OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 2 February 2017 commencing at 10.00 am and finishing at 4.05 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods (Deputy Chairman) District Councillor Jane Doughty District Councillor Monica Lovatt District Councillor Andrew McHugh District Councillor Susanna Pressel Councillor Arash Fatemian (In place of Councillor Tim Hallchurch MBE)
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Resources Directorate)
Part of meeting	Director of Public Health and Director of Law & Governance)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

1/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Arash Fatemian attended in place of Councillor Tim Hallchurch.

2/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

3/17 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 17 November 2016 were approved and signed subject to the following:

- Min. 62/16, line 2 - Declarations of Interest - deletion of the word 'Banbury'
- Min. 68/16, page 11, penultimate paragraph – Oxfordshire Transformation Plan and Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire & Berkshire West – Updates – deletion of the words 'would be' and addition of the word 'would' after 'engagement

4/17 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following speakers. All speakers to speak prior to discussion at the item itself:

Agenda Item 7 – 'Management of Pressures on Urgent Care'

- Ian Davies – Director of Operational Delivery, Cherwell District Council & South Northamptonshire Council
- Councillor Kieron Mallon – Banbury Town Council
- Eddie Reeves, Local Resident, Banbury

Agenda Item 8 – 'The Buckinghamshire, Oxfordshire & Berkshire West Sustainability & Transformation Plan

- Keith Strangwood – Chairman, 'Keep the Horton General'.
- Veronica Treacher – Member of 'Keep our NHS Public'

Agenda Item 9 - Oxfordshire Transformation Plan – Plans for 'Big Health & Care' Consultation

- Valerie Ingram – Horton Hospital Facebook Page and its supporters
- Clive Hill – Member of 'Chipping Norton Hospital Action Group'.

Agenda Item 11 – Closure of Deer Park Medical Centre, Witney

- Councillor James Mills – Leader, West Oxfordshire District Council
- Councillor Toby Morris – West Oxfordshire District Council
- Brenda Churchill – Chair, Patient Participation Group, Deer Park Surgery, Witney
- David Bailey – Patient at Deer Park Surgery, Witney

Order of Business

It was **AGREED** that Agenda Item 7 'Management of Pressures on Urgent Care' would follow Agenda Item 5 'Forward Plan'.

5/17 FORWARD PLAN
(Agenda No. 5)

The Committee **AGREED** the Forward Plan (JHO5).

6/17 MANAGEMENT OF PRESSURES ON URGENT CARE
(Agenda No. 7)

Ian Davies addressed the meeting in relation to Agenda Item 9 also. He urged the Committee to look at services under threat at the Horton Hospital as a whole, and not as a two stage consultation process, adding his warning that there was a real possibility that Accident & Emergency and Paediatrics service would also be closed. He added his concern that the two stage process lacked clarity and caused a prolonged uncertainty for the public. He pointed out that there were several small birthing units in the country with fully integrated obstetric services made up of a large number of doctors and which fully satisfied their training needs. He urged strong challenge from the Committee and for these services to be reviewed as a matter of urgency.

Cllr Kieron Mallon urged the Committee to consider the 'excessive' travel time from Banbury to Oxford in the event of a need for obstetric care as a result of complications. To add to this, as had been extensively reported on local BBC news, the Committee should consider the lack of public transport to Oxford from the suburbs of Banbury should travel by car be not an option; the 90 minute to 2 hour travel time; and the need to allow up to 1 hour for parking at the John Radcliffe. He highlighted his concern for vulnerable mothers from the ethnic minority population in the Banbury area who had been cited in studies as more likely to suffer complications in pregnancy. He reminded members that areas of Banbury had been included in the top 20% of the most deprived households in England, pointing out there had been no evidence to suggest that Health had considered demographic evidence in detail. He added that the Brighter Futures Programme had documented the importance of a feeling of safety as a contribution to a state of well-being for the most disadvantaged. Cllr Mallon also cited the 'misleading maternity information' given to pregnant mothers that most of the young were a low risk. In conclusion, he asked, on behalf of Banbury Town Council, that the proposals be reviewed as a matter of urgency.

Eddie Reeves addressed the meeting as a local resident of Banbury Calthorpe ward. He stated that he often found it a chastening experience when, in his occupation as a local solicitor he drafted wills bequeathing monies to Horton General Hospital. He urged the Committee to ensure that it remained a General Hospital. He made reference to the written submission made to Committee Members from Cherwell District Council and to the fact that the local MP was collating journey times to the John Radcliffe Hospital made by her residents. Mr Reeves stated his view that there was a great need for a fully functioning Horton General Hospital in Banbury, in view of its growing size and stature and in its role as a strategic centre in the north of the County. He re-iterated Cllr Mallon's belief that the two-stage consultation process was flawed and stated his concern that decisions had already been made ahead of the public consultation. Furthermore, these decisions were detrimental to both the residents of Banbury and those over the county border in South Northamptonshire who relied on the Horton's services.

