



Community Partnership Network
9.30am Tuesday 14 June 2016
River Cherwell Room, Bodicote House
(9.00am pre meet for CPN members only)

AGENDA

Item	Subject	Presenter	Time
1.	Welcome and Apologies	ID	9:30
2.	Minutes of the 8 March Meeting*	ID	9:35
3.	Progress Report on the Strategic Review of OUHFT Hospitals *	AS	9:40
4.	Integrated Health and Social Care Update Responsible Localities” – A new model for Adult Social Care *	AS	10.30
5.	OUHFT Update *	AS	10.50
6.	Devolution and Unitary Authorities – Implications for Health and Social Care Services *	ID	11.20
7.	Bicester Healthy New Town Initiative * (for information)	ID	11.30
8.	September and December Agenda items - OUHFT HR Transformation Programme , Cruse Oxfordshire Bereavement Needs Assessment, Health Inequalities; OUHFT Strategic Review and OUHFT Update.	ALL	11.40
9.	Dates of Next Meetings – 20 September and 13 December		

* Reports attached



Community Partnership Network

Tuesday 8 March 2016
River Cherwell Meeting Room, Bodicote House 09:30

Draft Minutes

Present

Ian Davies (ID)	Cllr Nigel Randall (NR)
Cllr Rosie Herring (Cllr RH)	Cllr Jacqui Harris (JH)
Andrew Stevens (AS)	Paul Brennan (PB)
David Heyes (DH)	Michelle Brock (MB)
Diane Hedges (DH)	John Westbrook (JW)
Melanie Pearce (MP)	Anita Higham (AH)
Keith Strangwood (KS)	Julia Johnson (JJ)
Dr Philip Stevens (PS)	Paul Park (PP)
Jackie Wilderspin (JW)	Dr Gwyneth Rogers (GR)
Peter Fisher (PF)	Jackie Gillespie (JG)

1. Welcome and Apologies

ID welcomed to the meeting John Westbrook, Divisional Director at OUHFT, and Michelle Brock, staff representative from the Horton. Apologies were received from Carol Moore, James Carter, Judith Wright and Pete McGrane.

2. Minutes from December 2015 Meeting

These were agreed as drafted, subject to the following amendment:

P.2 Q.5 the comment should be attributed to John Jackson rather than the hospital.

3. Review of the Delayed Transfer of Care Pilot Performance

Initial expectations had been exceeded, with 250 patient transferrals already recorded. Due to its success the intention was to continue with the programme and further discussions to determine its future were underway. Implementing an integrated control system to manage the re-ablement service, the existing intermediate beds, the management of the purchasing officers and the intermediate care beds had identified opportunities to streamline the pathway. A number of patients had been allocated a very low level of domiciliary care and as a consequence this had enabled a release of hours to further support other patients. An unforeseen lack of home domiciliary care workers was having an unfortunate effect on the pilot and, whilst proposals to increase the number of care workers were in hand, current low levels of unemployment in the district were proving challenging.



AH suggested that a level of dissatisfaction about the scheme had been expressed at the NOLG meeting though PP indicated this was not formally raised at the meeting and, GP practices as a whole felt that the project had been well managed, with a team of nurses made available to provide out of hours support. However, everyone was encouraged to record any individual concerns utilising the Datix system which would enable accurate monitoring.

Action: It was agreed that PB would provide the CPN with a regular update

It was intended that the scheme would be extended into both Northamptonshire and Warwickshire once a final analysis had been undertaken at the end of the pilot. Whilst the CCG had committed to fund the project to 31 March, subject to the appropriate staff being recruited funding would need to be identified to continue the scheme. Appropriate care would continue to any patients involved in the pilot exceeding the deadline date. The range of available beds should be kept at the optimum, and the changes to E-Ward had enabled more patients to be treated at the Horton. Bench-marking allowed all discharges and re-admissions to be accurately recorded and alerts triggered accordingly.

Whilst the level of specialist nurses assigned to the intermediate care unit at Chipping Norton was not individually monitored, there was a perception that it had effectively become a care home without nurses. This was not the case as the Order of St John would take over intermediate care beds from 1 April, although the level of nursing staff still needed to be decided.

Action: DH to confirm the nursing staffing situation

4. OUHFT Update

General

Whilst performance against other access standards was reasonably strong, and with financial stresses determining an anticipated break even, next year was looking difficult and assessment of the new tariff was underway. An external expert had been commissioned to consider the level of never events, and a publicly available report delivered. It was noted that the report commended the Trust on its safety culture. To support recruitment of Band 5 nursing staff, discussions with local housing associations and planning departments were underway to explore enhanced nomination rights and key worker accommodation. The provision of accommodation-related loans was also being considered.

Horton

Contingency planning in relation to a shortage of paediatric nurses had been reviewed. With additional shifts being created, and enhanced staff remuneration, implementation of any contingency had been avoided although this was only a short-term resolution through to the end of April. A medium-term solution was required. The CPN were asked to consider three contingency options. There was agreement that the relocation of the SCBU to the paediatric ward had the least adverse impact on patients and was preferred, although any decisions would be regularly reviewed and reversible. Mark Power, the Director of HR at OUHT was leading a HR transformation programme looking at pay scales, housing, commissioning of training, recruitment and retention, personal and professional development and overseas recruitment..

Action: AS to invite MP to the June meeting to discuss the HR transformation programme

Policy guidelines were updated and circulated regularly to enable staff to remain up-to-date with the latest information.



The formation of staff listening into action groups, together with a new staff rep on the CPN (MB) would enable staff to be able to raise concerns informally in addition to the Trust’s Raising Concerns arrangements. Both Cllr RH and AH would be regularly available at the Horton to receive staff concerns directly as OUHFT Governors.

5. Transformation Board Activities, Structures and Timelines

DH briefed the CPN on the emerging system-wide plans for transformation of the way in which Oxfordshire health and social care services would be delivered, addressing the future pressures and providing an overview of the governance arrangements for the programme.

The timescales for the proposals would be decided depending on the transformation proposed. Current individual groups will be taken account of and included within the stakeholder reference group. Working together with councils and developers, primary care resources would be carefully planned and placed within the communities they served. Whilst funding had been provided for the initial decisions, the CCG would need to identify and set aside a transformation pot of money to test new processes and approaches. Funding was based on a national formula derived from census data, although bids for additional funding could be made to account for large population increases such as that anticipated in Bicester.

6. Project Brief for the Strategic Review of OUHFT Hospitals

The OUH strategic review key themes were:

<u>Home Sweet Home</u> – getting and keeping the public in their own homes and within the community, the integration of health and social care, and working with the third sector and with patients themselves	<u>Less is More</u> - focusing on excellence, in relation to specialist services.
<u>Go Digital</u> - using technology in people’s homes, e.g with the Healthy New Towns initiative	<u>The Masterplan</u> – looking after our estate and ensuring patients are only being seen in clinically appropriate accommodation
<u>Good Quality Costs Less</u> – trying to drive forward innovation within the hospitals	

Due to significant patient and public engagement, the Horton was to be used as a pilot to look at new working models. Because its buildings were in poor condition it was impossible to develop the estate cost-effectively and various development options were under review. It was anticipated a more concrete proposal could be shared with the CPN in June, with a tentative timescale for completion of the project anticipated between 5-10 years although no funding plan is identified at present. As part of the development, those services with issues around sustainability or requiring reshaping including critical care, maternity and urgent care, would be reviewed. It was requested that adequate parking be included within any development scheme.. It was noted that this was a positive development for the Horton and would mean that several tens of thousands of patients would not need to travel to Oxford.

Action: AS to confirm release of the slides and circulate to the CPN (attached).



Next Steps

DH, PF and Cllr NR volunteered to assist with design and service proposals, and a special meeting of the CPN would be convened to discuss these proposals specifically. The intention was to make the Horton fit for purpose long term.

Action: JG to identify suitable dates and liaise with the AS to arrange Horton-specific workshop

7. Workshop Feedback and 2016 Agenda Planning

The feedback was reviewed and, due to the fast-moving pace of matters, it was agreed to focus on one meeting at a time. Members agreed that OCCG should be added to the CPN membership.

8. Bicester Healthy New Town Proposal

A bid to the Healthy New Towns partnership had been successful. The initiative was aimed at putting health at the heart of new neighbourhoods and the town by future-proofing new communities for the health and care challenges of the new century – obesity, dementia, new models of digital health, by designing in health and integrated modern care from the outset.

9. Oxfordshire Health Inequalities Commission

ID had attended two of the four evidence sessions. This is of relevance to the Brighter Futures in Banbury Programme in highlighting known inequalities and how these were being addressed on a multi-agency basis would feature in many future projects.

10. Potential June and September Agenda Items

Agreed for June were Progress Report on the Strategic Review of OUHFT Hospitals (AS), Bicester Healthy New Town Initiative (ID) (for information), OUHFT Update (AS), Integrated Health and Social Care Update (MP), Devolution and Unitary Authorities – Implications for Health and Social Care Services (ID) and OUHFT HR Transformation Programme (AS/MP)

Agreed for September – Health Inequalities

AH requested the engagement and consideration of health and social care issues of non-indigenous people should be considered, whilst approaching community relations associations for representatives.

