NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB Board Meeting in Public

Responses to the public questions submitted to the 21 November 2023 Board meeting:

Ref	Questions / Comments
No. 1 (Agenda Item 5)	Why is there no public participation session at the ICB meetings? *Question submitted by Cllr Stefan Gawrysiak, Henley on Thames, Oxfordshire*
Response	The Board meeting is a meeting in public not a public meeting. We welcome questions, submitted in advance, and when related to our agenda items we will try and answer them during the item. There are other mechanisms for wider and ongoing discussion and engagement with our public.

No. 2 (Item 6)	I applaud the item on the agenda regarding stories about personalised care. Maybe you should also have an agenda item about things that go wrong. In Oxfordshire OCC has unilaterally reduced short stay hub beds from 97 to 63. This has not been done on clinical need rather by market forces. It means that in South Oxfordshire we have no beds at all. This means that a frail elderly person and there relatives will have to travel 20 miles and 2 hr on a bus to visit. This is not personalised care. The removal of these beds has been done without any consultation with GPS who run the service and the local community. This is a clear example of NON personalised care which should be improved. Please explain why the beds have been removed and where is the nearest provision to Henley on Thames. *Question submitted by Cllr Stefan Gawrysiak, Henley on Thames, Oxfordshire*
Response	We use a range of resident/patient stories which will cover both good practice and highlight where things have not gone well and how this can be addressed. <u>Short stay Hub beds in Henley-upon-Thames</u> Evidence clearly shows that people recover more quickly and regain their independence faster when they are supported at home, in familiar surroundings. Improvements are seen in both their physical and mental health. Oxfordshire County Council and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board are committed to providing the best possible outcomes for residents and ensuring the right resources are focused on this Home First approach of supporting people to live as independently as possible within their own communities. This means we will need fewer short stay hub beds, so when the time comes that a contract ends with a care home which provides this service, it is our responsibility to make the right decisions about whether we need to retain the service or redirect the resources elsewhere. When making these decisions, the geographical location of the beds is not a consideration. Short stay hub beds are not reserved for residents neighbouring them but are available for anyone in Oxfordshire who has been assessed as needing one. The short stay hub beds are designed to support people for a maximum of two weeks to find their feet after a stay in hospital. They are not ‘clinical’ or ‘medical’ beds. The short say hub beds are contracted by Oxfordshire County Council. There is some confusion here as patients have, in the past, been discharged into these hub beds when they still need some sort of hospital care. This should not have been happening, but with hospital pressures, when there is a spare bed somewhere, they inevitably get used. This means they have had a very high occupancy rate, but they have been used inappropriately for patients with higher care needs. This will now stop. Patients who need supervised medical care needs would continue to be cared for at either the acute hospitals or in a community hospital bed. There will be more hospital beds available this winter as we have launched a new way of providing long term social care assessments at home, rather than doing them in hospital. The pilot of this programme showed a 25 per cent drop in the number of people going into short stay hub beds, which supports the national aim of reducing the numbers of people being discharged into these settings.

	We understand there are concerns about how we will provide the additional home care needed to support this change in strategy. As you would expect, we have been planning for this for some time and we now have more than enough capacity in the system to support this. Each week more than 30,300 hours of home care is provided for people in the county, which represents a 19 per cent increase in the last 16 months. This upward trend will continue, and we are in a position to deliver this quality service that provides the best outcomes for the people of Oxfordshire.