David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group (OCCG) and Diane Hedges, Chief Operating Officer and Deputy Chief Executive, OCCG attended. Diane Hedges introduced the report highlighting that the management of pressures on Urgent Care was a continual challenge due to a number of factors detailed in the paper, but Oxfordshire was performing well compared to other areas nationally. However there was no complacency and there was a recognised need to look at process at the front end, in particular, flow through the hospital.

Members of the Committee asked questions exploring a number of issues, including:

- The recent alert status at the John Radcliffe Hospital, which resulted in some elective surgery being cancelled;
- A complaint that an outpatient appointment was cancelled after the patient had started their journey to hospital;
- The split between Adult Social Care and the Health Service in relation to the 122 Delayed Transfers of Care;
- The length of time ambulances were waiting outside Accident & Emergency in order to discharge their patients;
- Lack of promotion by OCCG of the GP Out of Hours service;
- The relationship between discharge delays and the recent closure of beds across hospital sites and the possibility of some beds being re-commissioned;
- Possible additional pressure on GP practices from the discharge of patients to their homes;
- The new model of 'ambulatory by default' exposing issues in the post-acute sector.

Health representatives responded with the following:

- There was a period 2 weeks ago when 7 elective operations were cancelled but, in the main all the doors were open. Members of the public were being reminded to use their local GP or local pharmacy where appropriate;
- The cancelled outpatient appointment was unfortunate and an apology was given. This was not normal action to take and indicative of the pressure the hospital was under;
- The reasons for delayed transfers could be due to a number reasons affecting health care and social care. Management initiatives, such as the reablement contract were often multi-disciplinary and couldn't be singled out;
- There was not a major ambulance queuing issue currently compared to 2/3 years ago - Performance figures would be sent to the Policy Officer. Oxfordshire was performing better than many other Health authorities in the southern region;
- There were some staffing pressures for the Out of Hours service over this year's winter period but it has seen 6,000+ patients which was 20% more than in previous years. There had also been 30% more home visits than in the previous year. Thus, to some extent, the service was being successful at keeping patients in their own home;

- Approximately 146 beds have been closed and 164 patients had become medically fit for discharge from the JR and the Horton hospitals. The major issue was about the support given to patients when they leave hospital, not the beds;
- The Liaison Hubs were the right place to assess patients leaving hospital if they had any needs upon discharge. All patients then had the opportunity of reablement services. The intention was not to put pressure on GPs and the OCCG was mindful of getting the balance right;
- The current initiative of carrying out ambulatory care by bringing the GP Out of Hours service into the JR, had not proved as successful as was hoped because the current premises were not suitable. The OCCG was constantly seeking other ways of 'breaking the cycle'.

At this point with regard to the management of pressures on urgent care in maternity at the Horton General Hospital, the Chairman then invited local member, Cllr Arash Fatemian to speak about the continued temporary closure of the Obstetrics Unit and the proposals contained within Phase 1 of the Oxfordshire Transformation Plan. He stated that the latest update on the position (dated 23 December 2016) on the recruitment of Obstetric doctors by Oxford University Hospitals NHS Foundation Trust (OUH) which had stated that:

'The OUH Trust Board made a decision on 31August 2016 that obstetric-led maternity services at the Horton could not safely be maintained. They (the Board) required the decision to be reviewed so that if enough doctors were recruited to run the service it could be reinstated.

The service was initially temporarily suspended with effect from 3 October 2016 with the hope that if enough doctors were able to be appointed in the meantime, then the service could reopen in January. This decision was reviewed at the end of October, and it was clear that there would only be three doctors in post in January out of the 9 needed. Therefore the suspension was extended again until March and it was decided to review the situation again in December after the next round of recruitment and advertising.

That situation was reviewed again this week and unfortunately, the current number of obstetric doctors remains at 3 and the maximum number of doctors likely to be in post by March is 5, which is not enough to reinstate the service at that point.'

Cllr Fatemian referred to this Committee's decision at the 30 September meeting, when it decided not to refer this matter to the Secretary of State, on the evidence that it was satisfied that OUH had adequate reasons for acting without consultation on the basis of urgency relating to the safety or welfare of patients or staff. The Committee agreed to monitor the temporary closure and the recruitment plan which was in place to increase staffing levels. The Trust's update on performance of maternity services at the Horton, dated 23 December 2016, stated that they would not have enough experienced and skilled medical staff in post to reopen the unit in March 2017 as planned.

