

Other services within Scenario 3 were seen neither as priorities for local provision or for siting at Wantage Community Hospital. A full A&E service is available at the John Radcliffe if the case is serious, and the First Aid service sounds too much like a 'nice to have' – so the MIU is a more popular priority. Further, any MIU ought to be able to dispense First Aid, so the distinction seemed a little academic to many.

Jargon is an issue here. Throughout discussions and the comments on unplanned care, we note a lack of public understanding and "incorrect" use of clinical terms which have a specific meaning within healthcare management, but sound interchangeable to the non-specialist.

Local Specialist Services sound like they could be offered within a MIU and while we heard many complaints about the difficulty of seeing a GP, Urgent GP Appointments sound like replication of a service which should be available anyway.

6.5 PRIORITIES

6.5.1 PRIORITY-SETTING

Participants at the workshops were asked to indicate two sets of preferences:

- Which services they would like to see locally. They were given eight 'tokens'
- Which services they felt should be offered from the Wantage Community Hospital. Here they offered only three options (so the numbers against the hospital will always be lower than against local provision).

Clearly numbers are very small and no statistical robustness is claimed for these figures. However, they do give offer an idea of the direction of residents' priorities.

The first exercise gives a sense of local priorities across community healthcare options more broadly, while the second is probably most usefully seen as indicating expression of preferences – especially of preferences between the alternative services presented within each Scenario.

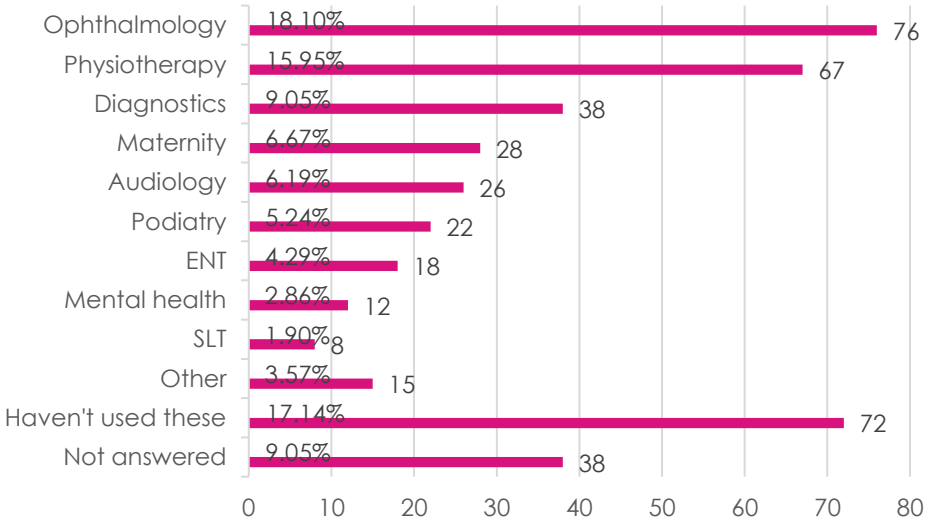
The summary of this exercise is shown in the table at Appendix 1, which indicates the levels of response for each of the 20 services described across all three scenarios.

6.5.2 SURVEY CODED QUESTIONS

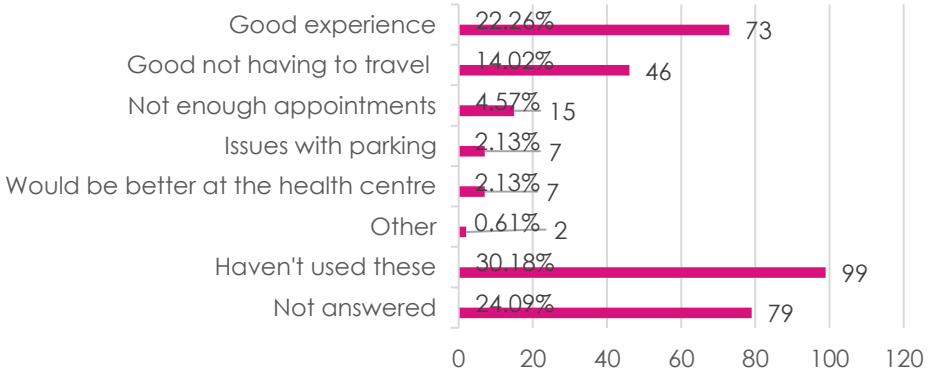
As described earlier (see 5. Approach to analysis and reporting) each free text comment received through the questionnaire was given a code to enable us to visualise the relative frequency with which each theme or comment was made.

These are shown in the following tables – there is one table for each questionnaire question.

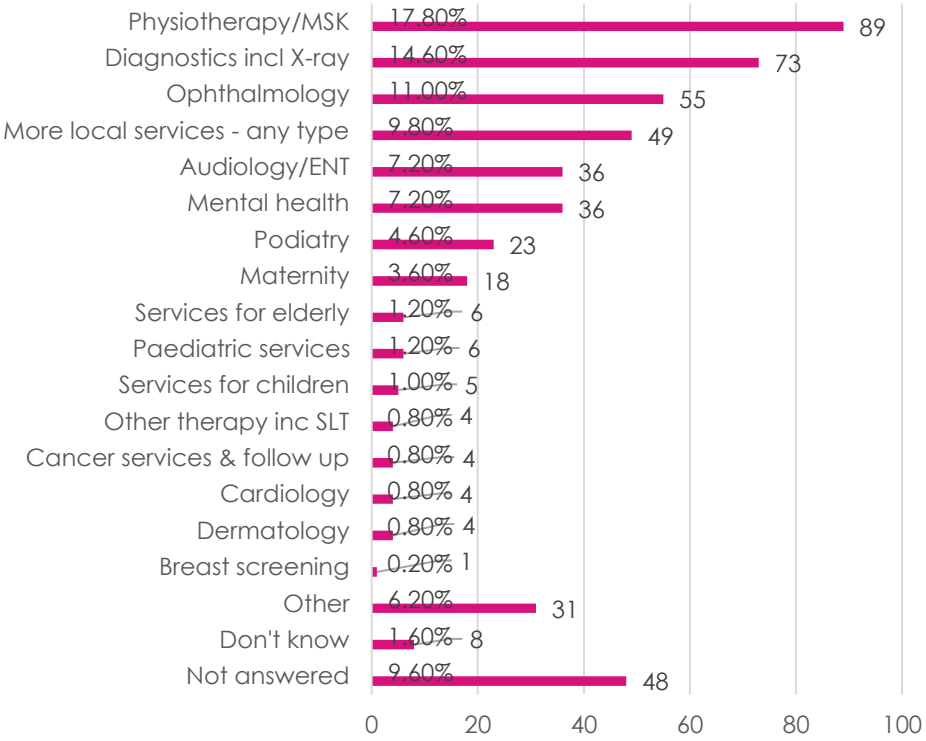
Q1. What type of planned care services have you or your family used or know about locally?



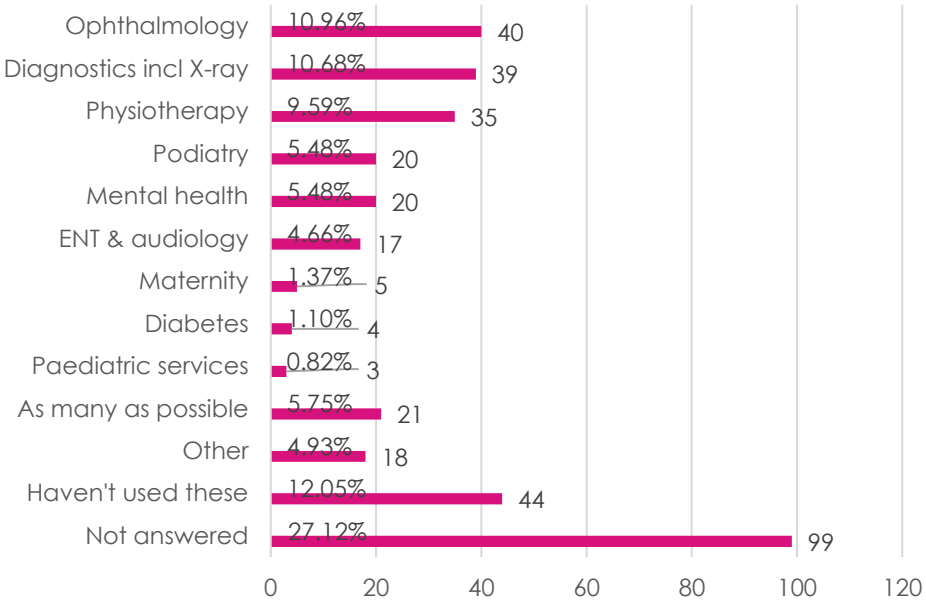
Q2. If you have accessed any of the outpatient clinics made available at Wantage Community Hospital (some of which have been running as pilots for the past 18 months), what has been your experience using them?



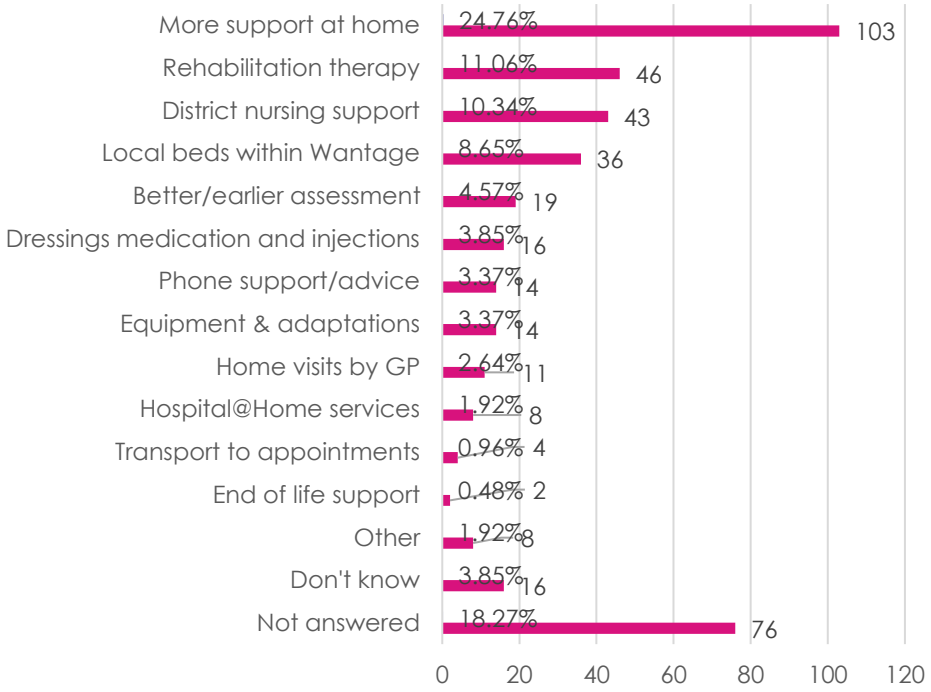
Q3. What types of planned care services would you value locally? These could be existing services (so a continuation) or services not currently available



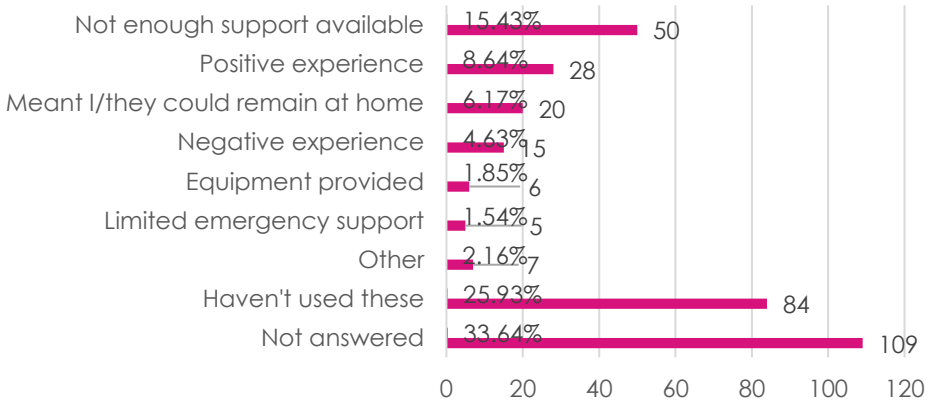
Q4. Thinking about the planned care services you or your family use most frequently (i.e., weekly or six-weekly), which services should be made available locally?



