Oxfordshire Joint Overview and Scrutiny Committee.
6th February 2020

Chairman's Report

1.0 Horton HOSC

1.1 The Horton HOSC met on the 19th of September 2019 when it unanimously agreed to refer the CGG Board decision to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future, back to the Secretary of State based on the following two requirements:

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

1.2 The referral letter was sent to the Secretary of State on the 2nd of December 2019. No response has yet been made to this letter. Copies of the letter can be obtained on request by emailing: Samantha.shepherd@oxfordshire.gov.uk

2.0 Child and Adolescent Mental Health Services (CAMHs)

2.1 During the committee's consideration of CAMHs on the 21st of November, Members considered a progress report on:

- Implementation of Mental Health Support Teams (MHSTs) in Oxfordshire schools
- New MHSTs fit within the overall Children and Adolescent Mental Health Service (CAMHS) provided by Oxford health NHS Foundation Trust (OHFT)
- Oxfordshire four week wait pilot, funded by NHS England, at its meeting on 21 November:

https://mycouncil.oxfordshire.gov.uk/documents/s48964/JHO_NOV2119R09%20CAMHS.pdf

2.2 A further item on CAMHs was originally planned to be on the HOSC agenda on the 6th February 2020. Owing to the need to consider a substantive item on the application of the 'Local Health Needs Assessment Framework' in OX12 on the 6th of February, the following information has been provided to respond to the Committee's questions (includes questions sent by individual Members of HOSC)

HOSC are keen to have a better understanding of the partnership arrangements in place with the third sector for provision of CAMHS

2.3 The Oxfordshire CAMHS Partnership is a new and innovative way of delivering mental health services and accessible support, outside traditional mental health services structures, to the young people of Oxfordshire. OHFT has built a unique partnership with local leading third-sector organisations spread across the county to increase the

options open to local young people. The Partnership is supported, managed and funded directly by CAMHS.

2.4 Led by the charity Response (who have a co-ordinating and bridging role between the third sector organisations in the partnership and CAMHS), a sub-group of seven specialist organisations, add a range of responsive options to the CAMHS services: Oxfordshire Youth, RAW, Ark-T, SOFEA, Synolos, Trax and Banbury Young Homelessness Project (BHYP).

2.5 This new Partnership offers a variety of venues across Oxfordshire, supporting young people aged 14-25yrs, and allowing us to support young people at 18 years of age. Response has a key role with the partners and the governance is set out under NHS Terms and Conditions with each organisation sub-contracted with OHFT from the main contract with Oxfordshire Clinical Commissioning Group (OCCG).

2.6 In addition, Oxfordshire Youth has been awarded the key training role in the partnership. Utilising a network of members, they coordinate the roll out of Children and Young Peoples Mental Health Awareness training for teachers and practitioners working with Children and young people in the county. Autism Family Support is sub-contracted to provide post diagnostic support for the Neurodevelopmental Service.

2.7 Recruitment is an ongoing challenge and the OHFT has adopted several strategies to support qualified staff to get jobs and sustain their working lives in Oxfordshire. However, the partnership enables OHFT to develop and recruit a new staffing group from the third sector. This has allowed OHFT to have access to a work force that is much more successful in recruitment and provides a robust workforce who can offer short term interventions for low-moderate mental health issues. This has greatly improved the ability to sustain a viable workforce as well as increase capacity to see more young people within the funds available. In addition, the partnership organisations are able to bid for external funding opportunities. Response has recently been successful in bidding for £250,000 to support young people aged 18-25 years.

HOSC are keen to have a better understanding on the impact of the Healios service on waiting times.

2.8 Healios is a specialist online provider of mental healthcare and is used by many other areas in England and Scotland. They contact young people, families and carers via their secure online clinical platform.

2.9 OHFT has commissioned Healios as part of the 4 week wait pilot to support the reduction of long term waiters within the ‘Getting Help’ Pathway. They are contracted to provide 800 assessments and 3840 Cognitive Behavioural Therapy (CBT) sessions for 640 young people. Currently there have been 391 referrals to Healios, who aim to hold the first clinical session within 14 days. They have completed 364 assessments and provided 2227 treatment sessions. There is excellent feedback from young people and families.

2.10 It should be noted that Healios is currently used to address young people with long waits; it does not therefore directly impact on the waiting time target. This continues to provide a challenge because demand is increasing.

Understanding of the steps which have been taken to reduce long waits to prevent prolonged distress for children and their families. Including how families are supported during their wait.

2.11 Despite the increase in demand and consequent pressures this brings, the CAMHS service has once again been rated as 'Good' by the Care Quality Commission (CQC) in 2019. It should be noted that waiting times in CAMHS in Oxfordshire are significantly better than many other areas of the country. CAMHS in Oxfordshire is recognised by NHS England as having a robust approach to managing waiting times, despite the challenges of demand that remain.