Action: MP to follow up

Action: ID to look into the provision of microphones in the River Cherwell Room

Date of Next Meetings: Horton DGH specific meeting tbc and Tuesday 14 June 2016

Strategic review of the Horton General Hospital

9 June 2016

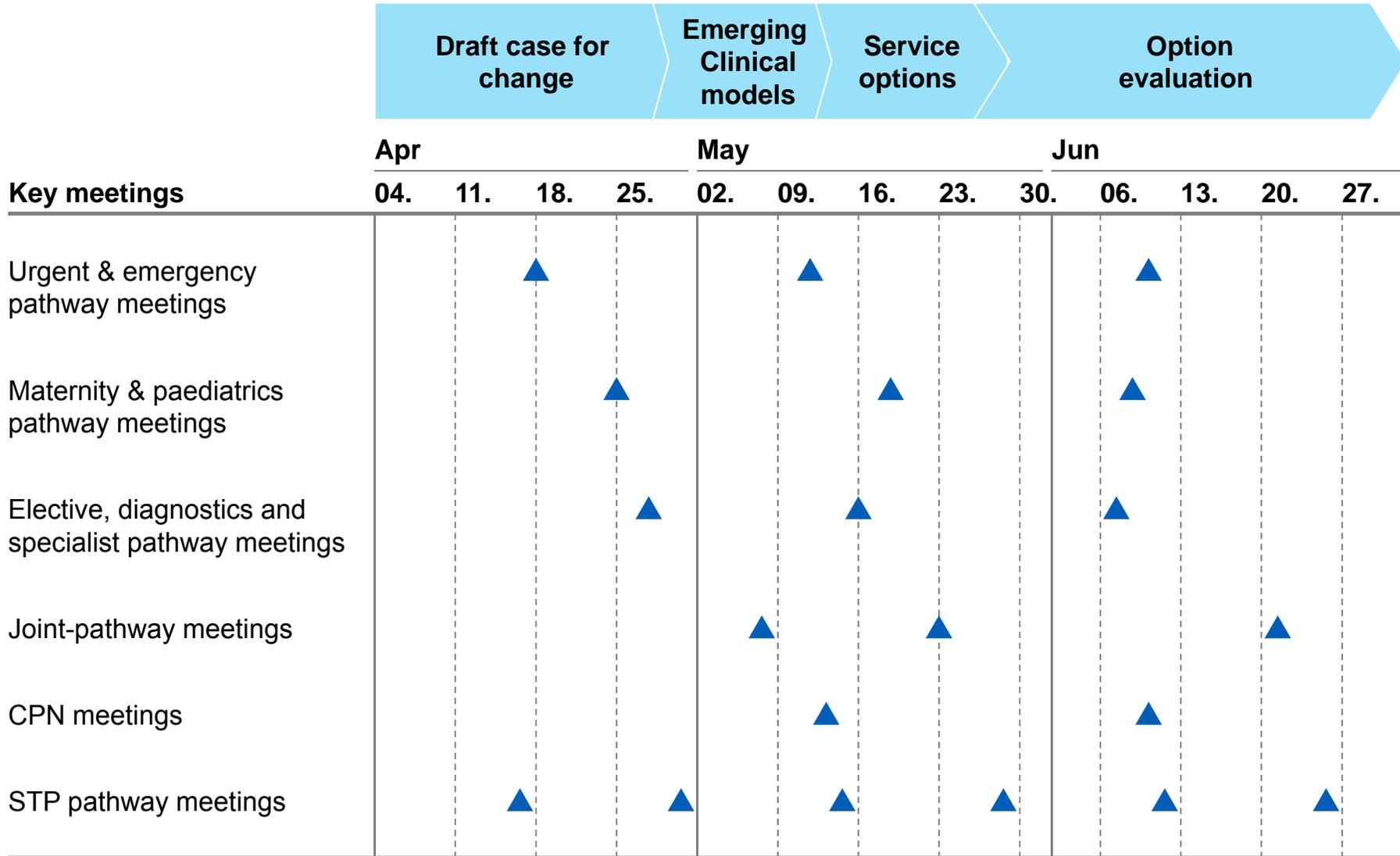
Context and objectives for today

- The Oxfordshire health and social system is undertaking a major strategic review as part of a transformation programme
- OUH has recently kicked-off a **clinically-led review of the Horton General Hospital** with the objective to develop a sustainable long term strategy for the site to enable the continued delivery of high and enhanced quality care to the local population
- The review will focus on generating potential options to meet the **future population health demand and needs** and **potential future service standards** while addressing the **existing and potential future challenges** of care provision
- As part of this process, we are engaging with a broad set of stakeholders of which **CPN is a key forum**
- For today's discussion, we would like to:
 1. Share overall process and how this review fits with the overall STP
 2. Play back key challenges identified by the OUH clinicians and gather feedback
 3. Obtain views on criteria to evaluate options

Key questions we are addressing

1. What is the current provision of services of the Horton site and beyond for the population of Banbury, in terms of clinical outcome, safety, patient satisfactions and operational performance?
2. What is the projected population healthcare demand?
3. What is the clinical vision for the 3 pathways (elective, diagnostics & specialist care, urgent & emergency care, maternity and paediatrics), what are the clinical evidence and case studies supporting these visions, what are activity implications?
4. What are the options for service configuration at the Horton?
5. What are the implications on activities and travel time of each option?
6. What are the estates, technology and workforce requirements under each options?
7. What are the financial implications for OUH under each option?
8. What are the evaluations of the strategic options?

How this fit with the overall process for developing the STP



Our vision for care provision to the population of north Oxfordshire and the surrounding communities

- Almost all patients currently being cared for at the Horton will continued to be cared for locally
- More services will be provided at the Horton, with the objective of becoming a centre of excellence for selected services
- There will be very few patients (with highly complex and / or severe illnesses) who will need to be cared for outside Horton, who will benefit from access to more specialised care than is currently available

Recap – site options (1/4)

PRELIMINARY

OPTION		OPTION 1	OPTION 2	OPTION 3
'Front door'		ED	GP urgent care with MIU (open out of hours) ^{1,3}	ED and integrated care centre (24/7) ^{2,3}
Stroke		Acute stroke and rehab	Rehab and early supported discharge	Rehab and early supported discharge
Surgery	ELDC	✓	✓ (limited day cases 8am-3pm)	✓ (+)
	ELIP	✓ (no NHS provided surgery except gynae and ortho (Ramsey))	✗	✓ (status quo + short stay IP)
	NEIP	✓ (trauma (NOF) and gynae)	✗	✓ (+)
Medicine	ELDC	✓	✓ (limited day cases 8am-3pm)	✓ (+)
	ELIP ⁴	✓	✗	✓ (status quo + short stay IP)
	NEIP	Inpatient ward + ambulatory care	Frail assessment unit (8-10) + better networked support	Inpatient ward + ambulatory care + better networked support
Diagnostics		See menu of options on next slide		
Outpatients		✓	7 day access ✓ (+ 'one stop' clinics)	7 day access ✓ (+ 'one stop' clinics)
Critical care adult		Level 3	✗	HDU on site + e-ICU (24/7)
Rehabilitation		Rehab/intermediary care beds	See menu of options on next slide	
Maternity	Births	Obstetric and midwifery	Standalone MLU	Standalone MLU
	Neonates	SCBU	✗	✗
Paediatrics	NEIP	Paediatric inpatients	Paediatric observation and assessment unit (8-10) ⁵	Paediatric observation, assessment and clinical decision unit (24/7) ⁵
	ELDC	✓	✓	✓ (+)
Research		✓	✓ (more clinical trial facilities)	✓ (more clinical trial facilities)

1 Current GP urgent care centre located on Horton site is open 24/7

2 Integrated urgent care centre with ED function + out-of-hours + minor injury unit + walk-in centre

3 Includes a clinical co-ordination and liaison operational function and a physical base for ambulatory functions

4 Examples of activity include red blood cell disorders, intermediate skin disorders, single plasma exchange, leucopheresis or red cell exchange, diagnostic colonoscopy with length of stay 2 days or more

5 Includes a Child Health Hub

Recap – site options (2/4)

PRELIMINARY

OPTION	OPTION 1	OPTION 2	OPTION 3
Diagnosics	<p>Menu of diagnostics:</p> <p>Radiology</p> <ul style="list-style-type: none"> ▪ Plain film X-ray ✓ ▪ Ultrasound ✓ ▪ Obstetric USS ✓ ▪ PET-CT ✗ ▪ Other nuclear medicine (incl. myocardial perfusion scintigraphy) ✗ ▪ CT ✓ ▪ MRI ✗ ▪ Mammography ✓ ▪ Interventional radiology ✗ ▪ Fluoroscopy ✗ ▪ DEXA ✗ ▪ Angiography ✗ <p>Other</p> <ul style="list-style-type: none"> ▪ ECG, ECHO ✓ ▪ Exercise stress tests ✗ ▪ Lung function tests ✗ ▪ Urodynamics ✗ ▪ Sleep studies ✗ 	<p>Menu of diagnostics (7 day access with extended opening hours)</p> <p>Radiology</p> <ul style="list-style-type: none"> ▪ Plain film X-ray ✓ ▪ Ultrasound ✓ ▪ Obstetric USS ✓ ▪ PET-CT ✗ ▪ Other nuclear medicine (incl. myocardial perfusion scintigraphy) ✗ ▪ CT ✓ ▪ MRI ✓ ▪ Mammography ✓ ▪ Interventional radiology (mobile C-arm) ✓ ▪ Fluoroscopy ✗ ▪ DEXA ✓ ▪ Angiography ✗ <p>Other</p> <ul style="list-style-type: none"> ▪ ECG, ECHO ✓ ▪ Exercise stress tests ✓ ▪ Lung function tests ✓ ▪ Urodynamics ✓ ▪ Sleep studies ✗ ▪ Ophthalmology kit ✓ 	<p>Menu of diagnostics (7 day access with extended opening hours)</p> <p>Radiology</p> <ul style="list-style-type: none"> ▪ Plain film X-ray ✓ ▪ Ultrasound ✓ ▪ Obstetric USS ✓ ▪ PET-CT ✗ ▪ Other nuclear medicine (incl. myocardial perfusion scintigraphy) ✗ ▪ CT ✓ ▪ MRI ✓ ▪ Mammography ✓ ▪ Interventional radiology (mobile C-arm) ✓ ▪ Fluoroscopy ✗ ▪ DEXA ✓ ▪ Angiography ✗ <p>Other</p> <ul style="list-style-type: none"> ▪ ECG, ECHO ✓ ▪ Exercise stress tests ✓ ▪ Lung function tests ✓ ▪ Urodynamics ✓ ▪ Sleep studies ✓ ▪ Ophthalmology kit ✓
<p>Rehabilitation Rehab/intermediary care beds</p>	<p>n/a</p>	<p>Menu of rehab/intermediary care</p> <ul style="list-style-type: none"> ▪ Generic rehabilitation for medically stable patients with a wide range of conditions led by non-medical staff (level 3b¹) ✓ ▪ Generic rehabilitation with some specialised input for specific diagnostic groups (e.g. stroke), led or supported by consultants with expertise in these areas (level 3a) ✓ ▪ Specialist rehabilitation for those with complex rehab needs who may require ongoing medical investigation/treatment, led by a consultant in rehabilitation medicine (level 2a/b) ✗ 	<p>Menu of rehab/intermediary care</p> <ul style="list-style-type: none"> ▪ Generic rehabilitation for medically stable patients with a wide range of conditions led by non-medical staff (level 3b¹) ✓ ▪ Generic rehabilitation with some specialised input for specific diagnostic groups (e.g. stroke), led or supported by consultants with expertise in these areas (level 3a) ✓ ▪ Specialist rehabilitation for those with complex rehab needs who may require ongoing medical investigation/treatment, led by a consultant in rehabilitation medicine (level 2a/b) ✓