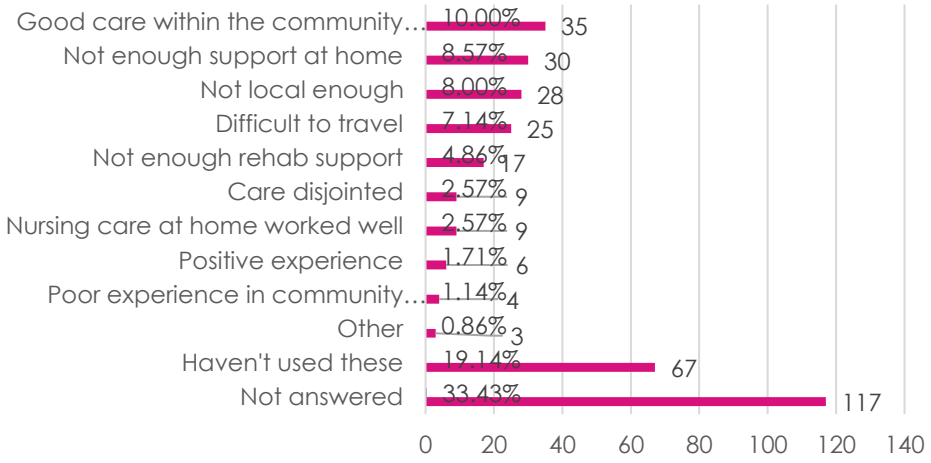
Q5. Most people return home directly from hospital. What type of help would get you or your family back to living independently and supported as quickly as possible?



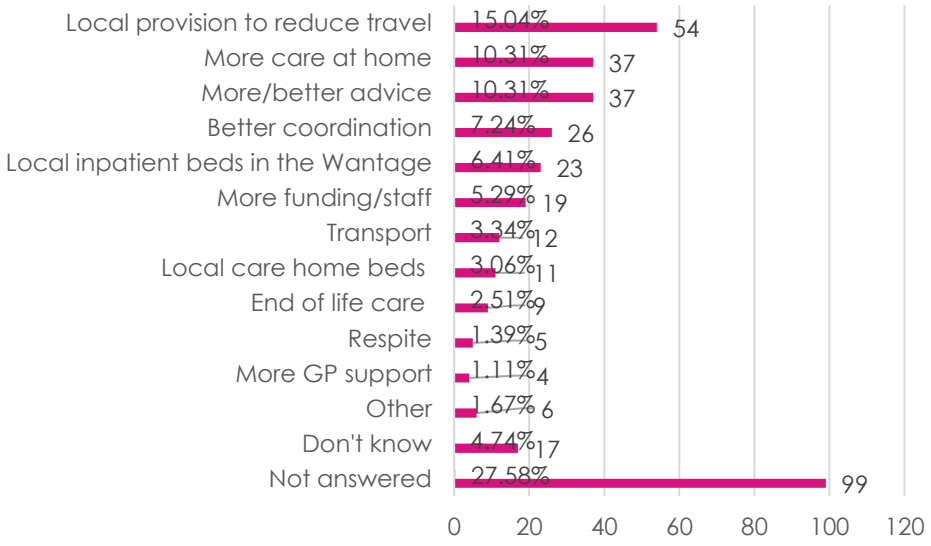
Q6. Can you describe your experience with services which support you and your family to remain at home during illness?



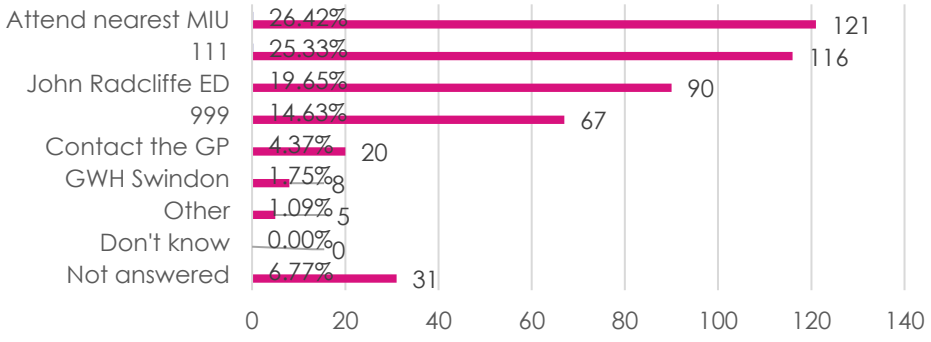
Q7. If you, or somebody you know, has accessed these services, can you describe your experience of care or rehabilitation in the following: other community hospitals; short term nursing and care home stays; palliative and end of life care outside of someo



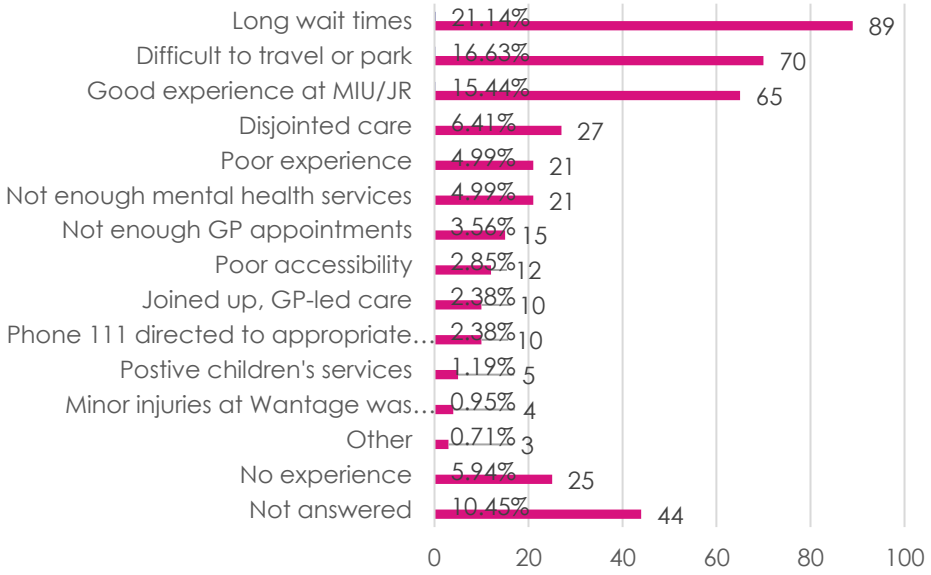
Q8. What would help to support you and your family in circumstances when you would need to access these types of services?



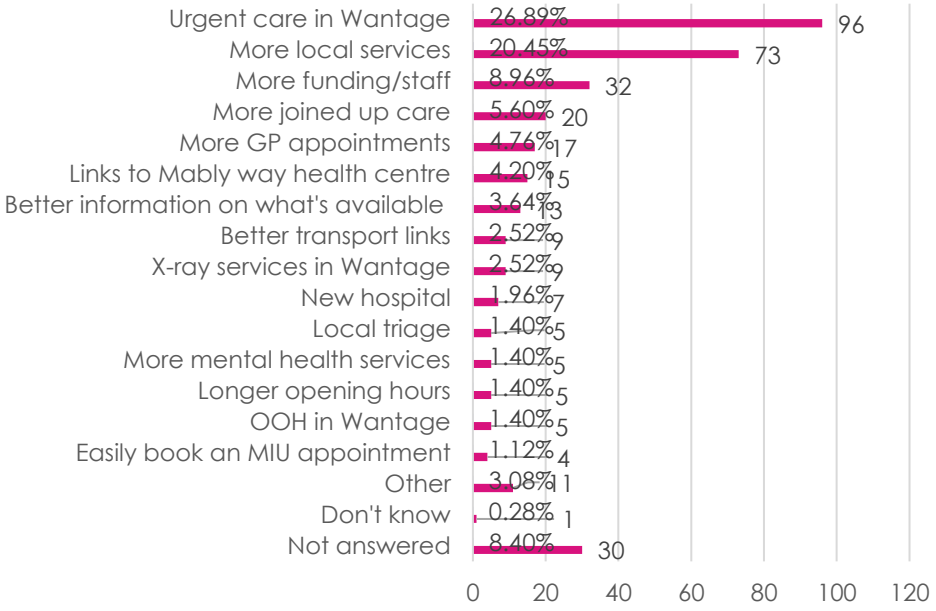
Q9. If you needed to access urgent care, what would you do?

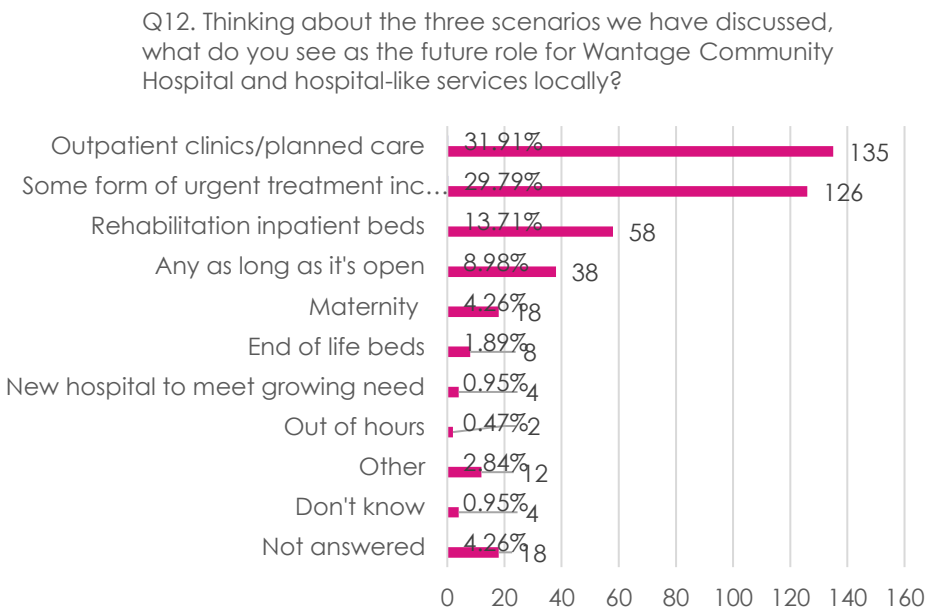


Q10. What has been your experience with accessing urgent care services for physical health and / or mental health issues?



Q11. How can we make it easier to access urgent care services for you and your family?





6.6 SCENARIO SUMMARIES

Within Scenario 1 (Clinic Based Services and Planned Care Appointments), the retention and expansion of outpatient services currently being piloted at the Wantage Community Hospital are strongly supported. Those who are aware that these services are currently being provided are loath to see them disappear, especially if they or someone they know has used them.

If not provided at Wantage Community Hospital, then the clear feeling is that these services should be retained locally. Thus, there will be a cohort of the local population who will feel that they have lost something if this is not part of what is offered either at best at the hospital or at worst elsewhere locally.

Within Scenario 2 (Community In-patient Beds and Alternatives), calls for some form of rehabilitation bed provision were strongest. Here too, if this is not provided at the hospital it is acceptable that it is at least provided locally. Although not a statistically valid exercise, the data suggests that overall inpatient beds are seen as less of a priority than other services.

Servies within Scenario 2 delivered at home seem to be less of a priority, although they are clearly popular and seen as eliminating the inconvenience of travelling to visit patients at regional hospitals and supporting carers. Views from those with experience of these services were mixed – some had a positive experience, while others were less positive, citing the level of support available and examples of poor communication, and rushed provision.

Within Scenario 3 (Urgent care), the strongest call was for a minor injuries unit (MIU) which people feel would be a valuable addition to the healthcare services provided locally, and for which Wantage Community Hospital would be an ideal location. This is the only service within Scenario 3 that gets much traction, with others felt to be well covered already elsewhere.

It was felt important by some that, if provided, this must provide a comprehensive urgent care offer e.g. X-ray with capacity for reasonable opening hours.

7. CONCLUSIONS

7.1 FACTORS DRIVING PREFERENCES

Factors driving preferences are:

- Travel and convenience. The major benefit of outpatient services provided locally is accessibility and convenience, and this is the same for local provision of a MIU for Wantage residents. Having to travel to and find parking at the John Radcliffe in Oxford or to the MIU at Abingdon is seen as a major inconvenience, especially when these journeys need to be made frequently or when already in some distress. This is compounded for those without cars.

- Filling a genuine gap. Residents took a generally pragmatic approach in prioritising the services they wanted to see. While it would be nice to have everything locally, people do realise that this is not possible and only want to see services made local that fill a genuine need or at least optimise added value (as with eliminating travel time above).

- Familiarity and stability. Those who are aware of and have used some of the existing piloted outpatient clinics at the hospital are reluctant to see them removed. In the focus groups every individual cited these outpatient services as something they felt it was important to be offered locally with many also feeling that the Wantage Community Hospital was the best site from which to provide these services.

- Services that people need regularly. The feeling was that clinic service provision should prioritise the kinds of tests and clinics that require people to go on a regular basis, rather than focus on services that someone might need on, say, an annual basis. This makes sense on an individual level - however not everyone will need the same services at the same frequency.

- Whatever is provided, it must be done well. Not unreasonably, residents seek reassurance that any services that are provided will be adequately resourced and fully functional. Thus, they qualify preferences with questions such as whether a Minor Injuries Unit (MIU) would be equipped with an X-ray machine and whether it will be open outside 'office hours', or whether the capacity for nursing support will be available at any inpatient facility.