2.12 The redesign and transformation of CAMHS was originally undertaken to address the increase in demand and to make CAMHS a service fit for the future. Since redesigning the CAMHS service demand has continued to increase in line with the national picture.

2.13 Oxfordshire are part of the national NHS England programme for the 4 Week Wait pilot, which is designed to establish what capacity is needed to meet a reasonable wait for a CAMHS Service. The pilot will help inform a national CAMHS waiting times standard. Oxfordshire are one out of 12 areas in England who are working with NHS England Improvement Team to ensure our service is efficient, effective and delivers good quality patient care. NHSE Improvement Team will be supporting Oxfordshire in this endeavour with tools and expertise.

2.14 Oxfordshire have received funding for an extra 25 whole time equivalents (WTEs) across the Getting Help and Getting More Help pathways as part of this programme and these posts are now fully recruited to. Oxfordshire have also received additional funding through a bidding process to recruit to an additional 3 WTE Band 6 and 0.6 Psychiatrist time for the Neuro Development Conditions1 (NDC) pathway to help reduce waits. OCCG is monitored quarterly on progress with the pilot.

2.15 All referrals are triaged in the Single Point of Access (SPA) for risk and possible reasons to prioritise (i.e. for Looked After Children). All referrals are received and triaged in Single Point of Access. Self-help tools and other resources are given to the young person to work through while they wait (e.g. mood juice), along with information on how to contact the service should they feel they have deteriorated. The young person/families also have access to a first responder (duty clinician) within the pathway. SPA also remains available for young people/ families to contact if they require further advice/consultation, and the crisis team can be accessed 24/7 for emergencies.

2.16 For those waiting over 16 weeks a checking in call is undertaken by a clinician, who reassess the situation and investigates if escalation is necessary. Oxfordshire had no escalations based on change in clinical need, but small numbers have been escalated due to changes in family circumstances and school non-attendance. This is monitored by both OHFT and OCCG through monthly contract meetings.

[1] Autism and Attention Deficit Hyperactivity Disorder (ADHD)

Priority on waiting lists – how will priority on long waiting times be determined for Healios? What is the anticipated length of time to clear the backlog of those waiting the longest for access to CAMHS?

2.17 All referrals come in through the Single Point of Access (SPA) and are triaged using nationally validated clinical assessment tools. A summary of the decision is sent to the right pathway for allocation. All referrals are screened for general functionality using the child global assessment scale (C-GAS). This supports the assessment by showing the impact on the young person's life at home, school and with peers, and this is then able to help CAMHS identify young people who may have a less acute mental health concern, but the impact on them is much greater and therefore risk is higher. All young people coming into CAMHS are given self-help tools to work through while they wait for assessment and are informed of how to contact the service should they feel they have deteriorated.

2.18 Not all young people waiting for a service from CAMHS accept a referral to Healios once offered, and even when referred young people can change their mind and wait for a CAMHS assessment. The backlog will not be cleared by Healios alone, this will require additional capacity in other parts of the service such as the Getting Help and Getting More Help Pathways. This is where the 4 week wait pilot money is targeted with twenty five new staff in those pathways. Healios is currently being offered to those waiting since November 2019.

How will successes and failures for the pilots be reviewed and reported? (i.e. will it be no's on waiting list reducing, or length of wait)? Can the metrics used to demonstrate success be shared with HOSC (in a similar way to DTOC figures)?

2.19 The pilots will end in April 2021 and NHS England will undertake a national evaluation of the pilots. The national evaluation has been commissioned by Birmingham University, and Cambridge Evaluation (BRACE) Centre and the Policy Innovation and Evaluation Unit (PIRU) at the London School of Hygiene and Tropical Medicine. This will consist of surveys with Senior Mental Health Leads (in schools) and key strategic stakeholders. This is due to start in January 2020. Both groups will be surveyed twice: once in early 2020, and again in early 2021. The purpose of the surveys will be to gather information that will not be collected routinely.

2.20 NHS England has not yet published the evaluation criteria. There are currently no performance indicators or targets in place for number of young people accessing MHSTs. Oxfordshire are primarily in a test and learn phase and aim to cover 8,000 children per team and to provide direct intervention to 500 individuals per team.

What is the demand for services and how will the additional resources address this demand? (i.e. 1 member of staff stated to be allocated per 1000 people, but what is the actual demand within the 1000 and how will additional staff be used to meet this level of demand).

2.21 There are on average 480 referrals to the Single Point of Access every month (3,058 so far April 2019 – December 2019). The additional MHST money is to help make CAMHS

be more accessible to all. The model has based the schools in-reach element for CAMHS on a foundation of joint working between schools, colleges, the Council's Locality and Community Support Service (LCSS), the school and college nursing service and our third sector mental health partnership. Identifying emotional mental health needs at the earliest opportunity. The MHST money is not for addressing the increasing demand for specialist CAMHS provision.

