OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 15 September 2016 commencing at 10.00 am and finishing at 3.35 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Jenny Hannaby (for Cllr Alison Rooke) Councillor Laura Price Councillor Les Sibley District Councillor Jane Doughty District Councillor Monica Lovatt District Councillor Susanna Pressel
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Corporate Services); Director of Public Health

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

44/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for absence were received from District Councillor Nigel Champken-Woods and Cllr Jenny Hannaby attended in place of Cllr Alison Rooke.

District Cllr Ian Corkin attended and took part in the Committee as a representative from Cherwell District Council but not in a voting capacity, as the vacancy had not been filled formally as yet.

45/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

46/16 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 30 June 2016 were approved and signed subject to:

- Minute 38/16 - references made on pages 6 and 7 to the STP (Sustainability & Transformation Programme) being amended to TP (Oxfordshire's) Transformation Programme;

- Minute 39/16 – page 8, paragraph 2, final sentence – to amend the sentence to read 'However, they would have been assessed prior to their release'.

Matters Arising

- Minute 38/16 – it was confirmed that Damon Palmer had circulated the Transformation Programme web link to members of the Committee;

- Minute 38/16 – final summing up, page 7 – confirmation was given by Stuart Bell that the Committee's request for separate chapters on proposed services in each locality to be included in the consultation document would be actioned. Also , in relation to the need for changes to IT systems to be placed firmly on the agenda for consideration, David Smith, OCCG, confirmed that he had invited Cllr Nick Carter to a meeting to discuss the matter;

- Minute 39/16 – Councillor Pressel undertook to specify the areas of interest in relation to performance data on healthcare in prisons and IRCs in order to inform the request for further information.

47/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following speakers, all of whom would make their address at the start of Agenda Item 8:

Representative for Victoria Prentis MP, Catharine Gammie
Keith Strangwood, 'Keep the Horton General'
Cllr Lawrie Stratford, Bicester resident
Cllr John Christie, Local Member

48/16 FORWARD PLAN

(Agenda No. 5)

The Committee had the draft Forward Plan before them for consideration (JHO5).

The Chairman advised that a report on the allocation, contracting and provision of District Nurses across Oxfordshire would be presented to the November meeting.

49/16 HEALTH & CARE TRANSFORMATION IN OXFORDSHIRE - UPDATE

(Agenda No. 6)

The Chairman welcomed Stewart Bell, Oxford Health (OH); David Smith, Dr Joe McManners and Damon Palmer, Oxfordshire Clinical Commissioning Group (OCCG) attended for this item.

Stuart Bell gave a presentation - the objectives for which were to:

- summarise the key messages from the public conversation regarding the case for change in transforming health and care in Oxfordshire and the emerging models of care;
- give a summary of the key messages from the public conversation;
- primary care development;
- to seek views to help inform the thinking and development of plans as part of the ongoing process of engagement.

Mr Bell pointed out that one of the key messages from the public pre-consultation was that there needed to be an interconnection between all services so that any questions relating to other services could be raised and may engender more useful work.

David Smith reported that there would be a delay in launching the consultation It was currently anticipated that the new date was early January 2017. He added that the Clinical Senate and NHS England had to sign it off primarily. He also stated that the earliest a final decision could be made was May 2017 and the implementation period would be up to 5 years.

Stuart Bell confirmed that transport matters were high on the public's list of priorities.

The Committee asked to receive a summary of information given out at all the roadshows, as it was a useful method of informing their constituents.

Damon Palmer confirmed that the next stakeholders meeting would be on 22 September. The Chairman confirmed that she would attend this event and relay any information to all members of the Committee.

Members of the Committee urged Health representatives to give more information on the ongoing remedial work that was currently underway, for example in relation to the closure of certain GP surgeries. More flesh was needed on the bones, for example what criteria was being used to determine which were to close. Mr Bell responded that access to services was a major factor being considered. He added that the Deer Park surgery, Witney was a slightly different situation in that the provider was proposing a difference in quality. He added that the issue was how do small practices continue to make ends meet in the plans for the future integration of primary care with the hospital sector and the community services. GPs and PML were looking at the whole primary solution trying to work it out for the whole population. With regard to a question about provisions being made to transfer patients to other surgeries, the current plan was to expand other practices to enable them to take on more patients. He stressed that patient support was the key issue. In answer to a question about the sustainability of care provision via primary care providers, David Smith responded that this came back to the importance of getting as much right before the consultation began. He added that lessons learned from elsewhere had informed them that if the consultation was to start too early, the outcome might result in it having to be

repeated. Furthermore, the difficulty was that each part of the system ie. voluntary care, primary care and social care was under pressure. They needed to be as clear as possible about their assumptions on what could be provided not only in the NHS, but by other providers.