At the request of the Committee, Nick Graham, Director of Law & Governance advised that the grounds for referral to the Secretary of State were limited to

circumstances where the Committee did not believe the reasons given for closure of the Obstetrics Unit to be adequate. In terms of procedure, if the Committee would have to demonstrate that it had taken steps to agree a local resolution with the Trust and there had been a lack of resolution.

David Smith confirmed that the OUH was still in a position that there were insufficient doctors to run the service. In response to concerns raised by the speakers that the two-phase OTP consultation was flawed, he stated that the OCCG was consulting in this manner as previously agreed with the Committee on 30 September.

On the conclusion of the discussion it was **AGREED**

(a) to thank the OCCG for the update on the management of pressures on urgent care;

(b) (on a motion by Cllr Fatemian, seconded by Cllr Bulmer and carried unanimously)**,** that, without prejudice, to refer the temporary closure of the consultant- led obstetrics unit at the Horton General Hospital to the Secretary of State for Health under Regulation 23(9)(b) of the 2013 Regulations, for consideration on the following grounds:

(1) that the Committee believed that the material grounds for not referring the matter had changed, ie. the Trust's recruitment plan had failed and the closure would now be longer than envisaged; and

(2) it considered that nothing could be gained by further discussion at a local level with the Trust.

7/17 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 6)

Eddie Duller OBE and Rosalind Pearce, Chair and Chief Executive, respectively, of Healthwatch Oxfordshire (HWO) presented their regular update to the Committee.

Eddie Duller wished to make it clear that HWO had no issue with the OCCG regarding the BOB STP engagement process, its issue was around the consultation process, and the fact that HWO had not seen the document prior to it being leaked.

In response to requests from three members of the Committee asking if the Witney Project could be extended to Wantage, Bicester and Thame in the future, Ros Pearce responded that HWO was trying to conduct geographically-based investigations and had not yet decided where to take them.

Eddie Duller was asked how HWO found the language and terminology in the OTP consultation document – which might either encourage or discourage the general public to truly reflect their views. He responded that he had found the language used 'difficult to the extreme', so much so that HWO had felt it necessary to run a translation service on their website.

In response to a question, Rosalind Pearce confirmed that HWO had not picked up any issues or concerns from other neighbouring counties about the consultations,

despite their close working with other counties. She undertook to look to HWO counterparts in those areas.

Eddie Duller and Rosalind Pearce were thanked for the report.

8/17 THE BUCKINGHAMSHIRE, OXFORDSHIRE & BERKSHIRE WEST SUSTAINABILITY & TRANSFORMATION PLAN (STP)

(Agenda No. 8)

Prior to consideration of this item, the Committee heard addresses from two members of the public:

Keith Strangwood thanked members of the Committee for its decision in relation to the closure of the Obstetrics service at the Horton General Hospital. He appealed to members to vote with their heart when its response to Phase 1 of the OTP consultation was considered on 7 March 2017.

Veronica Treacher stated that the capability of members of the public to influence many of the services featured in the STP was questionable, adding that despite the public engagement exercises carried out, it was driven by waiting times and audit. Plans had been presented as technical exercises and the language used constituted a language barrier. She added her view that the BOB STP largely remained secret and the public had not been given any information with respect to accountability and responsibility. Furthermore, that any changes had already been decided. She called for any re-configuration to be stress-tested to deliver effective services. She urged HOSC to make a stand and to call for further information about finance in light of public concern.

David Smith attended for this item in his capacity as both Chief Executive of the OCCG and the lead for the STP footprint over Buckinghamshire, Oxfordshire and Berkshire West. Stuart Bell, Chief Executive of Oxford Health also attended. Mr Bell stated that although he was working through some projects at the broader BOB level, which tended to concern specialist services that required a larger footprint (such as cancer services), much of the planning, consultation and delivery would be via the three local systems. Referring to the last speaker's address, Mr Bell clarified that the STP did not exist as a statutory body.

Mr Bell advised that a new approach was to be taken based on local planning in contrast to the market situation which was the previous approach. This was reflected in the transformation process in Oxfordshire. Changes described in the STP were in line with those of the rest of the country. Furthermore, this federal approach meant that revised Terms of Reference were required for the Oxfordshire Transformation Board to ensure regular reports were provided on the STP and also to ensure an Oxfordshire view would be presented in the STP. An event had been held 2 weeks previously involving the wider local authorities, and a range of other organisations, to do a stock-take and to develop a process of engagement. There was recognition that this would involve significant numbers of the social care and home care workforce.