7.2 QUESTIONS TO THINK ABOUT

The engagement brought comments about services which might be provided locally and, within this, from Wantage Community Hospital. The response suggests areas for consideration, both about needs and services, but also the future steps for involvement and co-design as the SRG and the NHS progress to the next stage.

7.2.1 HOW TO FOCUS DIALOGUE ABOUT NEEDS AND SERVICES FROM THE 'PLACE' PERSPECTIVE

Wantage Community Hospital – and its history – represents more than a 'bricks and mortar' health facility. The pride, sense of ownership, and local identity are palpable, and could play a hugely valuable role in making community healthcare services in Wantage and Grove successful - and a real asset for this growing community in future.

This suggests thinking about:

- Taking people on the journey: How to describe and involve people in the process? Where are people now, and what do they need to hear?

- Being clear and transparent: How to show the bigger picture of which community healthcare is a part? How to be clear on benefits and honest about constraints?

7.2.2 HOW TO MANAGE EXPECTATIONS AROUND CHOICES AND TRADE-OFFS

Whatever decisions are reached, it will be important for both the SRG and the NHS to avoid giving the impression there are "winners and losers".

This suggests thinking about:

- Making and communicating decisions: Which communication channels to reach people with consistency? How can all parties be represented? Who should be spokespeople?
- What to say and when: How to avoid news coming as a surprise? Who, how and at what stage to make announcements?

7.2.3 WHAT MIGHT FUTURE CO-DESIGN LOOK LIKE?

The involvement and commitment across agencies and institutions within (and beyond) the public sector stands out. Under the auspices of the SRG, a robust, inclusive process has been developed - arguably ahead of the curve in the design and commissioning of healthcare in partnership with communities.

This suggests thinking about:

- The engagement heard much more from some groups of patients than others: How to engage (particularly) younger people and families from the growing parts of the geography?
- Co-design means patients and residents playing a meaningful role in the design of complex clinical services: What are the right structures and processes to empower non-experts? How to draw insight from the expertise by experience that patients bring? How to strike the right balance between recognising community need while involving people in making (sometimes tough) choices?

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APPENDIX 1 – PRIORITY SETTING EXERCISE

Service	Priority local	Priority WCH
Scenario 1		
Hospital Outpatient Appointments: several are currently being piloted at the Wantage Community Hospital, e.g. Audiology; Ear nose and throat; trauma / orthopaedics and ophthalmology	17	7
Support for mental health - a range of services are being piloted at Wantage Community Hospital Community Hospital, including talking therapies and neuro-developmental services	10	5
GP clinics – being piloted at Wantage Community Hospital	1	0
Diagnostics (screening, tests and results) – e.g. haematology (blood tests). Diabetes screening is being piloted at Wantage Community Hospital	8	1
Local community healthcare clinics and therapies – already provide at Wantage Community Hospital Community Hospital are Podiatry (foot health), Speech and Language therapies, Physiotherapy / MSK (bones and joints problems)	11	5
Children's health services – a range of services for children and young people (some already provided at Wantage Community Hospital)	10	4
Online or virtual clinics - to enable you to communicate with a clinician remotely (e.g. video appointment)	3	0
Scenario 2		
Rehabilitation beds in a community hospital – short-stay for people recovering from treatment with medical needs or continued treatment before they are able to go home	8	6
Rehabilitation in a short-stay hub beds in the community – similar to a care home with support and some therapies. People from Wantage most commonly go to Abingdon Care Home for this service	7	2
Palliative Care (end-of life care) inpatient beds	2	1
Specialist stroke rehabilitation beds – e.g. linked to Abingdon Stroke Unit	3	0
Hospital at Home service – provide healthcare in your own home and facilitate earlier discharges from hospital	6	1
Urgent Community Response – Service to help adults, mostly older people, having a health crisis or difficulties being at home because their main unpaid carer is not able to cope with caring for them	11	3
Social care and community support for reablement (which may be provide by the Council or local charities and community organisations) e.g. Age UK	7	3
Scenario 3		
Hospital Emergency Department (A&E) and emergency Ambulance Service	3	2
GP-led Urgent Treatment Centre	2	3
Nurse-led Minor Injuries Unit (may also have other health professionals, e.g. Radiographer if X-Rays are available)	9	6
Nurse-led 'First Aid' urgent care service	4	1
Local specialist services – for older people to avoid having to go to A&E or be admitted to hospital (often located in a MIU)	9	1
Urgent GP appointments	1	1

APPENDIX 2 – STAKEHOLDER REFERENCE GROUP

As set out in JHOSC update report, the stakeholder reference group for this project has the following members:

- Wantage Town Council
- Vale of White Horse District Council
- Grove Parish Council
- Wantage Hospital League of friends
- Wantage Patient Participation Groups
- OX12 Project representatives
- GrOW Families
- SUDEP Action
- Wantage Rural and OX12 Village
- Sanctuary Care
- Oxfordshire County Council
- BOB Integrated Care System (ICS)
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Wantage PCN
- Vale Community Impact
- Community First Oxfordshire
- Healthwatch Oxfordshire.

APPENDIX 3 - LEAFLET

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

NHS Oxford Health NHS Foundation Trust

With input from wider partners and stakeholders

We want your views!

We are looking for residents of the Wantage and Grove areas, users of local NHS services and representatives of local voluntary groups to help shape potential future services at Wantage Community Hospital.

You can either take part in one of the sessions listed below, or fill in our online survey. Visit https://bit.ly/3tcr866 for more information or scan the QR code below.

Wednesday 11th October 12:30-14:00 - Public engagement session
The Beacon, Portway, Wantage, Oxfordshire

Wednesday 11th October 15:00-16:30 - Focus group
People living with long term/chronic health conditions. The Beacon, Portway, Wantage, Oxfordshire

Tuesday 17th October 12.30pm - 2.30pm - Public engagement session
The Beacon, Portway, Wantage, Oxfordshire

Wednesday 18th October 2pm - 3pm - Public engagement session
Via Zoom for those unable to attend a face to face session

Thursday 19th October 7pm - 8pm - Focus group online- via Zoom
Families with children and young people OR adults 18- 40 years living in or around Wantage and Grove.

Saturday 28th October - 10am - 4pm - Drop in information session
The Beacon, Portway, Wantage, Oxfordshire

If you have any questions please contact:
communityservicesfeedback@oxfordhealth.nhs.uk

APPENDIX 4 - DISCUSSION GUIDE

Explanation

Interviewer to introduce themselves
 	
As you have heard, we are keen to hear your views on **THREE SCENARIOS** for local services. (NB. Not necessarily mutually exclusive!)
 	
These are:
1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.
 	
We particularly want to hear from you:
• What local services you currently (or have recently) used
  o Your experience of accessing them
  o How things fit together
• Your thoughts on the range of services which might make up each SCENARIO
• Your ideas on how the Community Hospital can support health and wellbeing for the people of Wantage and the Grove.
 	
• Recognise you might have more general questions or suggestions: We will also ask you <u>as a group</u> to prioritise 3x points, ideas or questions for the final session.

• This session will take about an hour. • We would like to record the session, with your permission. • The recording will only be used to make notes for analysis and will be destroyed at the end of the project.
We would be grateful if you would be as open and honest as you can be in what you tell us. What you tell us will not be shared directly with clinical teams and everything you say will be kept anonymous when we write our report. We do not use people's names in our reports, and we do not give any information which means they can be identified.
Do you have any questions? May I record our conversation?

1. **Scenario – Clinic based services (tests, treatment and therapy) for planned care appointments**

   Prompts:
   - SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Which planned care services (outpatients, tests, treatment, follow ups, therapy type services) have you or your family used or know about locally?

c. Have you accessed any of the outpatient clinics at Wantage Community Hospital - some have been running as pilots for the last 18 months and others more long term?

   - What did you think about these? (Like or dislike?)
   - Were they easy to access?

d. If not provided at Wantage Community Hospital, where else could this type of service be accessed?

   - John Radcliffe or Churchill Hospital in Oxford?
   - Great Western in Swindon?
   - Oxford City Clinic bases (e.g. East Oxford Health Centre or The Slade)
   - Abingdon Community Hospital (some mental health and children's therapy services)

e. What types of planned care services would you value locally? These could be existing (so a continuation) or not currently available.

   Prompts:
   - One-off/short-term vs. Long-term/ongoing condition
   - Frequency
   - Physically accessible buildings?
   - Planned vs Urgent
   - Conditions for which travel might be problematic
   - Kinds of patients
     - Deprivation
     - LTC
     - Life-stage (families / working age / older etc.)
   - Connectivity / integration / co-dependencies

2. Scenario – Community inpatient beds and the alternatives

Prompts:

- SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Most people return home direct from hospital. What would help get you back to living independently as quickly as possible?

Prompts:

- Local authority social care (domiciliary / home care)
- Additional support (e.g. live-in or overnight check-in service for people with delirium)
- Specialist support for carers (e.g. dementia) – may be from the voluntary sector
- (Re)assurance (e.g. alarms)
- Reablement / support (e.g. therapies)
- Knowing your carer has someone they can call
- A local multi-disciplinary team able to help you access all services

c. What has been your experience of people accessing medical ("hospital-like") support at home so you don't need to stay in hospital?

Prompts:

- Discharge to Assess
- Local Hospital at Home service
- Urgent community response

What has been your experience of:

d. Care as an inpatient in other community hospitals?

e. Short term nursing home stays?

f. Care for when you know someone has needed to access palliative and end of life care outside of their own home?

g. What types of inpatient care do you think it is important to provide locally? (Do some of these need to be more local than others?)

Prompts:

- Rehabilitation e.g. for people who have had an operation or a stroke
- End-of-life care
- Short-term care e.g. during winter pressures
- Short-term nursing home stays e.g. during times of crisis or for respite
- Specialist inpatient care (e.g. for stroke)

3. **Scenario - Urgent care (minor injury, illness and mental health issues) access needs on the same day**

Prompts:

- SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Which 'same day' services have you used or know about?

Prompts:

- GP; out-of-hours GP; Minor Injuries Unit; NHS111; John Radcliffe hospital A&E
  - How did /(do) you / family travel to these?
- Have you used Apps, video appointment, or other "digital" services
  - (**NB. be sure to prompt with this one!!!!**)
- Urgent Community Response (rapidly-growing new service – same-day home visiting service, e.g. nurse, therapist)
- Do you feel any additional services would be helpful?

c. What has been your experience with accessing these types of services for both physical health and/or mental health needs?

d. What would make access to these types of services work well for you and your family?

Prompts:

- Effective triage to the right service
- An easy first point of access
- Streamlined referral between services
- Travel / transport
- Accessibility / easy access / experience
- Which services? Frequency

e. Which services is it most important to have locally?

Prompts:

- What do we mean by local?
- Frequency of need / conditions needing regular appointments?
  - NB. weekly follow-ups / less commonly
- Mental health services
  - NB CAMHS – large local school (NB2 – minimal CAMHS currently in Wantage Community Hospital)
- Urgent care?
- What specialties would it be better to have more locally?
  - Wantage Community Hospital – current list: Eyes; Hearing; Mental Health; Diabetes screening; Foot care; Speech and language therapy; Physiotherapy; Maternity appointments; School nursing
  - What kinds of appointments are the most common? e.g. Diagnostics/scans etc.; follow-up/regular check-ups; Test results; clinics (e.g. vaccinations)

4. **Thinking about the different scenarios we've discussed, what do you see as the future role for Wantage Community Hospital and hospital-like services locally?**

   Prompts:
   - What makes a high-quality service?
   - How could it be joined-up better with other health services you use? (e.g. outpatient clinics? navigation?)
   - Choice – currently available / in the future
   - What mix of services should be offered on site?
   - Adults and children's services in the same place?
   - How does it work with your GP – pathway / referral / records?
   - Is there anything which would make things easier for you?
   - Buildings and environment

Prioritisation exercises

a. Based on what you have heard – which of these would you like most to be most local?

   Prompts:
   - STICKERS / FLIPCHARTS

b. If you had to choose TOP 3 PRIORITIES for services at Wantage Community Hospital, what would they be?

   Prompts:
   - STICKERS / FLIPCHARTS

5. **Feedback questions or comments**

   Prompts:
   - What do we mean by "local"?
   - What services are under consideration
   - What is the process?

SHOWCARD LIST OF SERVICES

Scenario 1.

Clinic based services (tests, treatment and therapy) for planned care appointments

- **Hospital outpatient appointments** – several are currently being piloted at Wantage Community Hospital to avoid patients needing to visit to hospital departments e.g. audiology/ear, nose and throat; trauma/orthopaedics (bones and joints) and ophthalmology (eye health - currently the most popular pilot at WCH).

- **Support for mental health** – a range of services are being piloted at Wantage Community Hospital, including talking therapies and neuro-developmental services.