¹ Levels 1/2/3 defined by the British Society of Rehabilitation Medicine's description of how rehabilitation services are currently organised and delivered in the UK

Recap on site options (3/4) – examples of elective medical procedures

OPTION	OPTION 1	OPTION 2	OPTION 3
<p>Elective medical activity</p>	<p>Examples of current service lines and underlying procedures</p> <p>Endoscopy (gastroenterology)</p> <ul style="list-style-type: none"> ▪ Diagnostic colonoscopy/sigmoidoscopy/endoscopy ▪ Combined upper and lower GI diagnostic endoscopic procedures <p>Haematology</p> <ul style="list-style-type: none"> ▪ Single plasma exchange, leucopheresis or red cell exchange <p>Cardiology</p> <ul style="list-style-type: none"> ▪ Complex echocardiogram <p>General medicine</p> <ul style="list-style-type: none"> ▪ Heart failure or shock ▪ Intermediate skin disorders ▪ Iron deficiency anaemia ▪ Inflammatory bowel disease with length of stay 1 day or less <p>Nephrology</p> <ul style="list-style-type: none"> ▪ Other red cell disorders with/without CC 		<p>Examples of additional service lines and underlying procedures (extended opening hours in option 3 only) – filtering results from the funnels</p> <p>Included</p> <p>Gastroenterology</p> <ul style="list-style-type: none"> ▪ Additional diagnostic colonoscopy/sigmoidoscopy/endoscopy (see backup) <p>Haematology</p> <ul style="list-style-type: none"> ▪ Continuous intravenous infusion of therapeutic substance NEC ▪ Unspecified other blood transfusion ▪ Venesection ▪ Subcutaneous chemotherapy ▪ Intravenous blood transfusion of platelets ▪ Delivery of subsequent element of cycle of chemotherapy for ▪ Procurement of drugs for chemotherapy for neoplasm ▪ Insertion of central venous catheter NEC ▪ Removal of central venous catheter ▪ Subcutaneous injection of haematological growth factor <p>Cardiology</p> <ul style="list-style-type: none"> ▪ Transthoracic echocardiography ▪ Stress echocardiography ▪ Transoesophageal echocardiography ▪ Other specified diagnostic Echocardiography <p>Dermatology</p> <ul style="list-style-type: none"> ▪ Unspecified other excision of lesion of skin ▪ Excision of lesion of skin of head or neck NEC ▪ Excision of lesion of external nose ▪ Re-excision of skin margins NEC ▪ Excision of lesion of external ear ▪ Other specified photodynamic therapy of skin ▪ Excision of lesion of eyelid NEC ▪ Phototesting of skin using monochromator ▪ Provocation phototesting

Recap on site options (4/4) – examples of elective surgical procedures

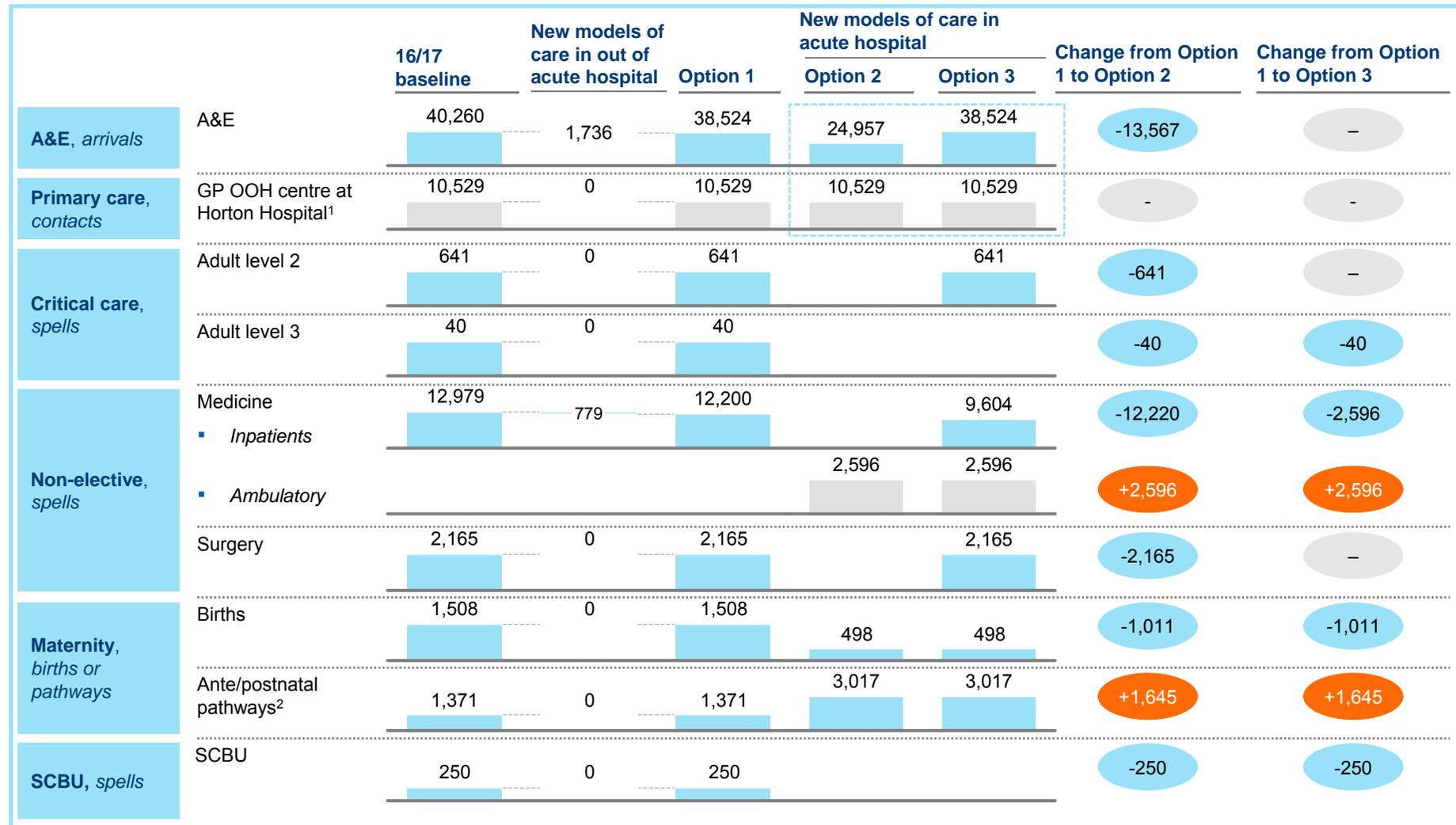
OPTION	OPTION 1	OPTION 2	OPTION 3
Elective surgical activity	<p>Examples of current service lines and underlying procedures</p> <p>Breast surgery</p> <ul style="list-style-type: none"> ▪ Unilateral major breast procedures with intermedicate CC¹ ▪ Unilateral major breast procedures without CC¹ ▪ Major breast procedure with lymph node surgery¹ <p>Urology</p> <ul style="list-style-type: none"> ▪ Endoscopic bladder procedures <p>Gynaecology</p> <ul style="list-style-type: none"> ▪ Upper genital tract major procedures ▪ Upper genital tract laparoscopic major procedures ▪ Lower genital tract intermediate procedures <p>Colorectal surgery</p> <ul style="list-style-type: none"> ▪ Miscellaneous vascular procedures ▪ Intermediate anal procedures 19 years and over <p>General surgery</p> <ul style="list-style-type: none"> ▪ Inguinal umbilical or femoral hernia repairs 19 years and over ▪ Laparoscopic cholecystectomy ▪ Appendectomy procedures ▪ Abdominal hernia procedures <p>Trauma and orthopaedics</p> <ul style="list-style-type: none"> ▪ Major elbow and lower arm procedures ▪ Major shoulder and upper arm procedures 		<p>Examples of additional service lines and underlying procedures (overnight surgery in option 3 only) – filtering results from the funnels</p> <p>Included</p> <p>Ophthalmology</p> <ul style="list-style-type: none"> ▪ Phacoemulsification Cataract Extraction and Lens Implant ▪ Vitreous Retinal Procedures - category 3 ▪ Oculoplastics category 1: 19 years and over ▪ Oculoplastics category 2: 19 years and over ▪ Glaucoma - category 2 ▪ Vitreous Retinal Procedures - category 1 <p>Urology</p> <ul style="list-style-type: none"> ▪ Bladder Intermediate Endoscopic Procedure 19 years and over ▪ Extracorporeal Lithotripsy ▪ Introduction of Therapeutic Substance into Bladder ▪ Ureter Intermediate Endoscopic Procedures ▪ Bladder Minor Procedure 19 years and over ▪ Penis Minor Procedures 19 years and over ▪ Bladder Major Endoscopic Procedure without CC <p>Gynaecology</p> <ul style="list-style-type: none"> ▪ Bladder Intermediate Endoscopic Procedure 19 years and over ▪ Upper Genital Tract Laparoscopic / Endoscopic Major Procedures ▪ Resection and ablation procedures for intra-uterine lesions ▪ Diagnostic Hysteroscopy ▪ Lower Genital Tract Minor Procedures - Category 2 ▪ Endoscopic or Intermediate General Abdominal Procedures 19 years and over without CC ▪ General Abdominal - Diagnostic Procedures ▪ Upper Genital Tract Major Procedures without Major CC ▪ Lower Genital Tract Intermediate Procedures without CC ▪ Vaginal Tape Operations for Urinary Incontinence ▪ Upper Genital Tract Laparoscopic / Endoscopic Minor Procedures <p>Plastic surgery</p> <ul style="list-style-type: none"> ▪ Skin Therapies level 3 ▪ Minor Hand Procedures for non Trauma Category 2 without CC <p>Trauma and orthopaedics</p> <ul style="list-style-type: none"> ▪ Minor Hand Procedures for non Trauma Category 2 without CC ▪ Major Knee Procedures for non Trauma Category 2 without CC ▪ Major Hip Procedures for non Trauma Category 2 without CC ▪ Intermediate Knee Procedures for non Trauma without CC ▪ Minor Foot Procedures for Non-Trauma category 2 19 years and over without CC ▪ Reconstruction Procedures Category 2 ▪ Major Knee Procedures for non Trauma Category 1 without CC ▪ Major Hip Procedures for non Trauma Category 1 without CC ▪ Intermediate Shoulder and Upper Arm Procedures for Non-Trauma without CC ▪ Intermediate Foot Procedures for Non-Trauma category 2 19 years and over