Members asked questions around the following areas:

- Whether there were other plans that had been through the Clinical Senate and NHS England;
- Why the BOB STP had not been consulted on and published as a holistic plan and not as part of the OTP consultation;
- How the work plan for the OCCG and the Senate worked out across Oxfordshire;
- Relation of the OTP/STP to common resource problems experienced by the Health service nationwide, such as over - use of agency staff, NHS equipment not being returned, charging foreign visitors for use of services etc;
- Sufficiency of staff numbers to undertake all that would be required;
- The source of the monies for investment;
- More managers meaning less money for the patients?
- A guarantee that there would not be commissioning with the private sector across BOB;
- How governance to tackle problems with a specialist service on the wider STP footprint would work– were there powers/sanctions to enforce by an oversight Board?
- The temporary or permanent nature of the STP. Will it become a new structure for the delivery of Health in this region and how would its governance work? Were STPs merely a re-invention of the Regional Health Authorities?

Mr Smith and Mr Bell gave the following responses:

- Oxfordshire was the first of the areas within the BOB STP to go out to consultation on its local plans;
- A plan is very different from a consultation. The STP was an attempt to pull together individual components relating to particular services, using the available resources in a more effective way. Each component would then need to be led by the appropriate statutory body - the components for Oxfordshire would be addressed by the OTP. Parts of the system were not delivering required quality of care, for example, waiting times and health inequalities that exist. It was necessary for the OCCG to do something about them, and this could not be done without making changes to the system;
- Regarding publicising the STP, the documents were on the OCCG's website, together with a short guide. There was a willingness to engage, and any comments on specific services included in the STP would be welcome. David Smith undertook to check whether the website was interactive;
- Phase 1 proposals had been through the Clinical Senate's assurance process which included a panel of clinical experts from outside the area. This report had been made public and Mr Smith undertook to provide a link to the report to members;
- There were projects looking at equipment and staffing issues at the moment. In particular, looking at ways of attracting people back to work from other sources, rather than via agency use. This had proved successful in relation to finding nursing staff, but was less so with clinical staff. The OCCG was looking at workforce issues across the BOB area, for example, looking at how

specialist services could be provided more locally within the BOB area. In addition, how the OCCG could make better use of electronic health records and also ways in which new digital technology could help provide healthcare and offset difficulties in recruitment;

- Staffing issues were more of a risk/constraint as training could be long-term. The OCCG was therefore taking a more systematic approach to the recruitment of people with different skills: for example, work with universities within the BOB network and the introduction of bursaries and graduate career progression in order to make the most of people's skills and supporting staff to operate at the top of their licence;
- The use of the STP as a basis for allocating investments of monies locally had already begun with bids submitted for Psychiatric and Diabetes services. As long as plans were already in place, responses could be speedy. Capital and national investment was very limited (for example, the OCCG had put in a bid amounting to £50m for investment in local GP practices, but only £2m was allocated). This made recycling a necessity, together with the need to seek opportunities for investment from other bodies. Mr Smith agreed that Health needed to tap into S.106 developer monies at every opportunity. The Committee would write to the Minister for Health about the underfunding of the NHS in Oxfordshire;
- There would be no new managers. In fact discussions were being held about how costs could be reduced via cuts in back office services;
- There was a Government Policy about Patient Choice and therefore the local NHS did commission services from the private sector. The OCCG was in the process of working up a delivery plan. Mr Bell commented that there was more provision of services in partnership with the voluntary sector;
- STPs were here to stay. However there was no intention to embark on wholesale change in the NHS. Individual CCGs would work locally and investment decisions would be made locally, thus giving greater accountability and more local control over the totality of the picture. Investment decisions for specialist services would be made centrally via NHS England across the STP footprint in accordance with gaps in care or inequalities. Some services might be commissioned on a bigger scale, for example, to include Swindon and Milton Keynes hospitals that were not in the BOB STP footprint. Conversely, this did not mean all commissioning of specialist services would be centralised through the STP: the OUH worked through a number of networks and alliances with other hospitals not in the STP according to the needs of patients and for better outcomes. One size did not fit all;
- Powers of compliance were decided between the CCGs – each might have different issues. The OCCG Board and each CCG still held statutory responsibility, but would work with other organisations for the good of the patients.

Mr Smith noted that whilst HOSC recognised that the OCCG did address some problems, such as the availability of sufficient domiciliary care to meet the changes made at Townlands Hospital, the STP was focussing on specific services. The Committee needed to see the local NHS working much more closely with local Councils with regard to planning consent and housing development.

Mr Smith agreed to come back to Committee with the delivery plans when they were available. This would provide the Committee with more information in relation to how the new system would operate.

Mr Smith and Mr Bell were thanked for the report and for their attendance.