- **GP clinics** – being piloted at Wantage Community Hospital

- **Diagnostics (screening, tests and results)** – e.g. haematology (blood tests). Diabetes screening is being piloted at Wantage Community Hospital

- **Local community healthcare clinics and therapies** – already provide at Wantage Community Hospital are Podiatry (foot health), Speech and Language therapies, Physiotherpy / MSK (bones and joints problems)

- **Children's health services** – a range of services for children and young people (some already provided at Wantage Community Hospital)

- **Online or virtual clinics** - to enable you to communicate with a clinician remotely (e.g. video appointment)

Scenario 2.

Community inpatient beds and the alternatives

Inpatient services

- **Rehabilitation beds in a community hospital** – short-stay for people recovering from treatment with medical needs or continued treatment before they are able to go home

- **Rehabilitation in a short-stay hub beds in the community** – similar to a care home with support and some therapies. People from Wantage most commonly go to Abingdon Care Home for this service

- **Palliative Care** (end-of life care) inpatient beds

- **Specialist stroke rehabilitation beds** – e.g. linked to the Stroke Unit in Abingdon

Increasingly, people go home from hospital quickly following treatment because the evidence is that it brings better health outcomes. Hospital-like care services are provided at home:

- **Hospital at Home service** – provide healthcare in your own home and facilitate earlier discharges from hospital

- **Urgent Community Response** – Service to help adults, mostly older people, who are having a health crisis or having difficulties being at home because their main unpaid carer is not able to cope with caring for them

- **Social care and community support for reablement** (which may be provide by the Council or local charities and community organisations) e.g. Age UK

Scenario 3.

Urgent care (minor injury, illness and mental health) access needs on the same day

- **Hospital Emergency Department (A&E)** and emergency Ambulance Service
- GP-led **Urgent Treatment Centre**
- Nurse-led **Minor Injuries Unit** (may also have other health professionals, e.g. Radiographer if X-Rays are available)
- Nurse-led **'First Aid' urgent care** service
- **Local specialist services** – for older people to avoid having to go to A&E or be admitted to hospital (often located in a MIU)
- **Urgent GP appointments**

APPENDIX 5 – QUESTIONNAIRE

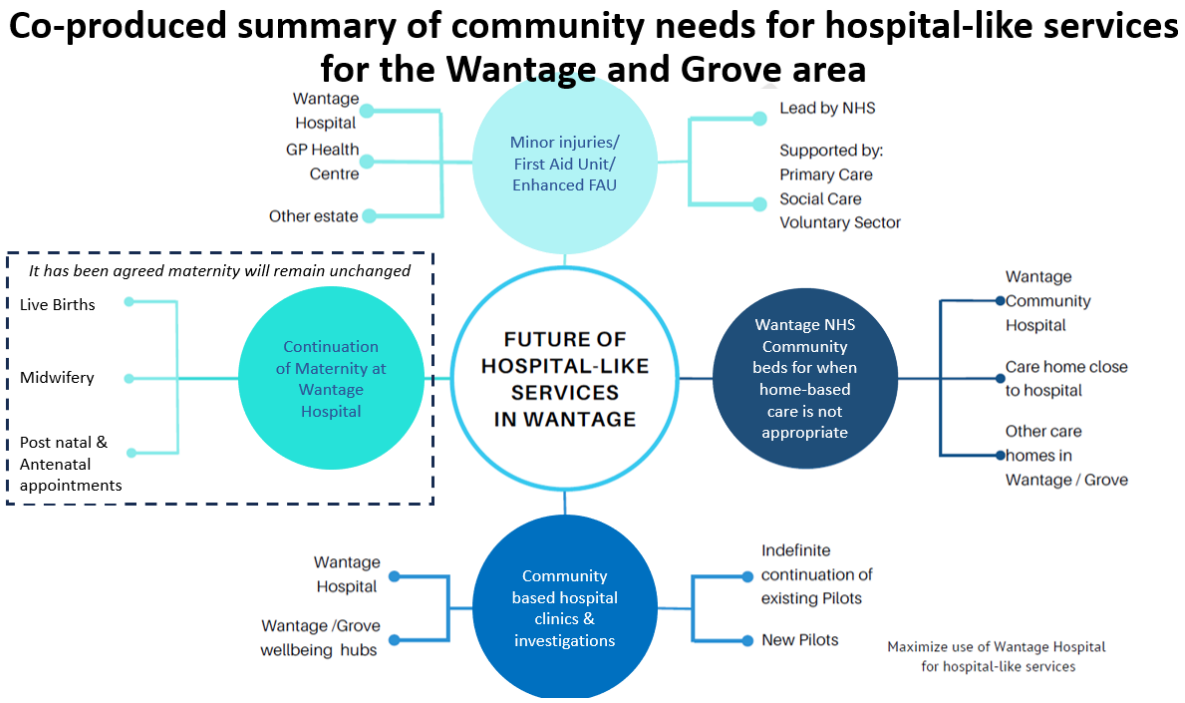
BACKGROUND INFORMATION

Wantage community hospital inpatient beds have now been temporarily closed for 8 years. The hospital is currently used to provide a range of outpatient services (tests, treatment, therapy, follow ups) for the local community, some have been running for some time and others as a pilot for the last 18 months after the space previously used as an inpatient ward was re-opened. We have been starting to co-design what future type of services could be provided from the hospital and now want to seek broader views upon to help shape final proposals.

Oxford Health and its NHS partners, have no plans to close Wantage Community Hospital. We are committed to keeping it open, but we need your input to help inform the types of services to be provided from the building that are sustainable and best meet the needs of the local community. Our objective is to provide sustainable hospital-like services from Wantage Community Hospital for the longer term to meet the needs of the local population now and in the future that maximises use of the available space.

We are not proposing any changes to the maternity services and support their continuation – located upstairs in Wantage Community Hospital. We have focused on three areas to explore further:

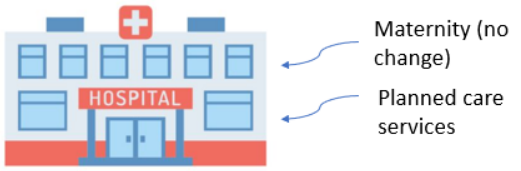
- Clinic based services (tests, treatment and therapy) for planned care appointments
- Community inpatient beds and the alternatives when care in your own home isn't possible
- Urgent care (minor injury, illness and mental health) access needs on the same day



SCENARIO 1: CLINIC BASED SERVICES (TESTS, TREATMENT AND THERAPY) FOR PLANNED CARE APPOINTMENTS

- Currently the most needed clinic service is **Ophthalmology** (specialist eye appointments)
- **1,445 patient**s came to an outpatient clinic as part of the pilot mostly from the OX12 postcode area
- On average **120 people per month** come to Wantage Community Hospital to access the range of clinic-services currently provided

Planned care services would take up the whole of the ground floor with scope for some more services to come in to maximise the available space



What this would mean:

- More planned care services could be provided within Wantage
- Hospital beds and urgent care services would need to continue to be accessed at other hospital and local care home sites

If Wantage Community Hospital didn't provide these planned care services, where else could this type of service be accessed?

John Radcliffe or Churchill hospital in Oxford

Great Western in Swindon

Oxford City clinic bases e.g. East Oxford Health Centre or The Slade

Abingdon Community Hospital for some mental health and children's therapy services

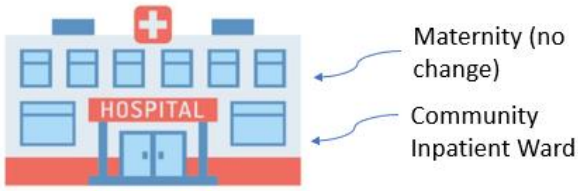
QUESTIONS

- Which planned care services (outpatients, tests, treatment, follow ups, therapy type services) have you or your family used or know about locally?
- What has been your experience of accessing any of the outpatient clinics made available at Wantage Community Hospital, some have been running as pilots for the last 18 months and others more long term?
- What types of planned care services would you value locally? These could be existing (so a continuation) or not currently available.
- Thinking about how frequently you or your family need to access these types of planned care services (e.g. weekly or 6 weekly for follow ups), what types of services should be available locally to those further away?

SCENARIO 2: COMMUNITY INPATIENT BEDS AND THE ALTERNATIVES WHEN CARE IN YOUR OWN HOME ISN'T APPROPRIATE

- Each month around **5 people from the Wantage and Grove area are admitted** to a community inpatient bed currently mostly in Abingdon or Dicot
- Each month, around 2 people from the Wantage and Grove area require less intensive rehabilitation and are **admitted to care homes (mainly to The Close in Burcot, 15 miles from Wantage)**
- Home-based care is also provided by a range of teams to help people get home after a hospital stay

The inpatient ward is likely to need the whole of the ground floor (around 20 beds).



What this would mean:

- If Community hospital beds would be provided in Wantage there would be no space for any outpatient (tests, treatment and therapy) services or potential urgent care type service. Wantage and Grove residents would need to access these at other hospital and community sites
- Community inpatient provision across the rest of the county would require a review to accommodate this new ward.

QUESTIONS

If Wantage Community Hospital didn't have any beds how would this type of healthcare be provided to the local population?

Living independently at home / in the community

- Most people **return home** direct from hospital. What would help get you or your family back to living independently and supported as quickly as possible?
- What has been your experience of accessing services to support you and your family to remain **at home** during illness?

Other care pathways out of acute hospital (if no inpatient beds at Wantage Community Hospital)

- What has been your experience of care in other community hospitals, short term nursing home and care home-based packages of care or for when you know someone has needed to access palliative and end of life care outside of their own home?
- What would help you and your family in circumstances when you would need to access these types of services?

SCENARIO 3: URGENT CARE (MINOR INJURY, ILLNESS AND MENTAL HEALTH) ACCESS NEEDS ON THE SAME DAY

- Wantage & Grove population made 1361 visits to an MIU over one year, which equates to an average of 3.7 total visits from this area this is forecast to increase by 2030 to around 4.8 visits a day to an MIU (1745 visits per year).
- Patients who need emergency treatment from Wantage & Grove largely go to the John Radcliffe Emergency department.

What this would mean:

- More urgent care could be supported in Wantage
- The range of planned care services (tests, treatment and therapy) currently provided would need to be reduced by around a half
- Hospital beds would need to continue to be accessed at other hospital and community sites

If Wantage Community Hospital didn't have an urgent care type service where else would this type of service be accessed?

Potential to explore an integrated model with local NHS and care partners at the Health Centre

Abingdon MIU

24/7 Mental Health line (via 111)

Mental health, social care and community health services and crisis support

QUESTIONS

- If you were to need to access urgent care, what would be the process you would follow?
- What has been your experience with accessing these types of services for both physical health and/or mental health needs?
- What would make access to these types of services work well for you and your family?

OVERARCHING QUESTION

- Thinking about the different scenarios we've discussed, what do you see as the future role for Wantage Community Hospital and hospital-like services locally?

ABOUT YOU – DEMOGRAPHICS

Please let us know what area you come from by entering the first 4 digits of your postcode

Age Group

- 16-25
- 26-40
- 41-60
- 60+
- Prefer not to say

Do you consider yourself to have a disability

- Yes
- No

What best describes your gender

- Female
- Male
- Non-binary
- A gender not listed here
- Unsure how to describe myself
- Prefer not to say

Is your gender the same as the sex you were given at birth

- Yes
- No
- Prefer not to say

Ethnicity

- See list

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NHS
Oxford University Hospitals
NHS Foundation Trust

Trust Headquarters
Academic Block, Level 3
John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

04 January 2024

Mr Grant Macdonald
Chief Executive Officer
Oxford Health NHS Foundation Trust
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road
Littlemore, Oxford
OX4 4XN

Dear Mr Macdonald,

I am writing to clarify Oxford University Hospitals (OUH) Foundation Trust position in relation to work undertaken on the future of Wantage Community Hospital.

OUH has been engaged throughout the co-productive process, facilitated by Oxford Health Foundation Trust (OHFT) and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) to determine the future of Wantage Community Hospital. OUH acknowledges the resulting recommendations regarding in-patient beds, planned care services and urgent care.

In the event recommendations on the future of Wantage Community Hospital be agreed, OUH will work with the ICB and OHFT to confirm the outpatient services currently being delivered in Wantage Community Hospital.

The OUH Clinical Strategy 2023-2028[1] contains a principle to transform where we deliver services; this approach includes delivering care which is closer to patients. We are therefore committed to working with system partners to explore the opportunities to provide sustainable community clinic-based services from Wantage Community Hospital.

Yours sincerely

pp Sara Randall.

Professor Meghana Pandit
Chief Executive Officer

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HOSC Briefing 16 January 2024

Supporting People to Leave Hospital: the Oxfordshire Way

Executive Summary

1. National Policy requires that Oxfordshire ensures that 95% of people who have been admitted to an acute in-patient bed return directly home to their usual place of residence after their hospital stay.

2. The policy also requires that people are assessed in their usual place of residence or outside the acute hospital setting.