¹ Not continued in options 2 and 3

Change in activities under different options (based on 2016/17 contract) (1/3)

Change in activity/number of spells/appointments at Horton

+X Increase in activity -X Decrease in activity
 ■ Activity shown not included in financial modelling



1 Additional activities from other primary care centres not included in this figure

2 Preliminary figure; assumed that all women from Horton catchment area will have their ante/postnatal pathway delivered locally under options 2 and 3

SOURCE: Contract FY2016/17, HES 2014/15

Change in activities under different options (based on 2016/17 contract) (2/3)

– assuming elective activity moves with travel time

Change in activity/number of spells/appointments at Horton

+X Increase in activity -X Decrease in activity
 ■ Activity shown not included in financial modelling



1,272 spells are inpatient surgeries that would move to the JR

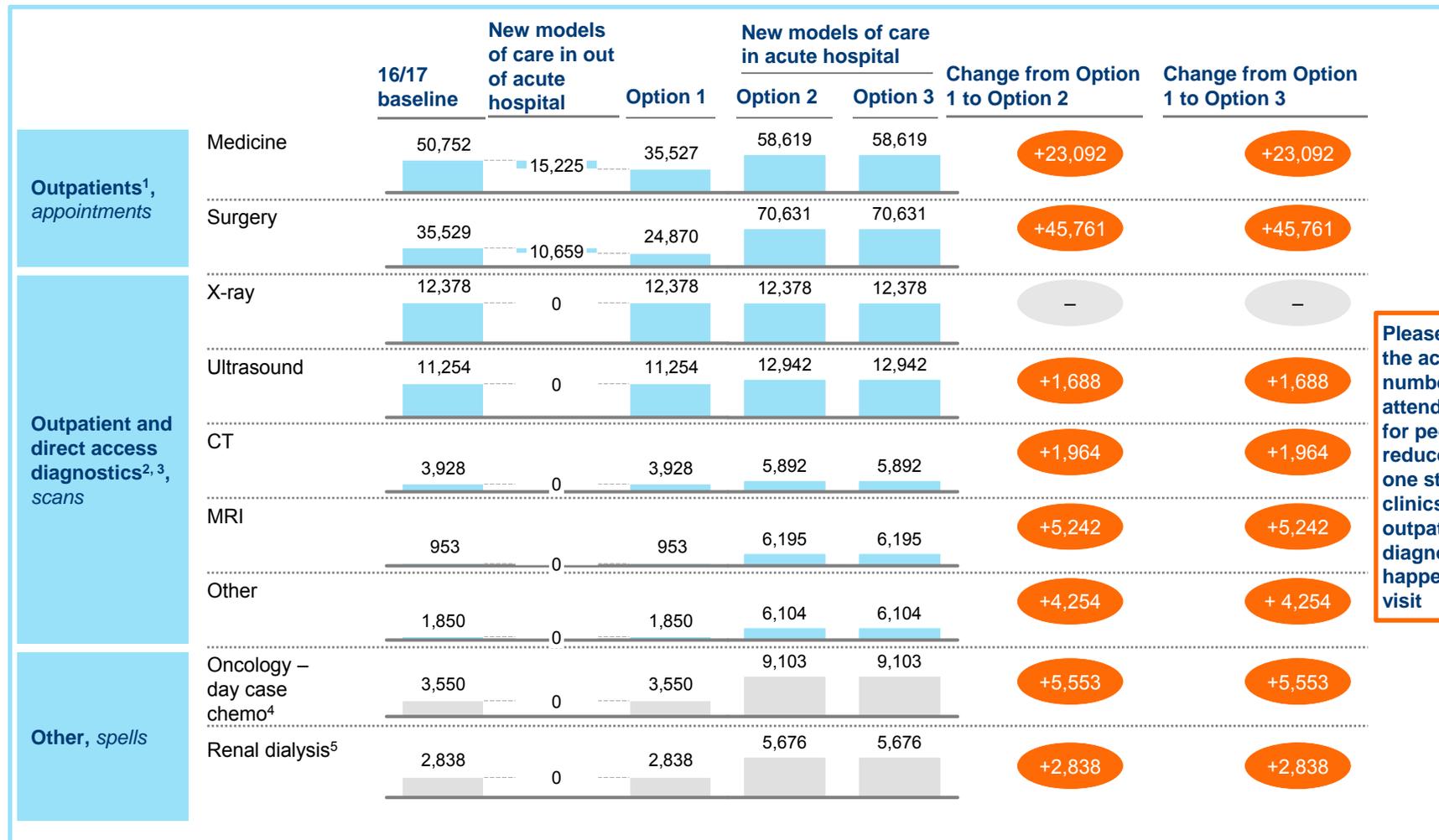
1 Includes neonatal acute non-critical care activity
 3 Activity for Ramsay Horton Treatment Centre from HES and does not include private patient activity
 SOURCE: Contract FY2016/17, HES 2014/15

Change in activities under different options (based on 2016/17 contract) (3/3)

– assuming outpatient activity moves with travel time

Change in activity/number of spells/appointments at Horton

+X Increase in activity -X Decrease in activity
 ■ Activity shown not included in financial modelling



Please note the actual number of attendances for people will reduce due to one stop clinics, where outpatient and diagnostics happen in one visit

1 Outpatient activity under new models of care in out of acute hospital assumed a 30% demand management via shifting 50% of follow up appointments to new delivery models (e.g., virtual)

2 Diagnostics includes paid activity only, not diagnostics performed as part of inpatient spells

3 Assumed diagnostics increases in line with outpatients to ~20% of OUH activity

4 Assumed activity can be consolidated according to travel times; service line not included in financial modelling

5 Assumed activity can increase by 50% with extra capacity (clinical input); service line not included in financial modelling

SOURCE: Contract FY2016/17, HES 2014/15

What criteria shall we use to evaluate the potential options?

	Criteria	Sub-criteria	Description
1	Quality of care for all	<ul style="list-style-type: none"> ▪ ▪ 	<ul style="list-style-type: none"> ▪ ▪
2	Access to care for all	<ul style="list-style-type: none"> ▪ ▪ 	<ul style="list-style-type: none"> ▪ ▪
3	Affordability and value for money	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪
4	Workforce	<ul style="list-style-type: none"> ▪ ▪ 	<ul style="list-style-type: none"> ▪ ▪
5	Deliverability	<ul style="list-style-type: none"> ▪ ▪ 	<ul style="list-style-type: none"> ▪ ▪
6	Other (e.g., research and education)	<ul style="list-style-type: none"> ▪ ▪ 	<ul style="list-style-type: none"> ▪ ▪

Next steps (whole system and Horton)

- Assess options
 - activity
 - workforce
 - finance
 - estates

- Evaluate options

- Continued engagement

- Consultation (?October)

Strategic Review of the Horton General Hospital

**Notes of the meeting of the Community Partnership Network and
Oxford University Hospitals NHS Foundation Trust**

12 May 2016

1. Present

Paul Brennan, OUH/CPN
Veronica Miller, OUH/clinician
Chandi Ratnatunga, Oxford AHSN/clinician
Judith Wright, Oxfordshire CCG/CPN
David Heyes, North Oxfordshire Locality Forum/CPN
Melanie Pearce, OCC/CPN
Keith Strangwood, KTHG/CPN
Andrew Stevens, OUH/CPN
Nigel Randall, Cherwell District Council/CPN
Michelle Brock, OUH/CPN
Carol Moore, Healthwatch Oxfordshire/CPN
Peter Fisher, KTHG/CPN
Anita Higham (part session only), OUH Governor/CPN
Graham Walker, OUH/clinician
Fiona McLoud, OUH/clinician

2. Purpose of the meeting

The purpose of the meeting was to:

- share overall progress of the strategic review of the Horton General Hospital
- discuss key challenges identified by the individual work streams
- discuss the evaluation criteria
- share the very initial thoughts on the emerging options for the Horton General Hospital

3. Process

Paul Brennan and Andrew Stevens described the process that was being adopted for the strategic review of the Horton General Hospital.

Concern was expressed that no materials had been circulated before the meeting. Paul Brennan and Andrew Stevens apologised for this. It was noted that the review

was having to follow a very tight timetable and also needed to be integrated with the system-wide work on the Sustainability and Transformation Plan.

It was noted that in keeping with the agreement with the CPN, discussions were first taking place with staff and were then being broadened out to other external stakeholders including the CPN.

4. Issues

Paul Brennan presented the work of the individual work streams. Key issues raised at the meeting are described in the paragraphs below.

Concern was expressed that the possibility of the first aid unit at Chipping Norton Hospital being closed had been raised at various times. It was noted that this service was provided by the ambulance service. Paul Brennan agreed to raise this issue at the system-wide STP group. It was noted that this issue illustrated the need to ensure that a whole pathway approach was adopted to any transformation work.

It was suggested that cultural issues within individual immigrant populations may impact on the way that particular services are accessed though it was noted this was not evidenced by a previous review.

There was a discussion around the provision of maternity services with a particular focus on how risk is defined and should be managed. Veronica Miller shared with the meeting the findings of the Birthplace Study.

The Trust agreed to revisit the information presented on paediatrics to ensure that the comparisons between the John Radcliffe and the Horton services were valid.

The OUH indicated that it would very much welcome the help of the CPN in determining how clinical data and information could be best presented to the public.

It was emphasised that in terms of the generation of options, the first task was to identify service models that were clinically viable. These models would then be looked at from an activity, workforce and finance perspective. Potentially valid options would then be looked at from an estates perspective.

It was noted that it was important that even though it may be felt that some services would need to change because they were not clinically sustainable in the future, this did not mean that those services were currently clinically unsafe. It would be important not to damage confidence in current services.

It was noted that further work was being undertaken on paediatric models and specifically to look at the possibility of having some form of 24/7 paediatric observation unit within relevant options.

Both in relation to the frail elderly and also paediatrics, there needed to be an increased emphasis on the provision of acute services outside of the hospital

environment in order to address effectively the patient need. It was noted that both in the case of the frail elderly and paediatrics, there were a number of service initiatives that were acting as pilots for this more integrated and community based approach. It was emphasised that other stakeholders including Oxford Health and GPs were involved in the system-wide discussions and would be inputting into the Horton specific work.

The important risks associated with workforce across a range of services and organisations was noted.

A question was raised around the definition of transformation. The OUH expressed a view that if the local health and social care system was going to respond effectively to the challenges it faced then it would need to consider radical changes that would redress and break down the boundaries between:

- Hospital based and community based care
- Secondary and primary care
- Physical and mental health
- Health and social care
- Organisational boundaries

It was also important for all viable options to be assessed.