9/17 OXFORDSHIRE TRANSFORMATION PLAN (OTP) - PLANS FOR 'BIG HEALTH AND CARE' CONSULTATION, PHASE 1

(Agenda No. 9)

Christine Ansell, speaking on behalf of Valerie Ingram, expressed concern, on behalf of the 22,000 supporters, that the Committee had voted to accept the split consultation. They considered it unwise, prejudicial and to the detriment of the people of Banbury and the surrounding area. It was their view that the services under review were interdependent. This would risk the potential removal of the obstetric led maternity unit, which would put into jeopardy the Special Care Baby Unit, Paediatrics and ultimately the Accident & Emergency department, effectively dispensing with all the acute services at the hospital. This would leave a rapidly expanding area with an inequality of health care, which in their view would go against council policies in core strategies drawn up by local authorities.

Christine Ansell queried whether maternity services were included within the discussion regarding the temporary closure of beds at the Horton.

She also put forward her view that the first consultation meeting on the plans, which had been held in Banbury, was not supported by any of the attendees. Furthermore it had been held in 'banquet style' rather than 'plenary style' which was limiting in terms of numbers able to attend, nor did it enable attendees to hear each other's views. She added that many of the meetings were held during the day which precluded the majority of the working population from attending. It was her view that this style of organisation called into question how meaningful the consultations were.

On behalf of Val Ingram, she urged the Committee to vote against the split consultation 'which delivered a second class health care service to Banbury', adding that the County's MP's were also of this view.

Clive Hill reported concern within the Chipping Norton community that there had been a 'complete lack of involvement of the people of Chipping Norton and district.' He informed the Committee that a request had been made by the Chipping Norton Action Group (CNAG) to the OCCG to hold a public meeting in Chipping Norton before options for Phase 1 of the consultation were determined. Mr Hill stated that despite a promise made by the Chief Executive, this event had not taken place despite repeated requests. Thus, the options had been decided with no public involvement in Chipping Norton. Following publication of Phase 1 of the consultation, the CNAG asked that the Chipping Norton consultation meeting be no earlier than mid to end February to allow time to publicise it. This was not taken into consideration. A meeting was arranged by the OCCG to take place on 2 February from 2pm – 4pm. This was not acceptable for a number of reasons, namely that it clashed with this meeting, was a weekday, most people were at work and young mothers interested in maternity services would be collecting their children from

school. An objection was made, but a change was not forthcoming. There were also concerns about the layout which was ‘cabaret’ style where numbers would be restricted. He expressed his concern regarding OCCG communication in general which had culminated in no advertisement to the community and confusion on the part of the public. The CNAG felt it was a ‘tick box’ process designed to minimise participation; and that the people of Chipping Norton and District had been ignored and side-lined.

David Smith , Dr Joe McManners, Chief Executive and Chair respectively, OCCG attended. They were accompanied by Julia Stackhouse, Communications & Engagement Manager, OCCG. Dr McManners and Mr Smith made a request that questions from members of the Committee be sent to the OCCG prior to the 7 March meeting itself, so that they could be certain that the correct people attended to respond to questions. David Smith encouraged the public to participate in the communication activities on the OCCG’s website, such as the survey and twitter feed, and not to limit activity to the public meetings.

Questions from the Committee covered the following areas:

- The difficulty associated with asking all the necessary questions if there was no co-ordination with the Sustainability & Transformation Plan (STP) or neighbouring areas. Would there be engagement with Phase 2 services on 7 March where there were links?
- Part of the rationale of care closer to home implied the use of Social Care/Neighbourhood Hubs and step down provision in community hospitals. How could the Committee make a decision on Phase 1 without knowing the proposals for that?
- The lack of reference to the Ambulance Service in the consultation documents;
- When there would be a further consultation date for the Thame area?
- The Rose Hill consultation venue was the only Oxford City one and thus travel for some people living in the City could be difficult;

Responses received to the above questions were as follows:

- A certain amount of flexibility was required on Phase 1 of the proposals, there being a need to ensure that the OCCG was engaging with colleagues across the board and HOSCs across the borders to give awareness of the impact on their residents. The OCCG had written to 80k households in the South Warwickshire, Gloucestershire and South Northamptonshire areas as part of the consultation. There had also been linkage with voluntary sectors across the borders and communications groups. HOSC had a clear expectation that there would be consultation on a number of proposals; this was part of the reason for splitting the consultation into two parts. The CCG was in the process of developing the proposals for Phase 2, for example, those for community hospitals. The intention was not to launch the Phase 2 consultation until the Autumn, but feedback in Phase 1 would be taken into the Phase 2 consultation;
- The OCCG would need to look at the system as a whole, including nursing care, community hospital beds, Social Care, GP provision etc

- The OCCG was engaging with the Ambulance Service in the same manner as with other organisations;
- The Thame consultation meeting was on Tuesday 14 March 2017;
- Rose Hill was an accessible venue and, as it was an area of deprivation, it allowed a different audience to engage with the consultation. The consultation as a whole was about a series of different events and a person could attend any of them. With reference to comments made by some of the speakers regarding layout, it was important for the OCCG to hear about what people said at the venues and a variety of layouts was employed in order to give the public the opportunity to raise their voice. Some were plenary, some round table etc. Any feedback from the public in relation to access problems at consultation meetings would be addressed.