3. This approach is better for patients as it reduces length of stay and the risks associated with that. It also works to improve hospital flow and so improves the safety and responsiveness of our emergency care pathways.

4. Oxfordshire's performance against the national policy target is monitored through the Better Care Fund Plan. In 2023-24 the Health & Wellbeing Board agreed that we should aim to improve our performance to 93% of people discharged to usual place of residence by March 2024 and improvement to the national requirement of 95% during 2024-25. Currently and historically we have not met the Better Care Fund plan targets, and this will require an effort to divert people from bed-based to home based discharge pathways.

5. Oxfordshire has reorganised its approach to hospital discharge to deliver on this improved care for patients and system performance. After a successful pilot, we are now rolling out a Home First Discharge to Assess approach to hospital discharge.

6. The changes we are making to the discharge pathways to deliver improved outcomes for patients and deliver system flow are underpinned by increased capacity in our domiciliary care market and changes in structure and approach of hospital-based teams.

7. A focus on getting people home will include a diversion from bed-based discharge pathways to home-based discharge pathways. That reduces the demand for short stay hub beds and may lead to a redesign of the model to meet specific patient needs.

8. The Oxfordshire Short Stay Hub bed model was developed out of the pressures on the acute hospital system in the winter of 2015-16 when Oxfordshire had some of the highest numbers of delayed transfers of care in the country. This was a temporary arrangement at the time. These were in turn driven by a lack of capacity in the local reablement and domiciliary care market.

9. The Oxfordshire Urgent and Emergency Care Board agreed to reduce the reliance on bed-based discharge pathways, and this was incorporated in the Better Care Fund plan for 2023-25. These changes will be kept under review and will need further operational changes from time to time to assure that we have the right resources in the right places and respond to changing patterns of demand.

10. A move from a bed-based to a home-based discharge pathway is safer for patients, delivers better outcomes and will be more economically effective over time. Our outcomes from reablement have improved significantly over the past two years. Currently 91% of people complete reablement with reduced care needs or fully independent (78% achieving full independence).

11. The changes are not risk-free but the whole approach is based on positive risk taking to support better outcomes for the individual and the system. We are developing community- based resources that support more preventative approaches to help people at risk of going into hospital. This approach is underpinned by and consistent with the Oxfordshire Way, our approach to enabling people to remain and thrive in their own homes and within their own communities. Strengthening our Discharge to Assess pathway is a vital contribution to this ambition.

National Hospital Discharge Policy: return to usual place of residence via *Discharge to Assess*

12. In August 2020 NHS England introduced a revised national Hospital Discharge Policy focussed on getting people home Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

    a. Under the Discharge to assess, home first approach to hospital discharge, the vast majority of people are expected to go home (to their usual place of residence) following discharge. The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed.

    b. This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

13. The Policy requires local health and care systems to move to *Discharge to Assess* approach. In the ADASS guidance Quick Guide: Discharge to Assess (www.nhs.uk) the risk of assessing people in hospital is characterised as

    a. Imagine leaving your home abruptly and never returning to it again.

    b. Imagine being told that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost.

    c. This is what happens to people every day because we assess people in a place that is not their normal environment.

14. The national policy is built upon key principles:

    a. To support the ability of hospitals to maintain flow and be able to respond effectively to patients needing emergency assessment and treatment, patients should be discharged as soon as they no longer require an acute hospital bed.
    b. Discharging people as soon as they no longer require an acute hospital bed reduces the risks to the patient arising from an extended length of in-patient stay.
    c. People cannot be appropriately assessed for their longer-term needs from an acute hospital bed and need to be discharged prior to that assessment taking place.

d. In the majority of cases, that assessment should take place in the person's own home and take into account their individual circumstances in their own community.

15. The national policy specifies the discharge pathways to be used and the numbers of people who should be discharged against each one:

Pathway	Pathway 0	Pathway 1	Pathway 2	Pathway 2	Pathway 3
Definition	Home with no support	Home with support (reablement or assessment)	Bed-based reablement	Bed-based rehabilitation (high medical needs)	Long-term care (residential)
% of patient discharges	50%	45%	4%		1%
How delivered in Oxfordshire	*Self-discharged* *In some cases- with support from Age UK*	*Home First Discharge to Assess working with Live Well at Home framework providers*	*Short stay hub beds*	*Oxford Health community hospital beds*	*D2A beds (either in short stay hub beds or spot purchased)*

Better Care Fund Plan

16. The Better Care Fund Plan is required to deliver the Hospital Discharge Policy requirement that 95% of patients discharged from hospital go home, with or without support. Oxfordshire has not yet managed to meet this target. In the Better Care Fund Plan for 2023/25 the Oxfordshire Health & Wellbeing Board agreed a trajectory for 2023/24 that we would achieve 93% by March 2024 and 95% in 2024/25.

17. See Agenda for Oxfordshire Health & Wellbeing Board on Thursday, 29 June 2023, 2.00 pm - Oxfordshire County Council

18. Performance against planned trajectory to 30 Sep 2023

	22-23 Q1 Actual	22-23 Q2 Actual	22-23 Q3 Actual	22-23 Q4 Actual	23-24 Q1 Actual	23-24 Q2 Actual
Actual	90.6%	91.1%	90.3%	90.1%	90.8%	91.3%
Plan					91.0%	92.0%
Variation v plan					-0.2%	-0.7%
England performance	92.6%	92.9%	92.7%	92.3%	92.8%	*93.2%*

19. In 2023/24 we have seen an improvement in performance but currently Oxfordshire remains behind our planned trajectory. The changes set out below have largely reduced delays for patients waiting on Pathway 1 to go home. To achieve the trajectory, we need to divert people from Pathway 2 and 3 to Pathway 1 wherever possible in line with the

Discharge to Assess approach so a change of approach moving away from reliance on beds is required.

2023-24	All Discharges	3,891	4,233	4,387	4,160	4,384	4,407
	Usual Residence	3,499	3,871	3,996	3,787	3,998	4,036
	Other outcome	392	362	391	373	386	371
	Usual Residence %	89.9%	91.4%	91.1%	91.0%	91.2%	91.6%
	Other Outcome %	10.1%	8.6%	8.9%	9.0%	8.8%	8.4%

20. To move from 91.6% to our agreed trajectory of 93% of people going home we need to reduce the current 370-380 discharges per month to beds to 308 per month. This amounts to a reduction of around 15 discharges to a bed per week. That level of diversion will need to increase in 2024/25 to around 20 discharges per week to achieve the 95% target.

Reorganising Hospital Discharge Pathways: moving towards *Discharge to Assess*

Transfer of Care Hub

21. In November 2022 the Oxfordshire health and care system instigated a Transfer of Care [TOC] Hub in the hospital. Led by a matron in Oxford University Hospitals NHS FT with system partners, the TOC Hub works to allocate patients to the right discharge pathway, anticipate and pre-empt any barriers to discharge and promote a discharge to assess approach.

22. Since August 2023 the TOC Hub has also been coordinating all Oxfordshire discharges from the Royal Berks Hospital.

23. The TOC Hub has taken responsibility for allocating the right patient to the right pathway. This has clarified the needs of patients and how we use our discharge pathways. It has, for instance, removed the risk that a patient who needs bed-based reablement (recovery of day to day living skills) ends up in a rehabilitation bed (medically supervised recovery of health function) because there is a vacant community hospital bed but no immediate short stay hub bed capacity. We can have more confidence now in the "pathway prescription" for people awaiting discharge from hospital and use that in planning resources.

Home First Discharge to Assess

24. Prior to June 2023 Oxfordshire operated a two-track approach to discharging people home: *Home First* for those people identified as having reablement potential; and a bed-based assessment/home care sourcing approach to those identified as having long-term care needs. For the latter group this often led to a delay in beds whilst long-term care was sourced.

25. Oxfordshire now has a model that is aligned to the national Home First Discharge to Assess approach. This has been introduced on a staged approach in the City (June), North (August) and County wide (November).

    a. Where a patient can go home (whether for assessment, reablement, or long-term care) they are allocated to a provider from the Council's Live Well at Home Framework to support at home in daily calls 7 days a week.

b. The patient is discharged with the appropriate medication, equipment, and support.
c. The resident is then supported in her own home for up to 72 hours during which time their needs are assessed by the Live Well at Home provider and the Council Home First team.
d. At 72 hours (or earlier if indicated) they will proceed to reablement, to long-term care, or discharged if they can manage independently. The reablement and the long-term care will usually be delivered by the same agency for continuity.
e. If they are assessed by the Council as needing long-term care after the period of reablement, that is provided by the same agency in line with our Live Well at Home contract model, thus ensuring continuity of care.

26. To support more complex home first discharges the Council has introduced in agreement with Live Well at Home providers:
    a. Short-term live-in reablement care and/or
    b. Short-term waking nights to support reablement.
    c. These measures assure the safety of the initial assessment and reablement periods and help the resident and her family/unpaid carers have confidence in this approach.

27. In addition, the Integrated Care Board is leading on the development of Integrated Neighbourhood Teams. Working with primary care, these teams create wrap around short-term interventions for people who are at risk of hospital admission and/or for people who have been discharged from hospital where there are ongoing medical needs. There are teams in Bicester and Oxford City based around specific practices or Primary Care Networks, and this model is being rolled out in Witney, Banbury, Wantage and eventually across the County. These services build out from what is already there and so there are different models based on specific local resources, but all have the capability to support more vulnerable people in their own home.

Impact of Home First Discharge to Assess

28. In the City, where the pilot has been running longest, we have supported 87 people home who would otherwise have been waiting for a long-term social care package in a bed.

    a. We had D2A capacity in 88% of cases.
    b. Where we assessed at home this was completed within 72h in 87% of cases
    c. Where we have completed assessments
        i. 24% were fully independent at 72h.
        ii. 32% were for reablement at 72h.
        iii. 33% were for long-term care.

29. This suggests that only 33% of people waiting in a bed had a long-term care need.

30. Where people proceed to reablement, our providers achieve full independence in 78% of cases and reduce the initial care package in a further 13% of cases.

31. Taken together, these approaches demonstrate the case made out in the national Hospital Discharge Policy: when we get people home; and when we assess people at home, we can put in the support that enables the overwhelming majority of people to retain full independence.

Assurance for Home First Discharge to Assess

32. This approach is new for Oxfordshire, but we are building an infrastructure that will assure its continued positive impact:

33. Crucial to the flow through any home-based discharge model is the capacity of domiciliary care when it is needed so that we can continue to take people home from hospital. There are now over 100 providers on the Live Well at Home Framework, and we have seen a significant increase in the hours of care purchased:

Home care hours 01/12/2022	27,888
Home care hours 01/03/2023	28,885
Increase in 22/23	3.58%
Current hrs (1/11/23)	31,095
Increase in 23/24	**7.65%**

34. Live Well at Home Framework providers have responded to the Discharge to Assess opportunity in terms of undertaking training, ensuring capacity and joining daily case allocation meetings 7 days a week. We have made changes to the contract that reimburses providers in the delivery of the 72-hour Discharge to Assess support in cases where the person does not proceed to reablement or long-term care.

35. As noted above we have commissioned additional live-in and waking nights capacity to support more complex discharges.

36. The developing Integrated Neighbourhood Teams will be able to provide further support in more complex cases.

37. The Council has reorganised hospital teams to align to the model of taking people home rather than assessing them on the wards. The Council also commissions Age UK to support patients in the discharge pathway to give an independent view of what is needed and what is planned for the patient and their family. In 2024/25 we plan to extend that to a specific process to identify and support unpaid carers in the discharge pathways.

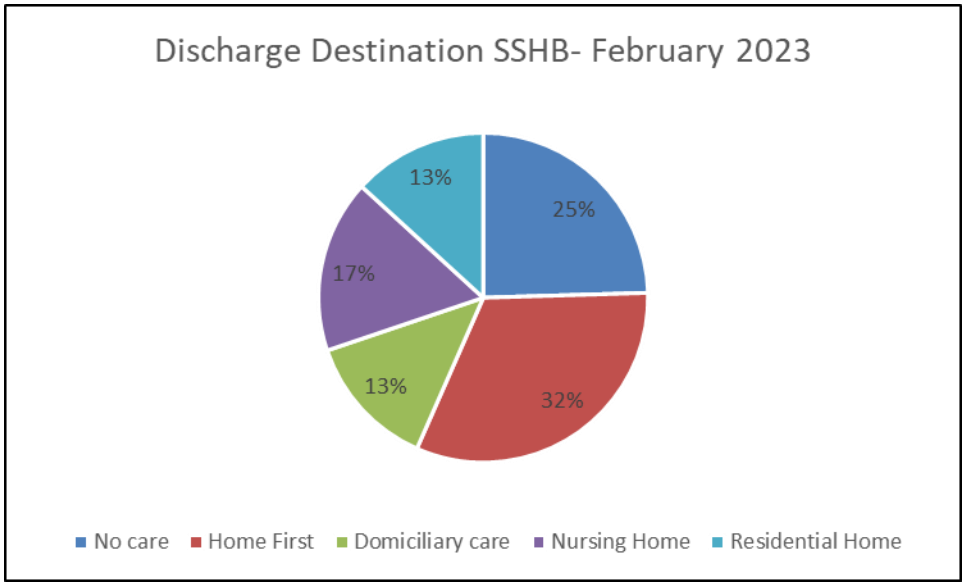
38. There is strong system wide leadership and support with a System wide Director of Urgent Care, TOC Hub Matron and Home First Lead hosted respectively by the Integrated Care Board, Oxford University Hospitals NHS FT, and the County Council. Progress and lessons learned and opportunities to develop the model and address any concerns are monitored in fortnightly system-wide Urgent Care Delivery Group meetings reporting monthly to the Urgent and Emergency Care Board.