No. 3 (Item 7)	**At the Board meeting on 19th September, in response to my question about public engagement in the development of the Primary Care Strategy, the verbal answer was followed up some 23 days later on Friday 20th October by the following written answer:** *"Work has started on analysing the current state of primary care across BOB. This includes reviewing the variation in access to primary care services (General practice, pharmacy, optometry and dentistry) across the geography as well as the current workforce and other enablers like digital tools and estates. These are aspects that we may already be aware of, but this will be the first time they are brought together to create a robust case for change. As part of this as well as seeking clinical input we are reviewing what we already know from our patients and the public through engagement work already undertaken. For example, reviewing the feedback from the engagement around the integrated care strategy and joint forward plan; reviewing the recent GP survey results and reports from our local Healthwatch organisations on primary care. This will also inform the case for change.* *As reported at the Board we had originally planned to launch public engagement in early October but are now aiming for November; information will be available **here**. The engagement will include the involvement of PPGs as well as wider engagement across our communities and voluntary sector through some online events, focus groups, a survey and opportunities for people and groups to give direct feedback to the ICB to inform the development of primary care across the area."* **The above link was finally activated 4 weeks later on Friday 17th November.** The link goes to a somewhat remote web page: Your Voice / Primary Care Development Hub / Have your say where the so-called "Survey" asks just two questions: *"What are your experiences of accessing primary care?" and "What is working well and what can be improved?"* - There is no closing date given for responses. - There is no mention of the "Survey" on the BOB ICB Home or News pages, or on the BOB ICB social media sites. - This seems to be a belated and tokenistic attempt at patient engagement. - The draft strategy is scheduled to be presented to the Oxfordshire Joint Health Overview and Scrutiny Committee on 8th February. There is no mention of a scheduled presentation to Buckinghamshire Health & Adult Social Care Select Committee. **Question: Will stakeholders and the public have an opportunity to comment on the strategy and, if so, how and when?** *Question submitted by Frank Donlon, 3W Health Patient Participation Group, Winslow*
Response	Thank you for the feedback. Yes, stakeholders and the public will have an opportunity to comment on the draft strategy. You will be aware, as part of the programme of work to develop a primary care strategy we have launched the 'Primary Care Conversation'. At this initial stage of engagement, we are asking the public to share their views, insights and experiences of primary care. The draft primary care strategy will be published mid-December for comment and feedback. The engagement runs from Friday 17 November 2023 until 31 January 2024. While this date was on the website, we have now made it clearer in the page content and on the key date section. The Primary Care Strategy Development Programme will be an agenda item at the Joint BOB HOSC on 24 January, not Oxfordshire; this was an error on the website which has now been corrected. The news page of the ICB does have a press release signposting to the engagement and in response to your helpful feedback we have also now sign-posted from the home page of the ICB website. As of 15 December, the following additional information has been published: • BOB Primary Care Strategy System Workforce Executive Summary • BOB Primary Care Strategy Current State Assessment

No. 4 (Item 7)	With better communication between all of primary care including GPs, the board could be encouraging local commissioning to actually include the POD workforce to better the health outcomes for the BOB population. In Optometry for example, there is a workforce which is capable of and willing to help reduce the pressure in the hospitals and GP practices. This would mean better access to eye health advice and care. What plans does the ICB have to commit to commissioning differently from before to include pharmacy, optometry and dentistry. *Question submitted by Sean Caske, Chair, LOC (Local Optical Committee) Berkshire*
Response	The ICB is currently developing a strategy for the future of primary care; which includes general practice, community pharmacy, optometry (eye care) and dentistry across BOB. The aims of the strategy: 1. Build a shared understanding of the current state of primary and community services and present a case for change. 2. Build a consensus on the future vision for primary care and its integration with community services. 3. Design the way we deliver this care (operating model) and other tools such as digital healthcare support. 4. Test the practical application of the new model through projects. 5. Capture learning and build capability for phased roll-out of the final strategy. The ICB values the services provided by community pharmacy, optometry and dentistry and is looking to commission in a different way. In June we introduced a flexible commissioning scheme for patients who have struggled to get a dentist particularly those patients in our more vulnerable populations and we now have community optometrists making direct referrals to secondary care services. Our next step is to pilot optometrists undertaking some diagnostic tests pre a hospital appointment to ensure better triage, so the patient is directed to the right place with the aim of freeing up capacity in secondary care.

No. 5 (Not on Agenda)	My question is about NHS funded IVF treatment and policy no: 11k (TVPC 11g) I would like this question printed in full. **Background** NHSE states "funding decisions for health services in England are made by integrated care boards (ICBs) and are based on the clinical needs of their local population. We expect these organisations to commission fertility services in line with National Institute for Health and Care Excellence (NICE) guidelines for assessment and treatment of fertility problems, ensuring equal access to fertility treatment across England." The Women's Health Strategy published on 30th August 2022 states in priority area 12, Fertility Care "*We will work with NHS England to review and address the current geographical variation in access to NHS-funded fertility services across England to ensure all NHS fertility services are commissioned in a clinically justifiable way."* BOB ICB currently does not follow NICE guidelines and offers access to IVF to a male of **ANY** age and to a female of **up to 35** years of age. Policy Statement 11g provides a summary of the rationale underpinning the decision of the BOB ICB in departing from NICE guidelines. One of the graphs in this policy statement (table 5.1) used to support this departure from NICE Guidance is based on Menken *et al (1986)* which uses *"***marital** fertility rates" from 1600 -1921, with one data set from Iran dated 1940-1950. Data that is mostly between nearly FOUR centuries and ONE century old. The second data set used is from Anderson *et Al (2000)* which is more up to date and details foetal loss and the maternal age of the mother. The Policy statement has no data relating to the paternal age of the father and its impact on foetal loss. A further study by Anderson *et al (2004)* on Advanced **Paternal** Age and Risk Fetal Death states *"The paternal age effect on late fetal death showed a tendency to increase from a paternal age of 45 year".* **Yet the BOB ICB offer no restriction to the age of the male partner for NHS Funded IVF.** **BOB ICB are currently an outlier in the age criteria they use to enable access to NHS Funded IVF, as has been recognised by the government. See Hansard extract below:** **Hansard: Volume 738, IVF Provision debated 24th October 2023.**