The Committee urged the OCCG that, whatever was implemented as a result of Phase 1, it was sufficiently robust and rooted in reality so that a case could be made for easy integration into Phase 2 proposals. Mr Smith responded that specific services would be included as part of the investment in primary care services. Part of the proposal would be to move diagnosis into more local settings in order to provide services closer to home.

The Chairman thanked Mr Smith, Dr McManners and Julia Stackhouse for their attendance. She thanked them for the wide scope in terms of methods of communication and requested that the Oxford venues be looked into.

10/17 FRAMEWORK FOR PRIMARY CARE IN OXFORDSHIRE

(Agenda No. 10)

David Smith, Dr Joe McManners and Julie Dandridge, OCCG attended for this item.

The Committee had before them a paper produced by the OCCG setting out a draft framework for primary care in Oxfordshire (JHO10). The Chairman, in introducing the item, referred to the Committee's discussion at the last meeting and the questions arising from it. A major issue raised was what could be done about the problems in the short term.

David Smith introduced the draft framework citing all the issues that primary care had experienced over the last 10 years, such as a rise in the numbers of older people with complex needs, double numbers of consultations for the over 80's and the difficulties in recruiting and retaining GPs and other professionals in primary care. He explained that the OCCG was trying to identify a broad strategy to be used by groups of GP practices, localities and neighbourhood areas. This would entail looking at population groups, ways of expanding the workforce and at issues relating to premises. An action plan would be compiled looking forward and also looking at what was required in the short-term, such as how to attract more GPs and professionals and also to look at how to establish different roles within practice teams.

Questions asked by the Committee were in the following areas:

- The size of the GP units – was there a standard size?

- Whether practices were being encouraged or ‘nudged’ towards working together;
- The recruitment of more doctors;
- The appropriate circumstances to award a 15 minute appointment;
- Progression of 7 day a week working in GP surgeries;
- More funding for larger practices;
- Installation of IT to support the changes;
- Inclusion of patient transport in the framework – not just for older people, but for all ages needing it;
- The impact of the framework on residents in Bicester and Banbury;
- Whether practices were opting out of the Out of Hours service;
- It had long been noted that patient discharge would be made more rapid in the future. Did the Framework take account of this?
- When would there be consultation on the Framework?

Answers received were as follows:

- The Strategy was not about stipulating practice size, it was more about working across practices of approximately 30-50k residents in a neighbourhood with multi-skilled teams. There was a need to look at having a few practices working together, sharing the risks and even teams. This was the direction of travel the service had seen over the last few years;
- The OCCG was careful not to stipulate how practices should be organised because, for example, City practices were very different to those in Banbury and the strategy would have to work for the local area. This was a framework, not a plan. However, the OCCG would assist them in their move towards a better service, such as the establishment of clinical pharmacists in GP practices who would follow up on notes, blood results etc. Practices would also need to ensure that there is proper value for money for services;
- The recruitment of more doctors was a local and a national problem. The OCCG was looking at how to make Oxfordshire more attractive to doctors and other professionals. GPs were very reliant on the teams surrounding them. If the workload balance was right in the practice, then the OCCG could begin to attract people. It was often found that if a surgery was difficult to recruit to, then a downward spiral would result;
- Some practices gave 15 minute appointments already and also had a triage in place as it was important to identify the right patient to provide for. A clinical triage process was carried out by a GP or nurse. Patients were encouraged to see a nurse or pharmacist for minor illnesses. There were a number of models for this and the OCCG was not going to be prescriptive;
- Most surgeries were increasing access to additional appointments from 1 February, and in Oxford City from 1 March. Information regarding this could be found on individual practice websites. No contact for routine appointments could be made at weekends when the Out of Hours Service or Service 111 was available for urgent access. Not all practices would be operating 7 days per week all at the same time. The Government had to provide 30 minutes for every 1,000 patients. At the moment it was not looking to provide appointments all day Saturday and Sunday. There was a need to look at demand and the availability of appointments. GP or nurse appointments were

already being offered across the county for at least one and a half hours in the evening and at least 3 hours on Saturday and Sunday. The OCCG was trying to tie the hospital and GP appointments together in a pragmatic way. By working across practices there could be quicker access for patients;