5. Criteria

The OUH shared with the meeting the emerging criteria against which options would be evaluated.

The meeting were asked to look at these and to feedback on whether or not any high level criteria were missing and also on what indicators performance against those criteria could be judged.

6. Emerging options

The OUH shared with the meeting emerging options for the Horton General Hospital. It was emphasised that these were options not proposals. The meeting was informed that only one of the Trust's internal groups had seen these options to date. The intention was to run these through each of the internal work groups to firm up potentially clinically viable options.

It was intended that a fuller discussion of the options would be held at the next OUH/CPN meeting scheduled for 9 June 2016.

7. Next steps

The OUH were thanked for the transparency and openness with which they were approaching this task. It was noted that this was an important opportunity for the local community to say what they wanted to be addressed within the review.

It was emphasised that the OUH was seeking feedback on three issues:

- What is it that the CPN wants to see within the review and what comments does it have on current and future service issues
- Have the right criteria against which options will be assessed been identified and what specific measures can be used to evaluate options against those criteria?
- What are the views on the initial emerging options?

Views and comments were asked to be submitted to Paul Brennan and Andrew Stevens ideally by 2 June 2016 so that they could be considered in the preparation of materials for the meeting on 9 June 2016.

8. Conclusion

Members of the Community Partnership Network were thanked for their time and input into this important process.

Community Partnership Network Meeting: 14 June 2016

Title	Community Partnership Network update
--------------	---

Status	For information
Purpose	To provide the Community Partnership Network with an update on developments within the Oxford University Hospitals NHS Foundation Trust both in general and specifically in relation to the Horton General Hospital.

Author	Mr Andrew Stevens, Director of Planning & Information
---------------	---

Community Partnership Network update

1. Introduction

1.1. This paper has two key purposes:

- To provide the Community Partnership Network with a general update on developments within the Oxford University Hospitals NHS Foundation Trust;
- To provide the Community Partnership Network with an update on specific issues relating to the Horton General Hospital. This paper focuses particularly on the work to develop a new strategy for the Horton General Hospital.

2. Oxford University Hospitals NHS Foundation Trust update

Performance

- 2.1. This paper provides a brief overview of the Trust's performance at the end of month 12, March 2016, of the 2015/16 financial year, as reported to the Trust Board in May 2016. The full set of performance reports are available on the Trust's website.
- 2.2. Over the course of 2015/16 the Trust performed relatively strongly. However, the end of the financial year has seen a deterioration in some performance measures. These are largely the result of increases in operational pressures and demand. A summary of the key highlights and areas of exception are given below:

Key Highlights on performance

- The percentage of adult inpatients that had a VTE risk assessment in March was 96.13% against the standard of 95%.
- Diagnostic waits over 6 weeks, 108 patients waited over 6 weeks at the end of March, achieving 0.87% against the standard of no more than 1% waiting over 6 weeks.
- MRSA bacteraemia; zero cases were reported in March, three cases reported for the year.
- Patients spending $\geq 90\%$ of time on stroke unit was 89.09% against a standard of 80% in March and 90.6% for the year.
- Zero same sex accommodation breaches were reported at the end of March with a total of eight for the year.
- C Difficile, three cases were reported in March equating to 57 year to date against a maximum threshold of 69.
- Staff vacancy rate is down to 3.57% against the standard of 5%.

Areas of exception on performance

- Performance against the 4 Hour standard was 78.91% in March.
- The 18 week RTT Incomplete standard was not achieved in March at 91.39% against the standard of 92%.

Oxford University Hospitals

- Delayed Transfers of Care as a percentage of occupied beds is at 9.21% for March against the standard of 3.5%. The system monthly average for March was 140.
 - Two of the eight cancer standards were not achieved in March.
 - Staff turnover rate is 13.9%, which is 3.4% above the standard.
 - Staff sickness absence rate was 3.5%, 0.5% above the standard.
- 2.3. Plans are being progressed to address those areas where performance has dipped below the required national standard.

Finance

- 2.4. The Trust achieved its financial plans for the 2015/16 financial year. Given the financial challenges faced across the NHS over the 12 months, this result represents a strong achievement. However, in order to meet its plans, the Trust was required to rely on a number of non-recurrent measures.
- 2.5. The financial year 2016/17 will be challenging for the Trust. In order to cover the non-recurrent measures identified above and to deliver the nationally required efficiency savings, the Trust will need to implement a cost improvement programme of £51m. As well as looking to the more traditional cost improvement schemes, the Trust will also be seeking to progress more transformational changes included the more efficient use of its beds, improved theatre utilisation and reducing its physical footprint through more efficient use of its estate.
- 2.6. The 2016/17 contracting round is nearing completion. The late publication of relevant guidance has resulted in the timetable being extended. The Trust has sought to work with its commissioners to ensure robust and fair management of the significant financial risks that are faced by the system. Within Oxfordshire, discussions are continuing on developing the contracting framework that most effectively incentivises transformational change across the system.

Quality account and priorities

- 2.7. The Medical Director, Chief Nurse and Deputy Medical Director co-chaired an OUH patient, public and staff engagement event on 19 April, to discuss the Annual Quality priorities. Ninety five people attended, including representation from OUH Governors, patients, members of the public and staff. The quality priorities from 2015/16 were reviewed and proposed quality priorities for 2016/17 shared.
- 2.8. For the 2015/16 quality priority review, the feedback was generally very positive with those present pleased at having the chance to review progress and provide the Trust with feedback.
- 2.9. For the proposed 2016/17 quality priorities, the comments were broadly supportive of the priorities proposed. There were no priorities which were highlighted as having being missed. The sentiment which came through most strongly was that the participants wished to hear a much stronger patient voice being represented both in the development of the priorities and in the review of

the progress against them as the year unfolds. To this end, the Trust has committed to increasing the number of patient, public and staff engagement events from one per year to three.

Update on Oxfordshire joint patient transfer plan

- 2.10. Over the period up to the end of April, around 320 patients waiting for rehabilitation and social care packages have moved from acute beds or community hospital beds to intermediate care beds in one of 17 care homes across the county. This is more than had been anticipated and is good news for these patients who have received assessment and care in a more appropriate environment while their ongoing care plans are arranged. Of the 320 patients transferred, 104 have subsequently been discharged home with appropriate support, and 78 patients have moved to permanent placements in a nursing or care home.
- 2.11. The transfer plan has enabled the Trust to release a total of 76 beds for a temporary period of time. Any recommendation to reduce the number of beds on a permanent basis will be discussed with the county's Health Overview and Scrutiny Committee before a final decision is made.
- 2.12. While the system has been successful in transferring patients to intermediate care beds, it is recognised that it has not reduced the numbers of patients who remain delayed in hospitals by as much as had been hoped. After a promising start last December when the number of patients delayed in OUH and Oxford Health NHS FT beds fell from 159 to 83, the figures have fluctuated from week to week, and as of 21 April, there were 87 patients delayed in OUH acute beds and 23 delayed in OHFT community hospital beds. The reasons for the delays range from waiting to move to bed-based care (community hospitals, permanent nursing and residential home placement), waiting to go home with a care package, or waiting for assessment.
- 2.13. To help to improve the discharge of patients waiting for reablement or domiciliary care in their own homes, the system has identified that there is a need to provide an additional 1,600 hours of home care each week. As a registered social care provider OUH is running a campaign to directly recruit 50 new home carers to the Supported Hospital Discharge Service which already employs 37 home care support workers providing interim support to people in their own homes for up to 14 days after their discharge from hospital. During this time the service can assess patients' ongoing needs and organise social care intervention if required. Last year the service helped more than 1,700 patients continue their recovery at home.

Oxfordshire sustainability and transformation plan update

- 2.14. NHS organisations in Oxfordshire and Oxfordshire County Council established a system-wide Transformation Board last year. The Transformation Board has made good progress in developing the scope and vision for change needed across Oxfordshire to address current issues and future demand against a backdrop of achieving significant savings and financial constraint in future years. Damon Palmer has been appointed as Transformation Director. He

started in post on 18 April and will be driving forward the work to redesign the local health and social care services on behalf of the Transformation Board.

- 2.15. Collectively the system is working to develop new models of care that will deliver more services in settings closer to where people live, reducing the reliance on hospital-based care and promoting greater levels of prevention and self-care. For the OUH, the vision involves considering whether all the services the Trust currently offers need to take place on our hospital sites.
- 2.16. In parallel with progressing the joint Transformation Programme, the Oxfordshire health and care system is developing a five year Sustainability and Transformation Plan. NHS England has set a requirement on all health and social care systems to develop STPs by the end of June 2016. The STP will be the single strategic plan for us and our partner organisations to unlock resources and drive transformation. Senior leaders and clinicians from across health and social care are working to identify the existing gaps in health and wellbeing, care, quality, finance and efficiency across the following service areas:
- Urgent and emergency care
 - Planned care
 - Specialist care
 - Maternity services
 - Mental health services
 - Learning disabilities
- 2.17. The footprint for the transformation plan is largely Oxfordshire, however we have formed an alliance with Buckinghamshire, and Berkshire West, led by Oxfordshire Clinical Commissioning Group's Chief Executive, to jointly develop transformation plans on a wider footprint where appropriate.
- 2.18. A process of public engagement has begun and all major changes will be subject to public consultation later in the year.

Trust business plan

- 2.19. At its meeting in May 2016, the Trust Board signed off the Trust's Annual Business Plan for 2016/17. The business plan:
- Provides focus and direction for the Trust over the coming 12 months
 - Serves as a yard stick against which performance and progress can be measured
 - Is a communication tool for describing to both internal and external stakeholders the Trust's objectives
 - Serves as the basis for individual plans of divisions, directorates, services and individual members of staff

2.20 As the CPN will be aware, the Trust is currently in the middle of a strategic review. This is, therefore, a transitional year during which the strategic focus of the Trust is moving away from its previous strategy as encapsulated in its Integrated Business Plan to its emerging new strategy which is centred around the five key strategic themes:

- Home Sweet Home – local health integration
- Focus on excellence – prioritising investment in services, to develop world class excellence
- Go Digital – digital transformation
- The Master Plan – long term estates planning
- Good Quality Costs Less – delivering continuous service improvement

2.21 The full business plan is available on the Trust's website.

3. Horton General Hospital update

Replacement of CT Scanner

3.1 Approval has been given to the funding required to work up the full business case for the replacement of the CT scanner at the Horton General Hospital. The importance of this piece of equipment to the functioning of the Horton is such that a scheme needs to be progressed in parallel with the strategic review work. A potential interim solution has been developed. This will require significant investment because of the nature of the Horton's estate. This illustrates the need for a new approach to the development of the Horton which is being taken forward as part of the strategic review work.