2.22 The 4 week wait pilot is based upon additional staffing; however, it has been difficult to recruit the new workforce, as it has been generally within CAMHS. Developmental posts are being used where it has been difficult to recruit experienced clinicians. This is a national issue within the NHS, for instance there is an 18% vacancy rate within Consultant Psychiatry within the south due to a national shortage.

2.23 OHFT are working to complete a demand and capacity modelling in CAMHS. This will identify improvements in patient management and flow through services to ensure that the new resources are used in the most efficient way and increase capacity to offer appointments to children. As we know demand continues to rise but the service benchmarks well against the national CAMHS access target. Nationally 34% of children who need CAMHS should have their needs met, in Oxfordshire current performance is 64%.

Financial resources: Is there any financial information that can be provided? E.g. what is the proportion of the mental health budget spent on CAMHS services? How does the allocation on mental health services for children compare to other CCGs around the country? Any other information about financial resources and how they are allocated would be helpful.

2.24 CAMHS is jointly commissioned between OCCG and Oxford shire County Council (OCC); OCCG is the lead commissioner. The CAMHS investment this financial year is £11,181,000 (excluding learning disability) and represents 15.7% of the OCCG mental health budget. This includes the OCC investment of £754,000.

2.25 Oxfordshire benchmarks well nationally in terms of investment in mental health services for 0-18 year olds. The national CAMHS Benchmarking Report2 for 2018-19 indicates that the average spend for 0-18 year olds is £ 5,463,262 per 100,000 population. In Oxfordshire the spend is £7,454,00 per 100,000. A further breakdown of the investments is published annually in the CAMHS Local Transformation Plan, which is available on the OCCG website3.

It was clear from the earlier presentations that prevalence of childhood mental health problems are associated with poverty and deprivation. What efforts have been made to allocate resources in relation to need? Are the new projects which were described in November targeted at those with most need? Can the CCG explain how the new services address the inequalities associated with CAMHS?

2.26 Please see answer 1.28 below.

[2] https://www.nhsbenchmarking.nhs.uk/news/launched-2018-mental-health-inpatient-and-community-tz738-a3et8
[3] https://www.oxfordshireccg.nhs.uk/about-us/oxfordshire-child-and-adolescent-mental-health-services-refresh.htm

2.27 ***An explanation/description of the data that is publicly available on the Public Health England website and describing how it could be used to assist in the development of services.*** (The website is: https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/)

2.28 OCCG uses the Oxfordshire Joint Strategic Needs Assessment (JSNA) and Public Health England Fingertips as well as other datasets and service reports to commission mental health services. An additional needs analysis report was developed for the bidding process for the Mental Health Team into Schools Pilot, using the available needs data from the JSNA and Fingertips. Oxfordshire did not receive funding to cover all of Oxfordshire so this analysis informed and supported the decision to target the teams on Oxford City, Banbury and Bicester. These areas have the greatest levels of need. This decision-making process was supported by the CAMHS Assurance Board which is multiagency.

Regarding priority on waiting lists. How does the CAMHs service prioritise between primary and secondary age pupils? How does the CAMHs service ensure that primary school pupils in rural areas are not disadvantaged with longer waits/greater delays before pupils are seen?

2.29 Oxfordshire CAMHS uses the new national model, named the Thrive Model (Anna Freud Centre- Tavistock), and is based upon need rather than the age of the young person or where they live. This has been endorsed by the 'Future in Mind' report and was also well received by stakeholders during the CAMHS review.

What is the service doing to ensure/ improve knowledge and information about CAMHs in areas outside the MHST pilot areas?

2.30 Part of the CAMHS Transformation programme is to improve information and advice as part of our prevention and early intervention approach. To improve this, the CAMHS website has undergone extensive redesign which has been co-produced with young people. This aims to provide accurate and accessible information about access, self-help tools and when and where to seek help. The Single Point of Access has also been in place for nearly two years. This provides information, advice and consultation to anybody who makes contact, including young people and parents. Self-referral is now also available to parents and young people aged 16+. The Single Point of Access is dealing with high volumes of enquiries every month for information and advice.

What will the impact/improvements be for pupils outside the MHST pilot areas with the introduction of these new teams will schools/pupils outside the pilot areas benefit in anyway?

2.31 It is early days for the MHST pilot and the teams in Oxford City only became fully operational from January. Oxfordshire is learning all the time and continue to coproduce and develop the model with schools. Our next meeting is on the 5th of February to get feedback from the Oxford City Schools on their experience of the pilot so far. Oxfordshire is planning to share its learning and good practice to improve whole schools working in due course.

2.32 All Oxfordshire children continue to have access to the core CAMHS offer that includes CAMHS in-reach and CAMHS training. They also have access to the wider offer from School Health Nurses and LCSS. The CAMHS Assurance Board is keen to apply for further funding to roll out MHSTs to other areas of Oxfordshire.