- The OCCG needed to think about whether there were sufficient numbers of patients in a locality to require a particular service to be run. For example, a diabetic specialist nurse might be available in a locality, but not a bone cancer nurse. The challenge was to get as good a fit as possible with what funding, staffing, local access, etc. was available. If there was a group of practices specialising in care for older people, this could be pooled. This would also support the aim of giving more support to older people in their own home;
- Much of the IT and technological work had already been implemented. GPs could already see each other's records in a large part of the county. There was a need, however, to work across practices sharing good practice;
- Currently GP practices were paying for their own transport for patients. More work was required on this, together with thought given to options to provide it for all age groups. Investment had already been made in holistic services, for example, the OCCG was looking to trial more local drop-in services to be available at the end of the school day. Julie Dandridge undertook to report back to the Committee at a future date on this issue;
- The OCCG had discussed services in neighbourhoods in Bicester and Banbury. The manner in which the services would be designed would depend on where the patient was registered;
- GPs are independent and separate businesses – it is their choice whether to join a large hub which includes an Out of Hours service;
- With regard to patient discharge, there was a need to become more creative in Oxfordshire with, for example, joint posts with acute hospitals, or with combining research with clinical practice and seeing patients. Furthermore, a full day's work used to be a lot less than nowadays. This was one of the reasons why doctors were retiring. It was thought that better use could be made of the John Radcliffe as a teaching hospital. As more patients are discharged earlier from the OUH, there would need to be proper multi-skilled teams of hospital doctors and GPs to provide aspect. The Framework was about looking at people's health holistically from a biological and a social side;
- Consultation on the Framework would be part of Phase 2 of the OTP consultation but, in the meantime, the OCCG would wish to engage with GP practices about what it meant for them. The discussion would be based on where primary care fitted in with community hospitals/community care. Also, to inform the Phase 2 consultation, thought needed to be given to what network of services would be provided in the patient's own home. Discussion groups and forums had already taken place on this subject. These discussions would roll out more widely once the OCCG could be more specific about what was happening in the localities.

All were thanked for their attendance.

11/17 CLOSURE OF DEER PARK MEDICAL CENTRE, WITNEY

(Agenda No. 11)

Prior to consideration of this item the Committee heard addresses from the following members of the public:

Cllr James Mills urged the Committee to support the closure of Deer Park Medical Centre as a substantial change of service. He expressed his concern that the informal meeting comprising some members of the Committee and representatives from the OCCG had not invited local representatives to attend, particularly when local issues around workforce and the local planning authority were to be aired. He pointed out that thousands of houses were to be planned which would cause major problems if there was insufficient provision of primary care.

Cllr Toby Morris stated that currently Witney was experiencing a 25% vacancy rate for GPs which caused concern particularly as 2,000 houses were due to be built in the Witney area. For this reason it was the Town Council's view that the closure of Deer Park Surgery constituted a substantial change in service as it was an important satellite for patients living in the West Witney, Cogges and central Witney which amounted to half the size of Witney. He pointed out that Witney Town Council had not been consulted on the proposed change by the OCCG and expressed concern that the OCCG had sent letters to the dispersing patients that morning, which was immediately prior to discussion by this Committee.

Brenda Churchill referred to the Court decision, from the previous day, not to continue with the application for judicial review on the grounds that the application had not been made early enough. It was the view of the Patient Participation Group that the OCCG should have discussed the procurement issues with them earlier. Furthermore, they believed that the OCCG should have conducted a broader and more meaningful exchange on the impact of the closure with the local public. She also expressed her concern that there had been too many meetings in private. She urged the Committee to take the view that it was a substantial variation in service, as requested by the district council, the local MP and others. She asserted that very few patients had left the surgery to go to other surgeries because they wanted to remain at the practice.

The Chairman assured Mrs Churchill that no conversation had taken place behind closed doors with the CEO of the OCCG at any time.

David Bailey stated that the decision to close Deer Park Medical Centre made even less sense after listening to the previous item relating to future changes in primary care in Oxfordshire. He told the meeting that in 1993 he had suffered a heart attack and, since that time, the Deer Park Surgery, which had been rated as a 'good' surgery, had taken great care of him. He expressed his concern that the Ambulance Service and the OUH might struggle to respond to emergencies leading to patients not receiving the same level of care. He asserted that GPs were leaving other surgeries, yet the OCCG were planning to remove three GPs from Deer Park who would not be transferring to another surgery. He concluded by urging the Committee to refer the closure to the Secretary of State.