	Maria Caulfield : Parliamentary Under Secretary of State for Health and Social Care *"As has been set out, integrated care boards are now responsible for delivering IVF services. They were previously determined by CCGs, but from July last year the 42 ICBs across England are now responsible. Since the ICBs were created, we have seen a levelling up of IVF provision in many. Where CCGs have come together, ICBs have often adopted the higher rate of provision, rather than the lowest level. That is to be welcomed, but by no means does it mean that the level of provision is where we want it to be. Some, but by no means all, ICBs, including in north-east London and Sussex—I declare an interest as a Sussex MP—are now fully compliant with the current NICE guidelines and the provision of three cycles.* ***Others are improving their integrated offer, but some ICBs have kept their pre-existing local offer. That is not good enough, and we are aiming to tackle it****.* Later in the debate *"…..Getting that information [local ICB IVF offer (BOB ICB Policy listed as under review)] is the first step, and then we are able to look at the ICBs that are not offering the required level of service, have those conversations about why and have a step change to improve the offer. That is just one tool in our box to fulfil our ambition to end the postcode lottery for fertility treatment across England."* **My questions are set out below.** **1. Why is the BOB ICB directly discriminating against women applying for NHS Funded IVF:** a. on the basis of their sex in contravention of the Human Rights Act 2010? b. patient on the basis of their maternal age in contravention of the Human Rights Act 2010? **2. As the BOB ICB Policy 11k (TVPC 11g) is under review – what patient/public involvement (if any) has there been in the review of this policy.** *Question submitted by Edward Ball, Witney*
Response Q1	A summary of the rationale for Assisted Reproduction Services Clinical Commissioning Policy Statement (CCPS) (TVPC11g) departure from NICE guidelines is published on the BOB ICB website here, which does answer many of the arguments stated in the background information provided with the questions. Whilst up to date when published in July 2015, the information still reflects the rationale for the current policy and is in the process of being updated through the review of the Assisted Reproduction Services Clinical Commissioning Policy Statement (see answer to Question 2). It is well established that the most important factor in predicting the success of fertility treatment is the age of the woman - birth rates from fertility treatment fall with increasing female age, however the effect of male age on the outcome of fertility treatment is less well established. Because female age has a significant impact on the outcome of fertility treatment, the upper age of women receiving treatment is an eligibility criterion recommended by NICE in Clinical Guideline 156 (updated 2017) and NICE Quality Standard 73 (2014), and the Human Fertilisation and Embryology Authority HFEA Commissioning Guidance (2019). None of this guidance includes male age as a recommended criterion for access to NHS funded fertility treatment. The HFEA collects data on all IVF cycles undertaken in the UK. This data continues to show that IVF success rates decrease as the age of the woman receiving treatment increases (assuming her own eggs and not donor eggs are used). Data collected by the HFEA shows that in general women aged under 35 are more likely to have a live birth following fertility treatment compared to women aged 35 and over.
Response Q2	BOB ICB Clinical Commissioning Policy Statement for Assisted Reproduction Services for infertile patients is currently under review in collaboration with Frimley ICB through the BOB ICB and Frimley ICB Priorities Committee (BOBFPC). (The current BOB ICB Commissioning Policy Statement for Assisted Reproduction Services for infertile patients is comprised of the legacy CCG Commissioning Policy Statements from each of our three places and all are linked through the BOB ICB website here.) Terms of Reference, Standard Operating Process (SOP) and Ethical Framework for BOBFPC are published here. So far, BOBFPC has considered a wide range of information and data, including patient advocate reports, national guidance and data, national audits, the costs of fertility treatments, the views of local clinical specialists, equality and equity issues, specialist legal and ethical advice, and

	consideration of ICB legal duties. NICE Clinical Guideline 156 (updated 2017) is itself in the process of being updated by NICE, and includes Lay member involvement as well as future public consultation of draft guidelines. As a Clinical Guideline, CG156 is not mandatory, but is taken into account during development and review of ICB Clinical Commissioning Policy Statements, and by BOB ICB when making a final ratification decision. Patient/ public involvement in the BOBFPC policy review process is through Lay Chair and Membership of BOBFPC and additional consultation with Healthwatch as appropriate, as described in the published SOP. BOB ICB is mindful of its responsibilities in relation to involving the public in decision making as set out in the National Health Service Act 2006, amended by the Health and Care Act 2022, and statutory guidance published by NHS England, and will undertake further patient and public consultation when considering adoption of the final BOBFPC Clinical Commissioning Policy Recommendation if appropriate.