2.33 ***What is being done about childhood mental health, poverty and housing? (So looking at the cause of poor childhood mental health.)***

2.34 CAMHS is not in place to address the totality of children's emotional well-being and behavioural challenges; it requires a partnership approach with social care, educational Psychologists and early help. It is also important that partners look to address the wider determinants of health and plan to prevent mental health problems. This is a multi-agency responsibility and not just the responsibility of CAMHS. These issues are addressed though Council's Local Strategic Plans for example. Building resilience and providing help at the earliest opportunity is a whole partnership responsibility, and work is underway on a Community Impact Zone in Oxford City where issues around the wider determinants of health such as poor housing, can be considered. The Children's Trust has identified emotional wellbeing as a priority and preventing mental health problems is a key priority for the coming year.

3.0 Muscular Skeletal Services (MSK)

3.1 Following requests from HOSC to provide additional information on MSK services, the following information has been provided.

OCCG to investigate and report back to HOSC whether Healthshare had benefitted from funding to support increased staffing costs related to changes in banding

3.2 The discussions on uplift, to cover the changes to agenda for change pay scales, are still ongoing. Healthshare have upheld all TUPE staff members' terms and conditions from their original contract and in addition have increased their salary in April by 1% as stated within the original Healthshare bid for services.

EQ5D - analysis requested- showing a full cycle

3.3 A paper has been supplied by Healthshare Oxfordshire, attached a separate document, in Appendix 1, providing additional detail of Healthshare assessment and reporting of the EQ5D measure of patient reported outcomes for MSK conditions.

Performance - KPI Measures

		Healthshare MSK	
KPI	**Target range**	**July 2019**	**November 2020**
Urgent referrals (%) seen in 7 working days	80-95%	86.4%	71.5%
Routine referrals (%) seen in 30 working days	75-95%	41.8%	66.3%
Referrals triaged within 48 hours	>65%	89.3%	83.6%
EQ5D % Improvement in 1 or more areas measured by EQ5D	50-85%	86.8% (n 566 responses)	84.1%
Patients satisfaction questionnaire % of people rating their care as good or excellent	64-90%	90.5% (n 1,486 responses)	90.5%
Self referral - # of referrals /month	20-35%	842 (37.7%)	807 (38.48%)

4.0 Process and learning around suicide

4.1 During the committee's consideration of the future approach to Health Inequalities on the 21st of November, a Member of the Committee requested information on the process, action and learning following any death by suicide in Oxfordshire. The response to this states that there is very well-established multi-agency response, both in the immediate aftermath of an incident and then in the following months.

4.2 The lead officers in the Public Health team are involved with other colleagues as follows:

- Public health are notified of sudden deaths likely to be suicide on a weekly basis by the Coroner's Office and Thames Valley Police. This allows monitoring of any potential clusters or contagion of suicide, and the ability to convene response groups if required looking at any immediate actions to mitigate further risk and offer support to communities.
- Thames Valley Police work closely with Oxfordshire Cruse (bereavement support charity) to offer immediate support to families and close friends of those who have died by suicide. This includes giving the Help is at Hand booklet and arranging a face to face visit to talk through the next steps for the bereaved.
- Public health lead on real time surveillance for Oxfordshire working in collaboration with the Coroner's Office. This data forms the basis of local annual data, which is used to inform the priority work of the multi-agency group.
- Learning from case reviews is shared and discussed at the multi-agency group.
- Any child deaths by suicide are also discussed at the multi-agency Child Death Overview Panel. There will usually be offers of support for schools from CAMHS and Seesaw, the latter also offering support to families bereaved by suicide.

4.3 Public Health colleagues are in the final stages of drafting a Suicide and Self-Harm Prevention Strategy and action plan on behalf of the multi-agency group, following a period of engagement with local residents including holding focus groups with those bereaved by suicide and those with lived experience. The draft strategy will be going out for public consultation in January 2020. If you would like more details on this please contact donna.husband@oxfordshire.gov.uk or sally.culmer@oxfordshire.gov.uk

5.0 Committee briefings and communication

5.1 The committee received the following written briefings since its meeting in November 2019. These are in the Appendices of this report and are on:

Appendix	Name	From	Received
2	Briefing on temporary closure of operating theatres at OUH	OUH	10/12/2019
3	BOB ICS Bulletin (December)	ICS	19/12/2019
4a & b	Moorfields Eye Hospital: a) post-consultation time line and b) decision-making	Camden CCG	19/12/2019 and 13/01/2020
5	BOB ICS Bulletin (January)	ICS	21/01/2020
6	Sue Ryder Nettlebed Stakeholder Briefing	OCCG	13/01/2020
7	OUH Brexit briefing	OUH	28/1/20