Health Overview and Scrutiny Committee.
08 February 2018

Chairman's Report

1. Reporting back from HOSC on 16th November 2017

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

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

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

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

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

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

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

1.6 OCCG and partners agreed to a review of mental health across the system to inform ongoing priorities; after an extended period agreeing the terms of reference for the review it was agreed it would concentrate on Oxfordshire rather than the original intention to include Buckinghamshire and Berkshire. Work is in progress to be completed during Q4 to:

- Produce a comprehensive mental health needs assessment for Oxfordshire, to include current and future prevalence data and trends, and consider social and physical determinants of health and include those with protected characteristics.
- Report on the effectiveness of current resources and practice, and consider further opportunities arising from improved coverage of a range of interventions to treat mental disorder, prevent associated impacts, prevent mental disorder from arising and promote mental wellbeing.

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

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

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

- Equality Analyses are completed for all pieces of work that could lead to changes in services or service re-design. These are published and are recognised as an important and integral part of the way OCCG works. For major pieces of work, additional expertise may be commissioned to support this assessment.
- The draft Locality Place based Plans for primary care will all include a key feature relating to addressing health inequalities reflecting the local differences across Oxfordshire's communities whether the inequalities relate to urban deprivation or social isolation in rural parts of the county.
- A specialist team is employed in OCCG to support work reaching into communities that might otherwise be missed. Their work focuses on Banbury and Oxford where the highest density of health inequalities exist but their work stretches to other parts of the county as needed.
- There are multi-agency Health Partnerships in the Oxford city regeneration areas and in Banbury, which have action plans to address the local health inequalities.
- There are joint workshops with Public Health to review data sets and ensure that anomalies in data for areas of inequality are highlighted and acted on.

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

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

1.12 *Report back on Item 9: Managing the impact of winter on Oxfordshire's Healthcare System*

1.13 **Question: What are the staff sickness levels in the Oxfordshire Provider Trusts?**

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

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

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

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

Oxford Health NHS Foundation Trust Data for beds available:	
Available Beds across the community hospitals	
10th Jan 2017	10th Jan 2018
153	151

Oxford University Hospitals NHS Foundation Trust Data for beds available:	
Available Beds across OUHFT sites	
7th Jan 2017	7th Jan 2018
1,151	1,071

2. Banbury Health Centre: update

2.0 At the Committee's meeting on the 16th of November 2017, information was sought from Oxfordshire CCG on its plans for future changes and consultation for Banbury Health Centre. The following provides a briefing on the current situation regarding Banbury Health Centre.

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

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

2.3 OCCG have listened to the patients of the practice and to the views of other stakeholders including JOHOSC, Cherwell District Council, the local Community Partnership Network and the local MP. Further discussions will agree the details but OCCG have determined that whilst they wish to continue with forming a new larger practice, it will continue to provide services from Banbury Health Centre building. OCCG have agreed a contract extension with PML[1] the current holders of the contract to allow new arrangements to be put in place. This means the consultation is no longer needed as it is anticipated there being no significant changes for patients. OCCG have written to PPG members and others who have been involved so far.

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

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

[1] PML (Principal Medical Ltd) is a not-for-profit organisation. It is owned and run by GPs in Oxfordshire and Northamptonshire.

3. Health and Social Care Liaison

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

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

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

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

4.0 A Judicial Review was heard on the 6th and 7th of December 2017 in response to a legal challenge on Oxfordshire Clinical Commissioning Group's (CCG) consultation for Phase One of the Transformation Programme. The challenge was launched by Cherwell District Council, with support from South Northamptonshire Council, Stratford-on-Avon District Council, Banbury Town Council and interested party Keep the Horton General. Following the hearing at the High Court Judge, Mr Justice Mostyn announced his decision on the 21st of December to dismiss the judicial review. Cherwell District Council and partners, had appealed six points relating the consultation process. All six of the following were dismissed;

- The interdependencies of clinical disciplines and the split consultation
- Misleading maternity information
- Insufficient information
- Not meeting the new Government test for hospital bed closures
- Legitimate expectation
- Inadequate ambulance service effect.