The Chairman then asked the County Council's Director of Law & Governance & Monitoring Officer, to give an update on events since he wrote the paper (attached at JHO11) in relation to the Deer Park Surgery. He reported that events had overtaken the content of the report since the Court hearing had occurred the previous day. His view was that it was not helpful to speculate on what the Judge had said at the hearing. A primary aspect on which the judgement had been made was the delay from the claimants (the Patient Participation Group) to make the submission and that there was no reason why the application could not have been brought earlier. He emphasised that there had been no delay on the part of the Committee, or criticism in the way that it had approached the matter. Committee members had given consideration as to whether the closure would be considered a substantial variation of service by the Committee on 12 December 2016 in an informal, further fact finding meeting to which OCCG representatives had been invited. The meeting today was the first meeting for it to be considered formally and in public by the Committee, subsequent to 12 December. He pointed out that the law did not assist in that there was no legal definition of what constituted 'substantial'. It was the OCCG's view that it was not a substantial change. He advised that if members of the Committee were in agreement with the OCCG, then it would constitute the end of the discussion, but if there was disagreement, then consideration would need to be given about how to go forward ie. consultation on the closure, or referral to the Secretary of State. He confirmed that it was the OCCG's decision about what action they wished to take in the future.

David Smith pointed out that a two hour discussion had taken place with HOSC members on 12 December; that a procurement process had been carried out and the current operator had been the sole bidder. The bid was too high and in the absence of an alternative suitable provider, the OCCG had to take a decision to close the practice at the end of March 2017. He added that the OCCG had previously extended the provider's contract by 1 year. He stated that the OCCG had to inform the patients as soon as the judicial review process had been completed, as it was getting very close to the closure date and patients had to be dispersed to other practices. Mr Smith stated that the OCCG were happy to accept that public consultation would take place, but asked the Committee when this should happen given the timescale.

Questions asked by members of the Committee were in the following areas:

- At the 12 December meeting, members of the Committee had asked for information on financial savings for analysis;
- The Committee ought to have been informed earlier so that different solutions could have been considered;
- On 11 August 2016 Virgin Care, the provider, had confirmed that they were prepared to continue providing services at Deer Park and this had been shared with the local MP;
- The OCCG's consultation process on the closure and their willingness to make it feasible;
- If there was any community-led initiative for the surgery to continue;
- Why letters to patients regarding their dispersal had been sent out that morning, despite an informal steer from Committee members on 12 December that they considered the closure to be a substantial change.

- Would there be patients who were 'orphans' who would not be able to find a surgery in Witney to register with?
- What about patients who were, prior to closure, part of a screening programme and, after closure to which their notes could be transferred? Relying on the Cardhill Formula that only 20% of patients were active on a GP list at any one time, could put patients at risk. The outcome of this would be to skew a receiving surgery's workload, without the funding that followed it.

Answers received from the questions posed by members were:

- The OCCG would make no savings from the closure of the Surgery;
- Virgin Care had confirmed that their original tender bid still stood as it was. Therefore Virgin Care's bid was not affordable within the contract. A consequence of paying more money to Virgin Care would be that more money would have to be paid to other practices and funding was not available for this;
- A 'toolkit' had been considered with HOSC on whether it was a substantial change. As of now, the practice was closing and patients had been written to. Practices were already taking on further staff to accommodate the rise in numbers of patients and some patients had already registered with other practices. It was reiterated that the OCCG had wanted to begin to inform patients much earlier and advise them on registering with other practices. The judicial review process had put a halt to the letters being sent out earlier. They then went out at the earliest opportunity on notice of the result of the hearing;
- It would be very difficult at this late stage to accommodate a community-led initiative to keep the surgery open. The contract had already been extended;
- The patients would have a choice of who to register with;
- The process of transfer of patients was worked out in conjunction with Virgin Care. Text messages were to be sent to patients reminding them to re-register and Virgin Care would be telephoning some. This would be the subject of ongoing reviews.

On the conclusion of the discussion, Cllr Bulmer put forward a motion, seconded by Cllr Dhesi, and carried by 12 votes to 0, that this was a substantial change in service.

In light of the above agreement that it was a substantial change in service, the Committee then considered what action it wished to take. David Smith stated that there was no time for the OCCG to undertake a consultation. Julie Dandridge reiterated that the OCCG could not leave the despatch of letters to patients any longer and confirmed that other practices were able to take the patients being dispersed. Moreover, it was unsafe for the patients not to have a service. Normally there needed to be three and a half months for the dispersal of patients.

Nick Graham advised that as the Committee was in disagreement with the OCCG about whether it was a substantial change in service, if any further action proposed by the Committee was not acceptable to the OCCG, then the only course of action left to the Committee was to refer the matter to the Secretary of State.

Cllr Bulmer then put forward a motion, seconded by Cllr Dhesi, to refer the change in service to the Secretary of State on the basis that consultation with the public and patients at Deer Park Medical Centre was inadequate and the closure of the surgery

would not be in the interests of residents and patients in the Witney area. This was carried by 12 votes to 0.

12/17 CHAIRMAN'S REPORT
(Agenda No. 12)

The Committee considered the latest Chairman's report (JHO12).

It was **AGREED** to note the report.

..... in the Chair

Date of signing