Stuart Bell was asked about the long-term sustainability of care provider services funded by the County Council. He responded that traditionally the care sector had been regarded as a separate world, but the Plan recognised its importance. At a practical level, the current outreach work being provided in nursing homes had proved to be very successful because patients were helped to leave hospital quickly. Integration of social care could increase the stability of the system, for example, the rotation of staff through the whole system. Part of the work being undertaken was to ensure that this would not be exposed to problems such as that of recruitment.

David Smith responded to questions about the possible closure of community hospitals and the impact of that on villages and rural areas with no available transport; what help or incentives would be available for key workers? and would the private sector be subsidised? He advised that the OCCG could not proceed with 'half-baked' proposals and it was far better to conduct a proper dialogue using information that was correct. He added that if the Health system did nothing, by 2020 there would be a £200m deficit, and in the face of demand rising significantly faster than the 2% financial growth monies that Health was receiving, this was not a reality. Should there be work undertaken with other sectors, there would need to be a radical series of trade-offs and a series of choices. Dr McManners explained that the Government had requested each area to provide cuts in service provision. £5m had been top-sliced from the NHS England budget to pay to nursing homes. Furthermore, acute hospitals were starting to work on locality planning. GPs were looking at services in localities, for example, what out-patient provision could be undertaken in their area. Also the future co-location of social workers, GPs and nurses was also in the process of being discussed for each locality. Once this had been completed then discussions would begin with the public.

Cllr Doughty, local member for Witney, expressed concern about the urgent issues to be addressed at the Deer Park surgery in Witney and the need to take on board the views of the residents in relation to future plans for primary care in Witney. Dr McManners responded that there was a need to organise an urgent briefing. The Chairman made reference to a similar situation in Bicester (see Chairman's report later in the Agenda) where members of this Committee had invited local Councillors and the local patient groups to a meeting about supporting people to transfer to other practices and the future of North Bicester Surgery.

A member asked why there had not been a road show in Abingdon, to which Stuart Bell responded that an event was planned to take place in that location during stage 2.

In response to a question about whether the possibility of more extra care housing in new developments had been considered in Banbury and other areas, David Smith informed the Committee that the OCCG's modelling assumptions had to include the best projections for housing across the patch and activity. He stressed that there was

not the same activity everywhere. Following that the OCCG would look at what primary care facilities were required.

A Councillor added his concern that Bicester had not been included within the list of sites in the emerging whole system options, making reference to the additional growth in housing in this area. He called for more forward thinking on the part of OCCG and more care given to the residents who are impacted by the closure of a GP surgery, citing as an example, the imminent closure of the surgery in North Bicester on 30 September where local residents had not had sufficient time to register with a new GP surgery. David Smith responded that Bicester was not the only area across Oxfordshire that was under pressure and the OCCG was trying to support primary care as much as possible. He added that there were specific issues that they were addressing, such as how to make some areas more attractive to GPs and how to introduce more funding into primary care to make services more sustainable.

Stuart Bell was asked how the Transformation Plan (TP) for Oxfordshire would fit into the BOB (Berkshire, Oxfordshire and Buckinghamshire) Plan (the Sustainability & Transformation Plan (SDP) and how it would feature in terms of available funding. He responded that the TP process for Oxfordshire pre-dated the STP process. He added that it had not been helpful that the STP Plans had not been published, but reassured the Committee that all the discussions taking place in this local arena were part of the STP and there would not be anything new when they were finally published. He reassured the Committee also that the Horton Hospital would be included in the pre-consultation and in the TP consultation. In response to a question, he confirmed that there would be data available on each option contained within the consultation, together with comment on whether this would be affordable or not.

The Chairman thanked Mr Bell, Mr Smith, Dr McManners and Mr Palmer for their attendance.

50/16 REBALANCING THE SYSTEM - PILOT EVALUATION AND NEXT STEPS

(Agenda No. 7)

The Chairman welcomed the following representatives who were attending the meeting in order to give details on the end of the pilot review and to give information on the next steps:

Paul Brennan – Director of Clinical Services, Oxford University Hospitals Foundation Trust (OUH)
Lily O'Connor – Divisional Head of Nursing and Governance & Liaison, Hub Manager, OUH
Karen Fuller - Adult Social Care Service Manager, City and Hospitals, Oxfordshire County Council
Dr James Price - Divisional Director for Medicine & Clinical Lead for Gerontology, OUH

Paul Brennan gave a brief overview of the information contained in the report JHO7 about the review of the pilot. He concluded by stating that the Hub was now in operation using 55 beds – a reduction from 150 beds at the start of the pilot. He

added that patient feedback had been good overall, particularly as people were being moved out of a busy acute ward to a different environment.

Mr Brennan agreed to provide the Committee with the key performance indicators which had been used to monitor during the evaluation.