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

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

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

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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POC_1097166

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

10 JAN 2018

Dear Cllr Fatemian,

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

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

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

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

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

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

Yours sincerely

Jeremy Hunt

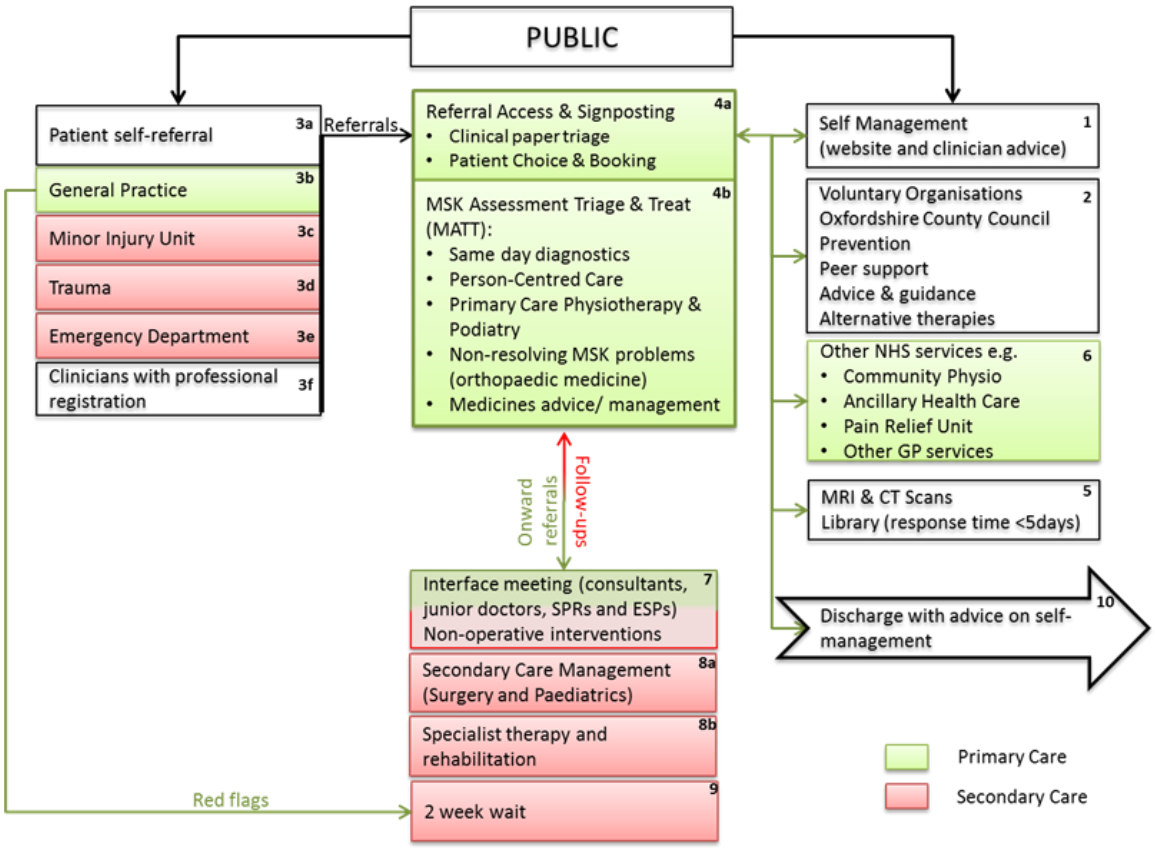
JEREMY HUNT

6. Musculoskeletal services

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

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

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



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

6.4 **For example, the business case made reference to commissioning a specific care package for "mental health" - was this included in the final agreement? Was it included? Were any elements of the final business case not included in the final contract arrangements?**

6.5 Pain management/rehabilitation has been included and yes mental health was included and the service staffing included psychology but the service will mainly use the IAPT service to ensure services are joined up. Nothing was removed.

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

6.7 All MSK conditions.

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

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

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

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

d. **If the commissioning structure will prevent any possibility of perverse incentives.**

All of those that we have thought of.

6.9 *Transition/implementation issues:*

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

6.11 Average waits were around 16 weeks as far as we know. OH waits were around 20 weeks and OUH waits around 8-10 weeks.

6.12 **Question: What has been the average waiting time for MSK services for the period following the introduction of the new service?**

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

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

6.15 Outcomes to be monitored:

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