Strategic review

3.2 As the Community Partnership Network has been informed, a major review of health and social care provision across Oxfordshire is being undertaken under the auspices of the Oxfordshire Transformation Board. The CPN has received presentations on the nature and scope of this review and on the emerging themes. Engagement with stakeholders has begun and there was a major public engagement event held on 6 June 2016 at the Kassam Stadium in Oxford.

3.3 As part of this overall review, the Trust in collaboration with its partners is undertaking a strategic review of services at the Horton General Hospital, taking into account the emerging new models of care arising from the system wide transformation work.

- 3.4 As part of the engagement on the strategic review of services at the Horton, a workshop was held between CPN members and OUH clinicians on 12 May 2016. Notes of that meeting are attached as appendix A to this paper.
- 3.5 A further meeting of this group will be taking place on 9 June 2016.
- 3.6 The initial work has been focused on:
- Assessing patient need and national policy and clinical best practice
 - Identifying options that are clinically viable
 - Developing criteria against which to assess the options
- 3.7 The outcome of this work has been shared with the CPN/OUH clinician group.
- 3.8 The current position on the emerging options is summarised in appendix B.
- 3.9 It is intended to consider further the emerging options at the CPN meeting, together with the developing criteria for assessment.
- 3.10 The next stages will be to evaluate the options from an activity, workforce and finance perspective. Potentially valid options would then be looked at from an estates perspective.
- 3.11 Engagement on the emerging options will continue over the next several months.
- 3.12 Any significant changes which are being proposed as part of the system wide transformation work including not only those that may be suggested at the Horton but also those relating to other components of the provision of health and social care across Oxfordshire will be subject to a full public consultation process. At present this has been provisionally scheduled to begin in September/October 2016.
- 3.13 Views on the form that the further engagement should take will be sought from the CPN at its meeting.

4. Conclusion

- 4.1 The Community Partnership Network is asked to note and comment on the contents of this report.

Andrew Stevens
Director of Planning & Information
7 June 2016

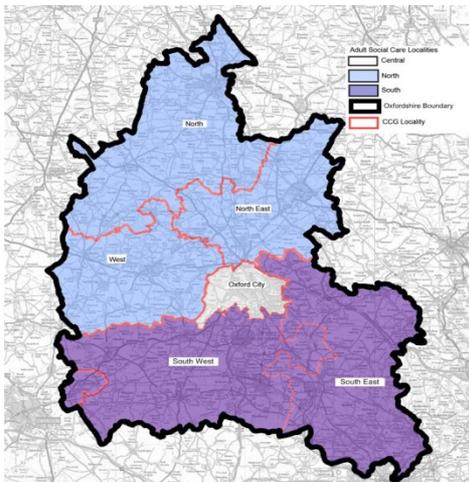
Integrated Health and Social Care Update

“Responsible Localities” – A New Model for Adult Social Care

The rising pressure on Adult Social Care due to demographic pressures, a wider range of statutory responsibilities and the challenge of significant funding reductions has led to a review of the way Adult Social Care is delivered in Oxfordshire.

The priority in this context is to meet our statutory obligations, to protect services for the most vulnerable and to be as efficient as possible, whilst utilising closer working relationships with health and proactively encouraging people to help themselves.

‘Responsible Localities’ intends to bring about the foundations for this change, with Adult Social Care becoming coterminous with the Clinical Commissioning Group (CCG) and Oxford Health (OH) boundaries, to utilise available resources together more effectively.



Proposed coterminous boundaries

The shared health and social care vision is for services to be delivered through ‘patches’ or ‘neighborhood teams’, with each serving a population of 30,000 to 50,000 or 4 to 6 GP practices. Adult Social Care teams will continue to focus and deliver on statutory responsibilities and where integrated working is required, teams will work with primary care and community services and local people to proactively and comprehensively manage local population health and social care needs. This will involve a shift to a more risk enabling culture, shifting from ‘I can fix it for you’ to ‘I will enable you to fix it for yourself’ wherever possible.

All teams in the new model will work across all service user groups (Older People, Physical Disabilities, Learning Disabilities), with the exception of Mental Health, which will continue to be provided by Oxford Health Foundation Trust.

The new model will include six distinct functions:

1. **Rapid Response** (North, City, South) - teams will work closely with health to provide a same day rapid assessment and service provision for people at acute risk of hospital admission or placement in a care home. They will directly liaise with local community hospitals to support hospital discharges. A person should not be with this team for longer than 6 weeks.
2. **Integrated Locality Teams** (North, City, South) - teams will work with GPs and health professionals to form multi-disciplinary teams. They will work more intensively and for a longer time with high end users of health and social care services to meet their needs.
3. **Reviews** - a countywide ‘Review Team’ will have responsibility for all community and residential annual support plan reviews.
4. **Acute Hospitals** (North, City, South) - staff will work with Acute Trusts both within and outside of Oxfordshire to achieve safe and timely discharges and promote patient flow.
5. **Safeguarding** (countywide) - the existing Safeguarding Adults Team will expand to form a comprehensive ‘Safeguarding Service’.

6. **Service Improvement** (countywide) – this will drive forward the integration, transformation and digitalisation agendas within Adult Social Care.

With a continued focus on protecting frontline services the council's buildings and office spaces will inevitably be rationalised. The intention is that Adult Social Care staff will spend more time working locally in neighbourhood patches alongside health colleagues.

Internal staff consultation on the 'Responsible Localities' model closed in early April and a consultation response has now been released to staff. The new model is planned to go live in October 2016.

Devolution, Unitary Councils and the Impact on Oxfordshire's Health and Social Care Services

Report to CPN 14 June 2016

Introduction and Background

Public bodies in Oxfordshire on 4 September, 2015 jointly submitted an expression of interest to Government that asks for greater local control over £4bn of funding for transport, skills training and health services.

The six Oxfordshire councils, the Oxfordshire Local Enterprise Partnership and Oxfordshire Clinical Commissioning Group jointly submitted the expression of interest, which was also endorsed by the University of Oxford and Oxford Brookes University.

It was submitted in response to a call by Government for local areas to propose new ways of working that will increase economic growth and improve services for residents as part of its devolution agenda. In return, Government is prepared to devolve power and funding to local areas as has already happened in greater Manchester.

The initial set of ideas submitted to Government set out how Oxfordshire partners will work together to address these issues in return for long-term government funding and more local powers. The four main themes of the expression of interest are:

- Delivering the infrastructure – particularly the roads network – that is required to support economic growth
- Helping people to get the necessary skills and benefit from good jobs created in hi-tech industries
- Tackling housing shortages and affordability
- Ensure health and social care services meet growing demand as the population ages and funding to public services is reduced.

The expression of interest also proposes to build on the effective joint working arrangements that already exist in Oxfordshire and to deliver better services for residents, including greater local control over health budgets. The expression of interest is outlined below.

Health and Social Care Proposals in Summary

This part of the proposal as well as having the support of six Local Authorities and the Local Enterprise Partnership also benefits from the support of the wider health and wellbeing community including specifically, Oxford University Hospitals Foundation Trust, Oxford Health Foundation Trust, University of Oxford, Oxford Academic Health Sciences Network, Oxfordshire Safeguarding Children Board, Oxfordshire Safeguarding Adults' Board, Ox Fed, Principal Medical (GP Federation

Organisations), Age UK Oxfordshire, and Oxfordshire Community First (Voluntary sector partners). The proposal has also been discussed with Oxfordshire Healthwatch and senior local officers of NHS England and Public Health England.

Devolution enables Oxfordshire to create a single approach for health and social care, bringing together organisations and budgets to create a system that will deliver the care that our residents need as well as delivering better value for money for tax payers. The proposed system will be more comprehensive yet more efficient and simpler for patients, with greater local accountability. The proposal also capitalises on the stronger links with six Local Authorities and the local Enterprise Partnership which devolution facilitates, enabling the health sector to boost further the local economy.

Three phases are proposed: Firstly, building on existing arrangements and powers, to integrate local commissioning teams, increase the current pooled commissioning budget to c. £0.5Bn, align all remaining resources (c. £1Bn) and strengthen the Health and Wellbeing Board. This would be followed by a further phase that sees national budgets and powers devolved in discussion with NHS England, national government and local organisations, and evolution of the Health and Wellbeing Board into a body, responsible for commissioning of all health and social care and public health services for Oxfordshire's residents. Further consideration will also be given to how health and social care governance arrangements interlocks with and complements those of any new Combined Authority structure.

Health and Social Care Proposals in Context

Oxfordshire has a unique local health economy that benefits from geographic co-terminosity of health and wellbeing organisations, along with long standing and close partnership arrangements.

It has a single Clinical Commissioning Group that covers almost the whole county and works closely with Oxfordshire County Council which provides adults' and children's social services and local public health services. The Clinical Commissioning Group and Council already have large pooled budgets, jointly appointed senior management posts and work effectively together with other key players through the Oxfordshire Health and Wellbeing Board.

In terms of service providers, there are also two major foundation trusts - the Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust.

Oxford University is an internationally recognised centre of excellence for biomedical and clinical research and teaching with over 5,500 academics, researchers, NHS clinicians and GPs. The University has long standing partnerships with local NHS Trusts, and newer collaborations with the Oxford Academic Health Sciences Network and the Academic Health Sciences Centre. This sector plays a key role in driving our strong local economy and also allows patients to benefit from close links between research and healthcare delivery.

Despite these local benefits, Oxfordshire faces practical difficulties from:

- The lack of a single overarching body with responsibility and accountability for aligning and delivering integrated local services
- Organisations working to different priorities and mis-aligned financial planning timetables

- Patients reporting that their experience often feels fragmented due to multiple organisations involved in their care with ineffective hand-offs and information sharing
- Oxford University Hospital NHS Foundation Trust is a major national and international player, this brings many benefits but also challenges, as over half of its funding streams come from outside Oxfordshire, making it hard for partners to plan and deliver effective services for local residents.
- Barriers to getting health innovation from 'pilot-site to bedside' meaning local residents do not benefit quickly from local innovation
- Failing to adequately link the need for health infrastructure and staff housing to the local planning system, making it hard to address communities' health needs and retain staff in an environment of very high house prices.