Impact of Home First Discharge to Assess on other discharge pathways

39. As set out at paragraph 15 and 20 the assumption in the national Hospital Discharge Policy is that we will divert more people home for assessment and onward care. In Oxfordshire there are several benefits to this:

    a. Fewer people will need to be placed in a bed on their journey home from hospital as we move to divert the 15-20 people per week who should be going home rather than to a step-down bed. Given the numbers that end up going home (see below) the opportunity to go “home first” is significant. The TOC Hub and Home First teams are now working with Live Well at Home providers to move people who need reablement to a home first pathway wherever appropriate.

b. Where people go into short stay hub bed the focus on "home first" from that setting will support a reduction in length of stay.
c. In most cases (over 70%) people who go to a short stay hub bed are discharged home. The increased capacity set out above will support that flow and reduce the risk of delays in step down beds, reducing length of stay in both settings.



40. Based on assumptions around a reduced demand for short stay hub beds arising from the diversion to home-based discharge, and the reduced length of stay, the Urgent and Emergency Care Board agreed in May 2023 to request the Council to reduce the contracted short stay hub beds to 63 for winter 2023-24, and plan to reduce further to 40-45 from April 2024.

41. Since that decision and the implementation of Home First Discharge to Assess there is assurance that the trajectory is correct in terms of bed numbers. There is a line of enquiry that suggests that we may need to rethink the specific short stay hub bed model based on specific needs relating to dementia care and/or to delirium presentations. The model of care will be reviewed by the Urgent Care Delivery Group as part of the refresh of the Better Care Fund plan for April 2024.

The Oxfordshire Short Stay Hub Bed Model

42. Oxfordshire historically faced significant challenges in achieving flow out of acute hospital beds. In the period to 2015/16 Oxfordshire was generally one of the worst performing systems in terms of *delayed transfers of care* with many people remaining in a hospital bed longer that was necessary with the risk of longer-term harm to their welfare.

43. In 2015/16 Oxford University Hospital NHS FT began purchasing "liaison hub beds" in care homes to support flow out of the hospital at times of pressure. The hospital had purchased 130 beds by March 2016 but reduced to 55 by August. The beds were supported by a Liaison Hub managed by the hospital and funded by the then Clinical Commissioning Group. The Hub comprised nurses, therapists (from both the hospital and from Oxford Health NHS FT) and social workers from the Council. The model was a mixture of therapy-led reablement designed to get people home from the hub bed and assessment where people may have long term care needs (eg people needing a Continuing Healthcare assessment).

44. The number of people delayed in hospital reduced from 140-150 in Nov 2015 to 95 by August 2016. It was agreed that the "liaison hub bed model" should continue in Sep 2016.

45. In parallel to the liaison hub beds the Council commissioned 34 intermediate care beds from the Order of St John Care Trust which had a similar function, to support reablement and lower levels of rehabilitation. These numbers were increased in Dec 2016 when the Council was asked by the Clinical Commissioning Group to commission 7 additional step-down beds in Chiltern Court, Henley. At the same time the Council was asked to commission 4 step-up beds to support people needing short term assessment under the care of the Rapid Assessment and Care Unit at Townlands Hospital.

46. From winter 2016-17 the Liaison Hub led by the hospital began to have oversight of the Council commissioned intermediate care beds and to place people discharged from hospital and then co-ordinate their onward discharge from the step-down beds.

47. From 1/11/2019 these 2 models (liaison hub and intermediate care beds) were brought together all commissioned by the Council:

    a. 56 Short stay hub beds commissioned from the Oxfordshire market.
    b. 41 intermediate care beds within the OSJ contract aligned to the Short Stay hub bed model.
    c. **97 beds in total November 2019**

48. In addition to these beds the Council
    a. would typically purchase 20-25 "interim beds" each winter for social care assessment outside of hospital.
    b. during the Covid pandemic response we additionally purchased up to 20 "covid designated beds" which ran to Mar 2022 for non-symptomatic but positive patients
    c. in both winter 20/21 and 21/22 we purchased 20 hotel beds with care to support flow.

Responding to demand and capacity pressures and reviewing discharge pathways

49. The overall performance of the Oxfordshire emergency health and care system is overseen by the Urgent and Emergency Care Board. The Board authorises the trajectories that we set against Better Care Fund and NHS Urgent Care metrics. It reviews performance and holds system partners to account and requires actions to address variations to planned trajectories.

50. The specific numbers of short stay hub beds have been flexed up and down in line with system demands in operational decisions made by the Council in partnership with the system and endorsed by the Urgent and Emergency Care Board. For instance, in August 2022, 17 beds were closed in line with operational demands at that point. Since then, there has been a core of 39 short stay hub beds and 41 intermediate care beds with capacity scaled up and down from time to time in line with Council contract provisions.

51. The Short Stay Hub Bed model was an emergency provision in reaction to acute hospital pressures which was developed into what the NHS Hospital Discharge Policy now defines as "pathway 2 reablement beds". Different local health and care systems have different models of discharge beds often derived from responses to immediate pressures at points in time. The national policy challenges this short-term reliance on beds and

asks us to see the patient as a person who would choose and would benefit from getting back to her own home as soon and as safely as possible.

52. Oxfordshire's historic heavy reliance on beds was derived from:

    a) A lack of reablement and domiciliary care alternatives to get people home.
    b) A system culture where beds were available and could be deployed and so relied upon to get the system moving when the hospital system was in danger of becoming overwhelmed. If in doubt we would buy a bed.

53. Oxfordshire has changed its approach to meeting the needs of people in hospital and we are now moving away from the bed-based discharge model. The system, in the Urgent and Emergency Care Board will continue from time to time ask the Council and other partners to scale up and down beds and other forms of provision in response to demand and capacity pressures, but our trajectory is to reduce beds and repurpose the ones we retain if indicated by the work we are doing to refresh the Better Care Fund plan for 2024-25.

54. Changes to the number of short stay hub beds will be determined operationally and managed by the Council within its contracts. This is considered business as usual activity.

55. Changes to the model of step-down beds would be subject to a wider engagement with providers, clinicians and users and their carers. If any changes are indicated they would probably lead to an open-market procurement exercise for interested providers to bid, but that would form part of the business case to support any changes.

Quality and financial impact of Home First Discharge to Assess

56. As set out above, where people don't need to be in a bed there are harms from them remaining in one. Where people do need a bed, it is much the better option that they are in their own bed at home.

57. Oxfordshire's strong performance on reablement outcomes in helping people get to independence and/or reduce care packages tells us we can support people appropriately at home. The numbers of people who use a short stay hub bed who end up at home with no care, or with reablement informs us that we have an opportunity to take some of those people "home first" rather than via a bed. The numbers of people who we have taken home under the Discharge to Assess pilot who have needed no care or have entered reablement when they would otherwise have been at risk of harm in a bed tell us that we are doing the right thing.

58. There is nothing wrong with a step-down bed when it is needed, and it will be the appropriate pathway for some people. However, by rethinking how we might support people at home (e.g. with live in or waking nights care) and by working with the rest of the system in the development of Integrated Neighbourhood Teams we can remove some of the risk and anxiety about supporting people home.

59. The economic case for taking people home is straightforward.
    a. A reablement episode costs <£1200 per person supported and generally people are supported for 2-3 weeks.
    b. where people are discharged and then become independent within 72 hours or move to long-term care, we are paying £250 as an episode cost for that 72-hour period.

c. By contrast, a Short Stay hub bed typically costs c £12-1400 per week with GP medical cover costs on top of that, and our target is that people are resident for up to 21 days.
d. If someone could go home, it may cost us £1200 with all the benefits to the individual of being at home. If she was placed in a short stay hub bed it will cost at least £4000 per episode. We may then have to additionally put in reablement to get the person home.

Home First Discharge to Assess-the way forward

60. A move from a bed-based to a home-based discharge pathway is safer for patients, delivers better outcomes and will be more economically effective over time.

61. These changes are not risk-free but the whole approach is based on positive risk taking to support better outcomes for the individual and the system. We have strong system leadership and partner commitment to making it work.

62. We are developing community- based resources that support more preventative approaches to help people at risk of going into hospital. This approach is underpinned by and consistent with the Oxfordshire Way, our approach to enabling people to remain and thrive in their own homes and within their own communities. How we respond to people after a stay in hospital should not undermine this ambition.

63. The development of the model needs to be better understood by our population and by stakeholders outside of the immediate urgent and emergency care system. HOSC can play a crucial and timely role in communicating and explaining this vision to a wider audience.

Lead Director:
Karen Fuller, Corporate Director of Adult Social Care.

Author:
Ian Bottomley, Lead Commissioner – Age Well
January 2024

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Winter Planning Item

Lead Cabinet Member(s) or Responsible Person:

- Lily O' Connor- BOB ICB Programme Director, Urgent and Emergency Care
- Daniel Leveson- BOB ICB Oxfordshire Place lead
- Ben Riley- Executive Managing Director Primary, Community and Dental Care OHFT
- Lisa Glynn - Director of clinical services at OUHFT
- Karen Fuller- Director, Adult Social Care/Victoria Baran – Deputy Director Adult Social Care

The recommendations are made to the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board, Oxford Health NHS Foundation Trust, Oxford University Hospitals, and Adult Social Care. It is requested that a joint response is provided on behalf all the relevant bodies to each of these recommendations.

Deadline for response: Friday 24th November 2023

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. To ensure that there are adequate support measures and processes in place to support staff throughout the winter months, given the anticipated increase in demand for healthcare services.	Accepted	All system partners have their own organisational support mechanisms for staff which does include, support helplines, operational huddles and if necessary more in depth support via HR.
2. To ensure that emergency departments are adequately resourced and staffed to cope with the prospects of increased attendances, as this could also have a knock-on effect on reducing waiting times as well as pressures on staff.	Accepted	Emergency department nurse staffing levels undergo bi-daily assessments, with adjustments made during heightened activity in our Emergency Departments. In such instances, nurses may be redeployed from other clinical areas, or NHSP/Trust pool staff may be utilised to ensure patient and staff safety, as well as the smooth functioning of the department. Daily reviews of medical staffing levels are conducted, and doctors are dynamically assigned to areas with the greatest need on an hourly basis. Additional resources are allocated as needed to facilitate ambulance off-loading, with fluctuations in deployment based on demand. Staffing considerations are deliberated during trust-wide safe staffing meetings and regularly communicated during operational flow meetings throughout both day and night periods. These measures aim to uphold a standard of safety for patients and staff while optimising departmental efficiency.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

3. To seek and dedicate adequate resources for Flu and COVID-19 vaccination programmes, and to also work towards tackling vaccine-hesitancy.	Accepted	BOB ICB will share national and locally produced materials, supporting tailored messaging that reach specific communities: i.e. cohorts identified by UKHSA and at high risk/ of low uptake in previous seasonal vaccine campaigns. We will use the most appropriate and proven communication channels at a system level. Place partners will also use their existing channels and contacts to reach target groups. Engagement and communications activities will take a flexible approach driven by regularly updated data, dealing with localised communication challenges as they arise, and sharing best practice across the region.
4. To develop robust structures and processes to support homeless individuals, particularly rough sleepers, who may be more susceptible to illness during the winter period.	Accepted	Oxfordshire has a robust approach to strategic planning and operational delivery in respect of Homelessness. The Homeless Alliance Directors Group is chaired by the Deputy Director for Housing in the County Council. This group has developed a strategic plan to address homelessness and ensuring oversight of developments and delivery at Director level. To support the Homeless pathway and to reduce the risks to those who are rough sleepers in Oxfordshire the Out of Hospital Team multi disciplinary team provide intensive support to a total of 34 step up and step down beds for those leaving hospital or who are at imminent risk of admission. The team has had additional staff assigned this year including a Dual Diagnosis worker. Staff works across acute sites, the community and mental health settings providing, intensive case management. Whilst the team work all year round, priority is given to those at highest risk of harm particularly during the winter months. During the winter periods where temperatures drop Oxford City Council initiate the Severe Weather Emergency Protocol (SWEP)

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		which offers additional beds to people who would otherwise be rough sleeping during the coldest nights of the year.