These issues lead inevitably to unnecessary fragmentation of local services, sub-optimal performance and inefficiency that affects Oxfordshire's health and wellbeing services. Devolution enables a radical step change in partnership working, taking local decisions in the interests of residents to overcome these barriers.

Devolution will enable the creation of a single health and care system for Oxfordshire that is more comprehensive yet simpler and more efficient, with greater local accountability.

It will bring together clinical and political leaders, unite generalist and specialist services, utilise academic creativity and link directly into economic development and spatial planning.

The vision is to create ***One Service with One Budget to create One Plan*** overseen by ***One accountable local body*** resulting in improved health, wellbeing and prosperity for local people

The Proposal in More Detail

This transition has begun, but devolution is needed to complete the task.

Government is asked to:

1. Support us in strengthening the existing Health and Wellbeing Board so that it can take on devolved responsibilities and budgets for the local NHS and local government, including the ability to employ a single co-located staff, manage contracts and drive the performance of the whole system
2. Work with us to devolve the current Practitioner budgets for Pharmacists, Dentists and Optometrists and the current spend on specialised commissioning budgets to be managed alongside the currently delegated budget for General Practice (total funding c. £400M) as a baseline minimum guaranteed up to 2025, plus Oxfordshire's share of any additional allocations granted within that time-frame.
3. Enable NHS funding to be held as five year rolling budgets and to extend to these monies current local authority freedoms in terms of holding reserves, accessing capital etc.
4. Give us freedom to create the clinical and management structures we need to take on the additional responsibilities
5. Devolve any health related grants originating in the Department of Health direct to the new Health and Wellbeing Board.

6. Create with us a single unified, strengthened and robust system of scrutiny, performance management and assurance which unites NHS and local authority audit, performance and scrutiny functions. This will include strengthened roles for adult and children's safeguarding Boards.
7. Allocate a transformation fund under the control of the Health and Wellbeing Board to enable transitional phases to operate effectively.
8. Work alongside us to create an aligned accounting practice across both adult social care and the health sector.
9. Work alongside us at all stages to implement the changes described in this proposal.

By 2020, the following measurable outcomes are expected to be achieved:

1. There will be a decline in age-standardised mortality rates from cardio-vascular disease (e.g. heart attack and stroke) which will outperform national reductions by 5% due to improved early detection and treatment of long term diseases including diabetes.
2. As part of this reduction, the gap in cardio-vascular mortality rates between the 1/5 most socially deprived wards and the 1/5 least socially deprived wards will reduce by 5%.
3. We will increase the proportion of people cared for at home and decrease the proportion cared for in hospital by shifting resources from hospital to community. We will reduce the share of current spend on hospital services by approximately £60 million and use this to both increase spend on community services (£54 million as well as increasing spend on disease prevention, around £6 million). We aspire to increase further the high levels of patient satisfaction reported across our health and social care services and to improve the current level of CQC ratings achieved by local organisations.
4. We will be among the best in the country with regard to measures of patient access, waits and delays.
5. We will reduce the health inequalities within Oxfordshire, especially those resulting from lack of parity for those using mental health and learning disability services.

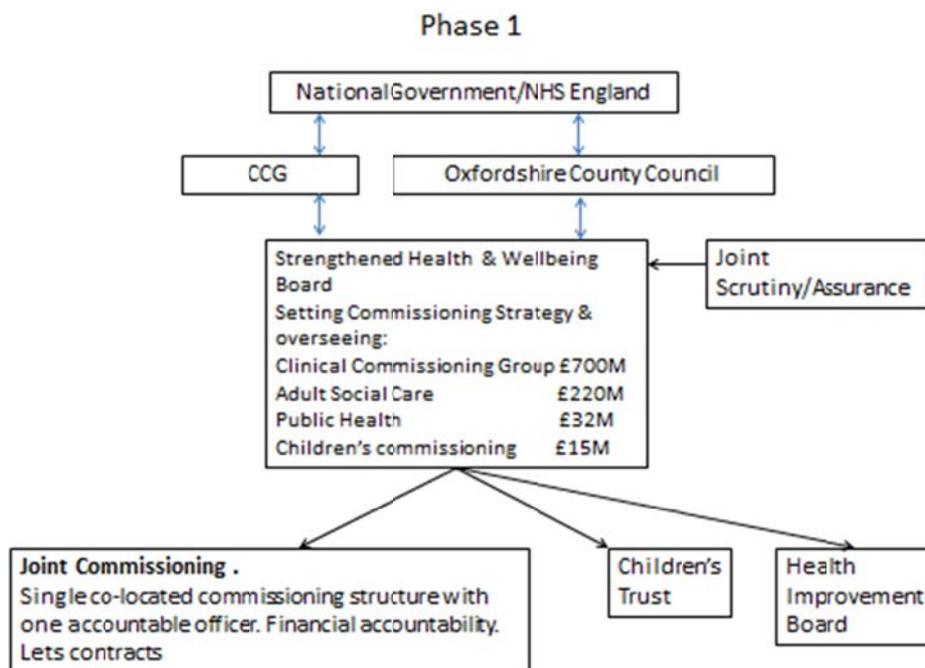
A one system approach will deliver better outcomes and value for money:

1. Services will be easier to use, access, understand and shape as they will be commissioned in a unified way. There will be a single point of accountability and therefore a single focal point for the public and patients to engage with whatever their needs. Local commissioning of specialist services will improve outcomes from our large hospital providers.
2. There will be more investment in prevention. Prevention is in residents' interests and reduces costs later on. Aligning the preventive services of the NHS and 6 Local Authorities will considerably strengthen our ability to prevent ill health. Existing arrangements with Public Health England would be maintained and mutual support strengthened.
3. Where services are required these will be configured in patient's best interests. Integrated commissioning will lead to integrated services. Wherever possible patients will be kept out of hospital and treated in their own homes or in the local community. This is what the public want and will also save the tax payer money.

4. Patients will experience a single approach from self-care to specialised care. Care will be delivered by a single team with shared records and shared plans for those with long term problems. Duplication will be eliminated and contacts will be minimised.
5. There will be reduced delays across the board, particularly in terms of delayed transfers of care as there will be a single organisation with a single budget making decisions in the best interests of the patient.

A Three Phased Approach to Establish a Radically Different System

Phase 1: Strengthening the system and working together



Proposals in Phase 1 are:

1. All staff involved in commissioning health and care services in Oxfordshire would be co-located and work in an integrated way to deliver the best outcomes for residents. This could be achieved by the secondment of County Council commissioning staff with the Clinical Commissioning Group staff, under a single accountable officer and would include commissioning activity for children's and adults social care services and local public health.
2. All County Council children's and adults' social care commissioning budgets (c. £267M) and substantial Clinical Commissioning Group commissioning budgets (c.£291M) would be pooled under section 75 arrangements and brought under the strategic guidance of the Health and Wellbeing Board acting as a joint committee of the CCG and the County Council. The remaining CCG funding would be aligned with the pooled budget and would be actively debated at the Health and Wellbeing Board, so that a single County strategy can be created. This makes a total resource of £967M.
3. The Terms of Reference, membership and supporting structure of the Health and Wellbeing Board would be reviewed and strengthened.

4. The Chief Executive of the Clinical Commissioning Group will be appointed as the accountable officer for commissioning health and social care services, and will report to the Health and Wellbeing Board.
5. During this phase agreement will be sought from NHS England with regard to appropriate interim arrangements for specialised commissioning and primary care commissioning.
6. During this phase, further work with Government would agree how to strengthen further the powers of the Health and Wellbeing Board to facilitate phase 2.
7. The statutory functions of the Director of Adult Social Services and the Director of Children's Services will remain with the County Council and will advise the Health and Wellbeing Board.
8. The Director of Public Health would be part of the new joint management team and would advise the Health and Wellbeing Board. Statutory duties will remain with the County council
9. Providers will continue to work with commissioners through the Transformation Board which includes the NHS Foundation Trusts and GP federations. Social care providers will also be brought into this work.
10. Adult's and Children's Safeguarding Boards will continue to provide independent scrutiny of the new health and social care arrangements and will provide additional assurance to the Health and Wellbeing Board and to Government about the effectiveness of the system.
11. We will work together to create a single robust system of assurance, including existing local authority scrutiny functions such as the statutory Joint Health Overview and Scrutiny Committee.

We will work with partners and national government to review phase 1 after 6 months in order to consider appropriate next steps, but further integration is proposed to proceed as set out below.

Phase 2: Devolution - timing to be considered further but we plan for this to occur within 12 to 18 months from the start of phase 1

The final details of this may depend on the application of the Cities and Local Government Devolution Act 2016. Our current thinking proposes:

1. A new Health and Wellbeing Board
 - The Board becomes an established body able to hold budgets and account for finances, let contracts, manage staff and be held to account for the probity, management, quality and performance of the local health, social care and local public health systems. The Board would have funding allocated to it to carry out its commissioning functions.
 - The Board would have the commissioning functions of the CCG, NHS England, Social care and local Public Health devolved to it.
 - Statutory officers will remain in place and continue to discharge their statutory obligations in relation to overseeing essential delivery of social care services.
 - The Board will create a single strategy for health and social care in Oxfordshire, built upon the evidence base in the Joint Strategic Needs Assessment. Commissioning activity and delivery will be driven by this strategy.
 - Financial flexibilities are devolved including 5 year budgets, the ability to hold reserves and access capital. The Health and Wellbeing Board has the

freedom to use the full range of contracts currently available in the NHS and Local Government.

2. A formal monitoring framework and key performance indicators are agreed between Government and the Health and Wellbeing Board to assure delivery and to uphold the NHS constitution. This includes the audit, governance, quality and performance oversight of the whole system.
3. Scrutiny functions are strengthened to span the whole of the health and wellbeing agenda, including specialist and primary care. This will include ensuring the effectiveness of safeguarding arrangements for children and adult through increased governance by partner agencies of the safeguarding children and adult boards.
4. Strong partnership arrangements will be put in place between the Growth Board (or a Combined Authority if is in place), the Local Enterprise Partnership, the Universities and Health and Wellbeing Board to link health and social care planning with spatial planning and medical innovation
5. Service providers
 - The Transformation Board will develop shared delivery plans between commissioners, health and care service providers and the public.
 - Formal alliances will be established between service providers which break down organisational barriers. This will result in an increase in contractual consortia arrangements and the increased inclusion of voluntary organisations.
 - The workforce can be deployed more flexibly across organisations and planned as a whole, including staff training and development. Long term plans will give providers the confidence to invest in the workforce.
6. Local health and social care teams will be fully integrated and will work closely with general practice. The team can assess risks together and make proactive plans with patients.