Work Programme 2023/24
Joint Health Overview and Scrutiny Committee

Cllr J Hanna OBE Chair | Dr Omid Nouri Omid.Nouri@Oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant strategic priorities	Purpose	Notes / Context	Lead witnesses
8 FEBRUARY 2024				
SCAS Improvement Programme	Prioritise the Health and Wellbeing of Residents	To receive a second update on the SCAS Improvement Programme in light of the most recent "Inadequate" CQC rating.	Overview and Scrutiny	David Eltringham
Director of Public Health Annual Report	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To review the Oxfordshire County Council's Director of Public Health Annual Report.	Overview and Scrutiny	Ansaf Azhar, Director of Public Health.
Oxford University Hospitals NHS Foundation Trust CQC Improvement Journey	Prioritise the Health and Wellbeing of Residents	To receive a report with an update on Oxford University Hospitals NHS Foundation Trust's CQC improvement	Overview and Scrutiny	

		journey, in light of the recent CQC ratings of the John Radcliff Hospital.		
18 APRIL 2024				
GP Provision in Oxfordshire	Prioritise the Health and Wellbeing of Residents	To receive a report on GP Provision within Oxfordshire	Overview and Scrutiny	Julie Dandridge Dan Leveson
Oxford University Hospitals NHSFT People's Plan 2022-2025	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report on the Oxford University Hospital NHSFT People's Plan, with details on the support mechanisms in place for the Provider's staff, (including staff recruitment, retention, and wellbeing).	Overview and Scrutiny	
Dentistry Provision in Oxfordshire	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report from NHS England/BOB ICB with a second/additional update on the state of dentistry provision within Oxfordshire, particularly in light of the recent delegation of dentistry commissioning responsibilities from NHS England to the ICBs.	Overview and Scrutiny	Hugh O keefe Julie Dandridge Dan Leveson

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
1	Minutes of 23 September 2022	Health partners to be invited to the next OCC scrutiny training	Tom Hudson / Omid Nouri	To be actioned in the new municipal year for 23/24. In progress *Update – OCC scrutiny are working up a training proposal with CfGS.*
	24 November 2022 Meeting			
2	Primary Care	Recommendation: Specified roles are filled within the ICB with the primary responsibility to work with District Councils at Place Level to coordinate use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.	Julie Dandridge/ Daniel Leveson	Progress/update response: The ICB have managed to recruit a Primary Care estates manager who will have a key role in working with Districts in terms of planning for new housing developments. The successful candidate starts in December 2023. Unfortunately, recruitment was delayed due to lack of suitable candidates.

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
3	Cllr Barrow's infection control report	OCC carries out a regular review of current infection control procedures in care homes and the support provided.	Karen Fuller, OCC	This is built into our routine procedures in relation to infection control and monitoring outbreaks. OCC works in partnership with Oxford Health care home support service, CQC and UKHSA. *UPDATE – Subsequent Care Home Visits to be arranged in conjunction with the Director for Adult Social Care.*
	10 March 2022 **Meeting**			
4	Access and Waiting Times	Information is supplied on the new elective care access offer across the BOB footprint (the provider collaborative)	Omid Nouri/Titus Burwell	BOB ICS Elective Recovery plan & provider collaborative would need to be presented by BOB ICS colleagues - In progress *Update – A scope is being drawn up for Titus Burwell, Chair of BOB Elective Recovery Backlog Group, to brief the Covid-19 Elective Recovery Backlog group on the subject with a particular focus on Symptomatic breast cancer 2WW and in respect of Urological Cancer referrals.*

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
5	Access and Waiting Times	That Members meet separately with James Scott to explore workforce challenges across Oxfordshire/the NHS	BOB HOSC, BOB ICS	*Eddie and OCC BOB HOSC Members to ask for the item to be placed on the BOB HOSC Work Programme.* In progress *Update – To be considered as part of future discussions amongst the BOB HOSC*
6	Chairs Update	That Members of the Committee come forward in which to develop a glossary of NHS acronyms.	Omid Nouri/ Cllr Nigel Champken-Woods	*Cllr Champken – Woods came forward at the last meeting to start an early draft. It was identified that Wokingham's HOSC glossary as a good model to follow.* In progress *This is currently being collated with Cllr Champken-Woods and will be appended at the back of HOSC agendas once finished.*
	14 July Meeting 2022			
7	Integrated Improvement Programme	Establish a sub group on the Integrated Improvement Programme to provide NHS / OCC colleagues the opportunity to engage with HOSC outside of formal Committee meetings (as well as in addition to). It should cover all aspects of comms and engagement and any issues relating to services at Wantage.	Cllrs Hanna, Edosomwan, Barrow and Barbara Shaw Omid Nouri	In progress – *UPDATE- The Integrated Improvement Programme met as a Member-only forum on 20 September 2022 and agreed to meet with a ICB representative in respect of the ICB's involvement in the IIP. The Group also agreed that a group would engage with representatives at OH in respect of the maternity closures and maternity closures across Oxfordshire.* *Terms of Reference for the Group will be drawn up for engagement in respect of the consultation and delivery plan relating to the IIP.*
	22 September 2022 Meeting			

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	Item	Action/Recommendation	Lead	Progress update
8	Action and Recommendation Tracker	NHS England Health and Justice to fill out the Committee's substantial change toolkit in relation to the SARC in Bicester; this is to then be reviewed by Members via email, with a view to meeting the Commissioner in person.	Lisa Briggs	In Progress - The Substantial Change Toolkit form has been received and was considered by Cllrs Champken-Woods, Hanna and Heywood. It was considered that there was no substantial change. However further information in respect of the service has been requested and waiting a response.
9	Chair's Update and Committee Sub-Group Updates	Further information is sought by the IIP Sub-Group as to how the Integrated Improvement Programme fitted in with the ICB's overall vision.	Omid Nouri/ Dan Leveson	In Progress- The Health Scrutiny Officer is to ask to write to the ICB Place Based Director to ask for his attendance at the next meeting of the sub group; to better understand the ICB Role's in the Integrated Improvement Programme, and clarity as to the leadership and timelines as to the Programme.
10	Chair's Update and Committee Sub-Group Updates	Following an initial meeting with the new provider, a HOSC member is appointed to Connect Health's service-user board	Danielle Chulan	In Progress- The provider is to get in contact when the board is set up.
	24 November 2022 Meeting			
11	**Primary Care**	The Committee is informed as to how much Community Infrastructure Levy funding has been received by the Oxfordshire CCG and subsequently the BOB ICB (from Oxfordshire), the amounts received from the 5 individual District Councils, how much of those CIL funds have been spent, which health related CIL funded projects have been commissioned; and what projects have been completed or are in progress using executed Section 106 funds.	Julie Dandridge	In progress – The ICB has been reminded of these questions and will feedback to the Committee outside the formal Committee process. *UPDATE – Julie Dandridge to provide an update on a list in respect of where the funds currently sat, time restrictions and other obligations.*

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	Item	Action/Recommendation	Lead	Progress update
12	**Serious Adult Mental Health**	A workshop on serious adult mental health is co-produced to allow further Committee exploration of the area.	Omid Nouri, OH, Karen Stephen Chandler	In progress – To be scoped after the 9th of February 2023 HOSC Meeting.
	9 February 2023 Meeting			
13	**SCAS Improvement Programme Update**	SCAS' performance data be regularly reviewed by the Committee's Covid-19 Elective Recovery Sub-Group.	Omid Nouri/ Tom Stevenson	In progress- The Committee is to be advised when the wait-time performance data can be broken down into (Middle Layer Super Output Areas) MSOA level. Likely to be Autumn 2023
14	**Committee Work Programming**	A Work Programming Meeting be arranged with all Committee Members	Omid Nouri/ Tom Hudson	In progress – a partial work plan has been suggested, but in light of the appointment of a new Scrutiny Officer the completion of the new work plan is to take place once they are in post and are better placed to help the committee deliver it.
	11 May 2023 Meeting			
15	**Dentistry Provision in Oxfordshire**	To collaborate with the Place Based Partnership, Public Health, and providers with a view to creating a base line dentistry data set that will mean local improvements to poor dental health of residents can be achieved and clearly communicated.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The Oxfordshire Joint Strategic Needs Assessment (2023) contains information about the oral health of 5 year olds in the county. This information is derived from national epidemiological surveys. The ICB will work with Public Health colleagues to review and update this information.

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				The ICB is developing a Primary Care strategy including dental services. This will include a review current data and the development of datasets to inform future commissioning plans. There is a strong link between socio-economic factors and health. The aim is to develop a strategy outlining how primary care via service delivery and partnership working with other agencies will improve the health of the population with oral health to be a key element of the strategy.
10	**Dentistry Provision in Oxfordshire**	To resolve any remaining uncertainty regarding the local flexibilities available to the ICB, and to consider investment of the underspend in Oxfordshire in targeted action to improve access to health and better serve Oxfordshire's children and residents with the greatest need.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The BOB ICB Flexible Commissioning pilot commenced on 1st June 2023. The pilot scheme will run to 31st March 2024 and is designed to support access to NHS dental care for patients who have struggled to access NHS dental care. The scheme supports access for patients who have not attended a local dental practice for 2 years; who have relocated to the area; Looked After Children, families of armed forces personnel, asylum seekers and Refugees. Practices can also see 'other' patients of they believe it to be clinically appropriate. It allows practices to convert up to 10% of their contractual capacity from the delivery of activity targets to access sessions, where more time can be set aside for patients likely to have higher treatment needs. 30 practices in BOB are

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				taking part in the scheme (18 from Oxfordshire) with plans to provide nearly 3,000 Flexible Commissioning access sessions in the period July 2023 to March 2024. In the first 4 months about 900 sessions were provided with 3,000 patients attending (3,500 attendances). About 70% of patients attending to date have not attended a dental practice for 2 years; 14% have relocated to the area; 12% 'other' (includes patients who have been unable to access care, urgent patients, maternity, patients with an on-going clinical need that requires dental intervention, vulnerable patients, children's emergency trauma and cancer patients needing dental treatment as part of their care). 4% of attendances have been from Looked After Children, families of armed forces personnel and asylum seekers and refugees. The service is subject to on-going review and development. National guidance in respect of Flexible Commissioning was issued in October 2023. Whilst access to NHS dental services is continuing to improve, some capacity has been lost following decisions by some practices to leave the NHS or reduce their NHS commitment. The ICB is working with local practices on a re-commissioning

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				plan to replace this capacity from 2023-24 onwards.
	21 September 2023 Meeting			
17	**Oxfordshire Healthy Weight**	Recommendation: To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): We currently commission two healthy weight services at Local Authority level, one that works with adults and another working with children. We also link closely with partners (NHS) who offer services at tiers above and below our own with a view to offering a seamless pathway. We identified some gaps in service as part of the recent Health Needs Assessment (HNA) on Healthy Weight. The current contract is coming to an end and we are planning to commission an 'all age service' with some additional elements to meet the gaps identified in the HNA. We are also planning a review and refresh of opportunities to raise awareness of support that is available.
18	**Oxfordshire Healthy Weight**	Recommendation: To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): The current healthy weight service has specific programmes for ethnic groups

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				who are more likely to develop excess weight. This includes innovation pilots working in mosques, women only sessions, and tailoring content to be specific (e.g. on food types) The new service will build on this learning/modelling and is likely to have community development as a delivery component within key priority areas and populations, including ethnically diverse.
19	**Oxfordshire Healthy Weight**	Recommendation: To work on providing support to the parents, carers, or families of children living with excess weight, and to help provide them with the tools to help manage children's weight.	Derys Pragnell	Recommendation Accepted, HOSC will receive future progress update in April 2024.
20	**Oxfordshire Healthy Weight**	Recommendation: To explore avenues of support for residents who may struggle to afford healthy diets in the context of the cost-of-living crisis.	Derys Pragnell	Comment on Recommendation: This should be an action/link for Food Strategy work across Oxfordshire, which is led by Laura, Rushen, Senior Policy Officer at OCC– each District Council has been commissioned to undertake work for their District.
21	**Oxfordshire Healthy Weight**	Recommendation: To ensure that consideration of the ill-effects of being underweight is also built into the language adopted, and the services being commissioned, as part of promoting Healthy Weight overall within the County.	Derys Pragnell	Response and Rejection of Recommendation: This wasn't part of the discussion at the meeting which was focussing on excess weight. Whilst this is a very important issue we need to remain focussed on tackling excess weight. There are significant differences between the causes, behaviours and actions that can

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				be taken associated with underweight as opposed excess weight and none of the preventative, environmental actions or services commissioned have synergy. To set context while over 30% of children in year 6 and 60% of adults in Oxfordshire are living with excess weight around 1% of children experience underweight.
22	**Oxfordshire Healthy Weight**	Recommendation: In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this.		A separate response to this recommendation will be sought from BOB ICB.
23	**Oxfordshire Healthy Weight**	Recommendation: To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils and lead officer responsible for advertising/sponsorship policy as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and the advertising of HFSS products.	Derys Pragnell/ Omid Nouri	Health Scrutiny Officer (Omid Nouri) to liaise with relevant officers to facilitate this meeting in the near future.
24	**Health and Wellbeing Strategy**	Recommendation: To ensure careful, effective, and coordinated efforts amongst system partners to develop an explicit criteria for monitoring the deliverability of the strategy; and to explore the prospect of	David Munday	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024):

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		enabling input/feedback from disadvantaged groups as part of this process.		The Health and Wellbeing board has committed to the development of a delivery plan and outcomes framework for this new HWB strategy. This is to ensure the strategy is delivered by the partnership. We expect that an initial version of this will be presented to the HWB in March 24 and it will build on the strong public engagement that has already occurred in the strategy formation to date.
Page 169	**Local Area Partnership SEND**	Recommendation: For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Partnership leadership, assurance, and oversight of SEND provision is by the Oxfordshire SEND Improvement Board (SIB). The Board provides transparent visibility of progress, constructive and robust challenge, as well as celebrating what is working well and improving. The progress of improvements will be routinely scrutinsed by appropriate scrutiny arrangements (People Scrutiny, HOSC and ICB Quality Group). Operational delivery of the Priority Action Plan (PAP) is via the Partnership Delivery Group (PDG), supported by time-limited Task and Finish groups. SIB, PDG, and Task and Finish groups all include Parent/ Carer representation. Continued improved communication with families and stakeholders is a key focus of our SEND action planning. It underpins our

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				governance arrangements, is a key priority within the PAP, and is a focus area of our Working Together Task and Finish group.
Page 170	**Local Area Partnership SEND**	Recommendation: To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to develop explicit Key Performance Indicators for measuring the effectiveness of improvements that are open to scrutiny. The Committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent. The SIB will consider at its inaugural meeting how best to ensure information easily and publicly available.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): The Priority Action Plan includes development of an Integrated Local Area Partnership SEND dashboard, based on partnership KPIs, with performance overseen by the SIB. As above, ongoing PAP action planning is operationally overseen by PDG and Task and Finish Groups. PDG reports monthly to the SIB.
	Local Area Partnership SEND	Recommendation: For the Leadership to adopt restorative thinking and practices with utmost urgency to reassure affected families, and for this thinking to be placed at the heart of any co-production exercises to help families feel their voices are being heard as well as for the purposes of transparency.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Restorative Approaches are well-established within Children's Services. Co-production with children and families is at the heart of PAP and wider action planning. As noted, they are represented within all leadership & delivery bodies for SEND improvement.

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Page 171	**Local Area Partnership SEND**	Recommendation: To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be considered in tackling the systemic failings highlighted in the report. The Committee also recommends that the Partnership considers timely allocation of seed funding for the development of co-production involving people with lived experience; and for joint commissioning of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector, and families.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): SIB responsibilities include ensuring that co-production is embedded in the culture of SEND services. Our Multi Agency Quality Assurance (MAQA) forum has the purpose of setting out consistent, service specific processes for the quality assurance of Education, Health, and Care Plans, ensuring that good practice and learning is shared, informs training and professional development for all professionals involved in the process, underpinning our vision for shared responsibility for improving outcomes, on the improvements achieved and next steps. Partnership training, and impact measures, are included in the PAP. All PAP actions are time-specified, ranging from December 2023 to post-July 2025, dependent on prioritisation and practicability.
	Local Area Partnership SEND	Recommendation: To continue to improve working collaboration amongst the Local Area Partnership to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are existing arrangements to enable the sharing of information across partners. The effectiveness of these will be considered as part of the improvement journey.

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	Local Area Partnership SEND	Recommendation: For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/ alternative services available which a child may also need a referral to. It is also recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council, using the budget agreed by cabinet immediately following the Ofsted report.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Priority actions within the PAP include co-production of both refreshed Local Offer and development of local area partnership early help and early intervention strategy. Together with improved EHCP assessment process, and Team Around the Family, this will enable the delivery of needs-led provision and the progression of outcome led plans with families. As noted above (Paragraph 8), continued improved communication with stakeholders and families is a key priority.
	Local Area Partnership SEND	Recommendation: To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Timeliness and quality of EHPCs, along with improved parental access to the digital portal, are addressed within PAP item 3. Actions include ensuring accurate, timely, and effective assessment, and effectively meeting needs, particularly at points of transition. Assessment timeliness is improving, despite increasing demand. Timeliness of completion within 20 weeks has improved from 40% in June 2023 to 50% in the last month.

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Page 173	**Local Area Partnership SEND**	Recommendation: For SEND commissioning to be developed using the Ofsted report as a baseline, and to place person-centred mental and physical health of children and their families with SEND at the centre of decisions on how funding is spent to maximise social value. The Committee also recommends for the Local Area Partnership to map all funding sources available for, and to explore joint commissioning of services and training that could improve the overall health and wellbeing for children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): PAP priority actions include a focus on improved commissioning and strong relationships with commissioned providers, to improve capacity, meet demand, and meet the needs of children, young people, and their families. The PAP is also focused on ensuring commissioning arrangements support timely decision making and transition arrangements, and that there is a multi-agency approach to meeting the needs of children with emotional and mental health difficulties. The Leadership and Partnership Task and Finish group has responsibility for integrated commissioning of SEND services. The Oxfordshire Joint Commissioning Executive, which plays a key role in the delivery of many Priority Action Plan actions, reports into the Partnership Delivery Group.
	Local Area Partnership SEND	Recommendation: To ensure that there is clarity of information on any physical or mental health services for children with SEND, to reduce the risk of confusion and lack of awareness of such services amongst parents, carers or families of children who require support for their mental or physical health.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): A local area pathway is being developed for children and young people with emotional wellbeing and mental health concerns. The i-THRIVE framework (an integrated, person-centred, and needs-led approach to delivering mental health

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				services for children, young people, and their parents/carers) will be linked to the Early Help Strategy and Team Around the Family.
Page 174	**Local Area Partnership SEND**	Recommendation: To exercise learning from how other Counties and Systems have provided well-coordinated and effective SEND provision; particularly where measures have been adopted to specifically reduce the tendency for poor mental or physical health amongst affected Children and Young People.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Our response to the SEND inspection, including development of PAP and KPI dashboard, has been informed by learning from other local authorities. Children's Services senior leadership bring a wealth of experience in delivering transformation and service improvement within other local authorities. This includes both the recently appointed independent chair of the SIB, Steve Crocker (Former President of Association of Director of Children's Services) and new SEND/ Children's Services Improvement. We have invested in an additional Assistant Director for Early Help & Prevention, and Strategic Lead for Specialist Projects. Deputy Directors for Children's Social Care/ Education are likewise experienced.
	Local Area Partnership SEND	Recommendation: To ensure that staff involved in Health, Care, Education, and any relevant Voluntary Sector organisations are sufficiently trained and aware of children that may be neuro-divergent, have a learning difficulty or a disability (SEND); and for such staff to be adequately aware of the support and resources available, and	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): As noted above, partnership training is embedded within the PAP. The Working Together Task & Finish group leads on Workforce Development.

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		the processes for referring such children for any relevant mental or physical health services that they might require.		
	Local Area Partnership	Recommendation: For HOSC to continue to follow this item and to evaluate the impact of any changes or improvements made, with specific insights into the following; the Partnership's Action Plan as requested by HMCI; the overall measures taken to address the concerns raised by the Ofsted/CQC inspection; the progress made by CAMHS in reducing waiting times for treatment of children with SEND who require mental health support; and on how the NHS is working to increase the overall acquisition and availability of data on SEND children's mental health from key mental health providers.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are clear governance and reporting structures, as outlined above. We can provide updates as required.
	Winter Planning	Recommendation: To ensure that there are adequate support measures and processes in place to support staff throughout the winter months, given the anticipated increase in demand for healthcare services.	Karen Fuller/ Dan Leveson/ Lilly Oconnor	Recommendation Accepted: Response: All system partners have their own organisational support mechanisms for staff which does include, support helplines, operational huddles and if necessary more in depth support via HR.
	Winter Planning	Recommendation: To ensure that emergency departments are adequately resourced and staffed to cope with the prospects of increased attendances, as this could also have a knock-on effect on reducing waiting times as well as pressures on staff.	Karen Fuller/ Dan Leveson/ Lilly Oconnor	Recommendation Accepted: Response: Emergency department nurse staffing levels undergo bi-daily assessments, with adjustments made during heightened activity in our Emergency Departments. In such instances, nurses may be redeployed from

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				other clinical areas, or NHSP/Trust pool staff may be utilised to ensure patient and staff safety, as well as the smooth functioning of the department. Daily reviews of medical staffing levels are conducted, and doctors are dynamically assigned to areas with the greatest need on an hourly basis. Additional resources are allocated as needed to facilitate ambulance off-loading, with fluctuations in deployment based on demand. Staffing considerations are deliberated during trust-wide safe staffing meetings and regularly communicated during operational flow meetings throughout both day and night periods. These measures aim to uphold a standard of safety for patients and staff while optimising departmental efficiency.
	Winter Planning	Recommendation: To seek and dedicate adequate resources for Flu and COVID-19 vaccination programmes, and to also work towards tackling vaccine-hesitancy.	Karen Fuller/ Dan Leveson/ Lilly Oconnor	Recommendation Accepted: Response: BOB ICB will share national and locally produced materials, supporting tailored messaging that reach specific communities: i.e. cohorts identified by UKHSA and at high risk/ of low uptake in previous seasonal vaccine campaigns. We will use the most appropriate and proven communication channels at a system level.

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				Place partners will also use their existing channels and contacts to reach target groups. Engagement and communications activities will take a flexible approach driven by regularly updated data, dealing with localised communication challenges as they arise, and sharing best practice across the region. Additional detailed response provided specifically from BOB ICB: *"The ICB currently have numerous Access & Inequality projects running throughout Oxfordshire for this Autumn/Winter campaign targeting COVID-19 vaccine hesitancy & uptake through understanding barriers and dispelling myths across different populations, particularly those from ethnic minority/low uptake areas. This includes a Community Champions Project in Oxford City, where Champions are engaging with communities/populations where hesitancy is high. BOB ICB are working with the Oxford City Council to run this (through community insight) as part of a wider health promotion/protection approach to health and well-being. Cohorts being targeted as part of this include BAME populations; pregnant women; LD/SMI; homeless and asylum seekers/refugees as well as areas of high deprivation.*

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				The ICB have supported a Maternity Champion's project running in partnership with Oxford University Hospitals (OUH) targeting hesitancy in pregnant women and aims to raise vaccine uptake within this cohort. As well as running a project with the Community Hepatology Team from OUH. They have a van that they take around the Thames Valley testing for and treating HCV, HBV, syphilis etc. They see a wide range of patients who don't otherwise engage in primary and secondary care and who wouldn't normally have access to COVID-19 vaccination. This project will allow the team to provide education regarding vaccines to these patients, addressing hesitancy and then administering them to those who want it, increasing uptake across an underserved community. *Further projects are focused on targeting an asylum seeker hotel in Oxfordshire, where our provider will run a clinic administering vaccinations to eligible asylum seekers, who would not have had access to a vaccine prior to this clinic's development. We are also running a couple of pop-up clinics in Oxfordshire to target gaps and help increase uptake in areas where people may have difficulty accessing a vaccination.* *The ICB has worked with a provider running to support an outreach project in the Banbury area aiming to ensure all their*

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				patients, especially those from disadvantaged backgrounds, get access to COVID-19 vaccination. These groups include BAME, learning disability, significant mental illness, asylum seekers, elderly patients with significant comorbidities and those who have poor access to IT/internet facilities and/or need English language support. As part of this the team will address any vaccine cultural barriers and hesitancies with certain cohorts of patient groups (as mentioned above)".
	Winter Planning	Recommendation: To develop robust structures and processes to support homeless individuals, particularly rough sleepers, who may be more susceptible to illness during the winter period.	Karen Fuller/ Dan Leveson/ Lily OConnor	Recommendation Accepted: Response: Oxfordshire has a robust approach to strategic planning and operational delivery in respect of Homelessness. The Homeless Alliance Directors Group is chaired by the Deputy Director for Housing in the County Council. This group has developed a strategic plan to address homelessness and ensuring oversight of developments and delivery at Director level. To support the Homeless pathway and to reduce the risks to those who are rough sleepers in Oxfordshire, the Out of Hospital multi-disciplinary team provide intensive support to a total of 34 step-up and step-down beds for those leaving hospital or who are at imminent risk of admission. The team has had

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				additional staff assigned this year including a Dual Diagnosis worker. Staff work across acute sites, the community and mental health settings providing, intensive case management. Whilst the team work all year round, priority is given to those at highest risk of harm particularly during the winter months. During the winter periods where temperatures drop Oxford City Council initiate the Severe Weather Emergency Protocol (SWEP) which offers additional beds to people who would otherwise be rough sleeping during the coldest nights of the year.