Phase three - longer term:

Further consideration could be given to how health and social care governance arrangements fit with that of any new Combined Authority structure.

Further working arrangements with relevant Government Departments such as DWP and Home office would be facilitated.

This arrangement also facilitates the emergence of new models of health care such as accountable care organisations.

The Advent of Unitary Councils for Oxfordshire

The subsequent unitary councils expression of interest to Government submitted by the Oxfordshire Districts and South Northants and Cotswold District Councils intended to retain and build on these devolution proposals using the combined authority model with a particular focus on addressing the practical difficulties outlined above. More recently, and following further research, it has been collectively decided to rule out cross-county boundary options, which might have seen further investigation into a Cherwell District Council and South Northamptonshire Council unitary and West Oxfordshire and Cotswold District unitary councils proposal.

The remaining five Oxfordshire Districts are undertaking work to develop Combined Authority proposals for:

- **A new model of integration and joint commissioning for Adult Social Care and Health services across the Oxfordshire Clinical Commissioning Group area.** This work will be undertaken in partnership with the OCCG and close engagement of the Department of health and other key stakeholders.
- **A new governance and operating model for Children and Families Social Services** to develop proposals for service redesign and delivery of Children and Families Services could be delivered across the Combined Authority area, including consideration of how a “Lead Authority” or Children’s Trust models could operate.

Bicester - Healthy Town, Healthy Lives

Report to CPN 14 June 2016

1. Introduction

1.1 In June 2015, the NHS issued a prospectus to invite bids to participate in a Healthy New Towns (HNT) Programme. The initiative was aimed at putting health at the heart of new neighbourhoods and towns by future-proofing new communities for the health and care challenges of this new century – obesity, dementia, new models of digital health, by designing in health and modern care from the outset.

1.2 The objectives of the programme were:

- Designing in healthy living (developing new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent);
- Capitalising on new home-based care and technologies to support older people at home;
- Sharing infrastructure across public services to make smarter use of taxpayer investment;
- Making learning available to other national programmes as well as other local areas and to show what is possible when we radically rethink how health and care services could be delivered, freed from the legacy constraints.

1.3 The NHS was seeking long-term partnerships from across the country covering housing developments that meet the following criteria:

- Are in areas identified for future population growth or housing need (e.g. in regional or local plans);
- Are in the pre-application, pre-master planning or master planning phase;
- Are planning schemes of at least 250 homes (with no upper limit on the size of a development);
- Have the active backing of the relevant local authorities even if subsequent planning decisions are outstanding;
- Applications from local authorities, housing associations and the construction sector (as well as other key stakeholders who could form a broader coalition or partnership, including the Local Planning Authority).

1.4 Led by Cherwell District Council, representatives from a range of local health sector organisations, local government, the voluntary sector and A2Dominion - the NW Bicester lead developer, submitted a Bicester – Healthy Town, Healthy Lives partnership based expression of interest (EoI) and then, following long-listing from the 114 EoIs nationally, a presentation for a day's 'Dragon's Den' shortlisting event was held on 3 February 2016. On 1 March

2016, the NHS announced 10 shortlisted bids to become part of the Programme, of which Bicester was one.

2. The Bicester Healthy New Town Partnership

- 2.1 The lead partners who presented to the NHS and have shaped the proposal so far are:

Ian Davies - Director of Operational Delivery, Cherwell District Council
Rosie Rowe - Head of Provider Development (Out of Hospital Care),
Oxfordshire Clinical Commissioning Group
Dr Nick Scott-Ram - Director of Commercial Development, Oxford Academic Health Science Network
Louise Caves - Strategic Partnerships Manager, A2 Dominion Housing Group
Jenny Barker - Bicester Delivery Manager, Eco Bicester Project Team, Cherwell District Council

- 2.2 The wider Bicester partnership contains the following additional organisations:

NHS England South, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust, Oxfordshire County Council, Bicester Town Council, Oxford Brookes University, Oxford University, Age (UK) Oxfordshire, Healthwatch Oxfordshire, Bicester Locality Patient Forum, North Oxfordshire Community Partnership Network, ISIS Innovation, ONEFED GP Federation, Health Education Thames Valley, Oxfordshire Sport and Physical Activity, Oxfordshire Local Enterprise Partnership and the Oxfordshire Health and Wellbeing Board.

- 2.3 The partnership already has an 'engine of innovation' in the Eco Bicester Living Lab set up by Bioregional and Oxford Brookes University to provide support for research and innovation and the Digital Health Network led by Oxford University, ISIS Innovation and the Oxford AHSN to improve health outcomes through providers of innovative digital technologies and health services.

3. The Bicester Healthy New Town Bid

- 3.1 The bid focuses on Bicester - a market town that is planned to near double in size, including the innovative national exemplar Eco Town development at North West Bicester led by A2Dominion. The HNT Initiative provides the opportunity to develop further the innovations at NW Bicester and to identify the impacts they have on public health and be replicated across the later phases of large scale planned growth for the town, other areas of the town and elsewhere in the country.
- 3.2 The town currently has approximately 13,000 dwellings and a population of about 30,000 people. Over the next 20-30 years a further 13,000 homes are planned to be built which will effectively double the size of the population. Bicester was designated as a Garden Town in 2014 under the government's

Garden Cities initiative and is a strategic location for growth within the Oxfordshire Strategic Economic Plan.

- 3.3 The NW Bicester development is the only site in the UK being developed to PPS1 Eco Town standards, including design for healthy lifestyles, and as such is unique in the holistic approach to sustainability that has resulted in innovative new development. The first phase of this is the 393 home Elmsbrook site, with the first occupations taking place in May 2016.
- 3.4 At Elmsbrook we have a built environment which will be **a catalyst for Healthy Living** through:
- Its **integrated design**, featuring highly energy efficient, adaptable homes that support independent living within a well designed public realm, where 40% of the site will be multi-functional green active space supported by a network and hierarchy of safe cycle and walking routes with accessible public transport.
 - Digital, community and travel connectivity functions which are hard wired into the design. Digitally enabled communities with smart tablets called Shimmy's in every home to encourage healthy lifestyles with real-time energy, travel and community information.
 - A community and physical infrastructure to promote and actively engage residents to live **healthy lives** as the norm.
- 3.5 The scale of development in Bicester is such that lessons from early developments such as NW Bicester can be used to inform further town development and innovation in the built environment and community buildings. This learning will be relevant countywide and nationally as the level of housing delivery increases to meet the country's need.
- 3.6 Bicester was identified in the Oxfordshire Clinical Commissioning Group's 5 Year Forward View as a Garden Town offering opportunities to deliver innovative health and social care to its rapidly growing population. The scale of the development creates opportunities to:
- Improve **access** to health and social care services;
 - Facilitate **early detection and prevention** through active monitoring and management;
 - Assist the **management of long term conditions** to improve outcomes;
 - Help individuals **remain in their own homes and communities**;
- 3.7 These objectives will be achieved through:
- Delivering a **greater number of services locally** than traditionally available in general practice;
 - Using **new technologies** within the home, health and social care settings;
 - **Enhanced integration** between health and care, housing, transport, and other public services, and of services (between primary and secondary care, mental and physical health, health and social care, and preventative and treatment services);

- Using a **place based approach** to funding of health and social care services and expanding outcome based contracts currently in place;
- Developing **workforce initiatives** that deliver health and social care in innovative ways.

3.8 The Bicester HNT Programme is proposed with four multi-agency work streams. It is these which will be the main focus for delivering innovation and change. The four work streams and leads for are;

1. Urban Environment and Design – led by Cherwell District Council, this includes the healthy living aspects for all ages of the urban and built environment of new developments in Bicester, with learning from what's being implemented at NW Bicester – energy efficient and life time adaptable homes, cycle ways, walkways, sustainable transport, public transport, urban design especially physical connectivity and accessibility, multi-activity open space, green corridors and community assets.
2. Digital Innovations – led by Oxford Academic Health Science Network. This includes new digital technologies and health related applications to promote self-diagnosis, self-monitoring and self-care. To consider the optimum approach to matching the needs of the Bicester HNT with the technology opportunities available and how such technologies could be introduced. This is to include the joint development of A2D's Shimmy tablet and the public need to adopt an inclusive and healthy lifestyle.
3. Health Care Services Remodelling – led by Oxfordshire CCG, this includes adopting the care closer to home principle plus full social and health care service integration and remodelling by providers and commissioners. Exploration of new models of care and patient activated self-care where appropriate.
4. Community Infrastructure Support – led jointly by A2Dominion and Cherwell District Council, this revolves around people based activities and the social support infrastructure. It therefore includes the voluntary sector, new and emerging local groups, education and learning opportunities, healthy lifestyle activities and programmes, social inclusion programmes, carers etc.

3.9 A stocktake workshop was held on 26 May 2016 in order to develop further detail of the multi-agency activities of these work streams.

4. **NHS England and Other Support**

4.1 NHS England is seeking the relevant local authority to become the lead and accountable body for this initiative. It is offering £150,000 grant aid in 2016/17 plus a range of other support interventions such as access to further capital funding sources, national expertise, co-ordination of research and innovations, shared learning opportunities with other shortlisted HNT locations and evaluation support.

4.2 The process subsequent to the formal bid has called for an indication of spending priorities associated with the NHS grant. At such an early stage in the process, the indicative Bicester spend proposals submitted included seed

investment/match funding for innovations, programme management, communications, healthy lifestyles activities, research, partnership management and clinical engagement.

- 4.3 The NHS England funding is for 2016-17 only at this stage as officials are unable to provide any funding certainty beyond this period. Such a programme calls for a longer term approach to maximise the benefits and, whilst further NHS funding is anticipated, an effective collective effort is required locally. Other external funding opportunities are already being pursued enabled by the NHS England HNT Programme. It will however be important for the Bicester partners to develop a local fund for programme continuity purposes and to lever additional external finance for individual initiatives. In this respect, £20,000 has been agreed by Cherwell District Council to act as a catalyst for other local partners to contribute financially for this purpose.

5. **Relevance to the CPN**

- 5.1 This is about a shift in emphasis to ill health prevention. The essence of this programme is about changing behaviour to create healthy lifestyles, generally improving health as a means of reducing demand for health and social care services, enabling independent living into old age and remodelling health and social care services to support this. This means that there will be different health and social care service delivery solutions which are more patient activated, community/home based and which in turn, will lead to adjustments to current primary and secondary services.