A member asked from which areas were the staff recruited. Mr Brennan reported that 70% were targeted from retail with an attractive package, including a good wage, full-time work for those who wanted it, access to a full NHS Pension Scheme, possible access to a nurse's induction programme or development into the Healthcare system.

In response to a question, Paul Brennan reported that the 55 patients still in hub beds were there for further assessment and work with the family. The beds were used as though they were community beds and were not classed as delayed transfers of care as they were not in the acute sector. Lily O'Connor explained that many patients in community hospitals were there for rehabilitation reasons and were not categorised as delays. She added that it normally took a long time to work out their long-term care, requiring talks with the patients themselves and with their families. Paul Brennan further explained that the pathway had been changed for patients in acute beds, so that before they became a delay, they were moved out and placed in intermediate care beds. A member commented that it was difficult to tell where the 476 patients cited in the report had been placed. Paul Brennan explained that one third had been placed with nursing or care homes, one third had gone home and one third had either died or been readmitted to hospital. Karen Fuller further explained that social workers worked very closely with community colleagues to ensure that patients were moved out and negotiated into homes. Their presence in the Hub put Social Care in a position to ensure that the market was managed well. Paul Brennan added further that when the audit of the first 150 patients had been undertaken there had been no expectations as to where they would be placed.

In response to a question, Paul Brennan reported that the total number of delated transfers of care was currently 78 and 30 were in community beds. He added, in response to a further question, that Oxfordshire was no longer near the bottom of the national table and these figures had reversed the trend (expected 185). He added the view that nationally the measurement tool had changed a number of times. The focus was always on getting patients home quicker.

Dr James Price commented that in the experience of patients, and in that of expert staff, all were very motivated to deliver. Staff working in the Hub Teams were very positive about both because of the good outcomes for patients and because of the learning and innovations gained over the period. He added that care homes had learned the important capability to manage change, the Trust had learned how to apply principles more generally and families and carers how to manage people in their own homes as a result of the changes.

Dr Price was also questioned about the mortality rate from those readmitted to hospital. He reported that mortality figures had fallen during the study, adding that many patients want to return to their own home, even if it may mean a readmission was necessary a few days later.

A Committee member commented that it was pleasing to see that family carers had been included in the figures. Karen Fuller responded that this was shared and updated in the Hub at present. A member also commented that it was also pleasing to see the inclusion of medicine management so that patients arrived in homes with their prescribed medicine.

In response to a question about the availability of nursing home beds, Paul Brennan explained that there was now a partnership approach to this. Karen Fuller commented that currently at any one time there were over 200 beds available at different prices and staff in the Hub had been successful in providing beds. She assured the Committee that there was an availability of beds in Oxfordshire.

A Committee member asked if Health and Social Care were experiencing problems in getting homes adapted for patients. Karen Fuller commented that it was very unusual to have a delay regarding home adaption. Social workers worked closely with District Councils who were very proactive in dealing with it early. Across the board there were very few delays regarding adaptations and alternatives were considered if there was a problem to ensure that patients were not remaining in acute care.

The Chairman thanked all the representatives for responding to questions about the evaluation of the review. She then introduced the next part of the discussion the purpose of which was for the Committee to understand the next stage of the reconfiguration, which it was understood would not be funded by the OCCG. Prior to this she invited Councillor Mrs Judith Heathcoat, Cabinet Member for Adult Social Care, to make a written statement to the meeting, as follows:

‘As the Cabinet Member for Adult Social Care I am hugely concerned about the paper before you today, Before I talk of my concerns can I say that I do wish there to be a ‘working together ‘ of Health and Social Care so that the system is more joined up and easier to navigate. I attend Transformation meetings representing Adult Social Care.

Adult Social Care in Oxfordshire is nationally high performing, being the sixth best rated authority in the national outcome framework for social care. There is a high level of satisfaction from people who use the service – 90% of our users are reasonably/ very/extremely satisfied. Nationally in the last 12 months social care delays vary by 32% whilst here in Oxfordshire they fell by 36%. The numbers of people we support has not fallen and the amount of home care we buy has almost doubled since 2010.

I am genuinely concerned about this paper – ‘plans for acute bed and service reconfiguration’, the word ‘reconfiguration’ has an air of permanency. The proposal is to shed a further 118 beds – the word ‘release’ keeps being used but there is no mention of a trial period, so to go through all this upheaval must mean permanent. The paper discusses ‘details of Ward Relocations’ which sees an immense amount of work for a pilot. With the 74 beds already released, plus the proposal for 118, this brings the figure to all but 200 beds to be released. What period of time is being envisaged to be given to this pilot? The 74 beds that were released initially were for a ‘pilot’ but we have no end date for this I believe?

I understand that there is no funding from the CCG for this further closure of beds. Adult Social Care had not been able to quantify the costs and the impact on the Care Home provider market or the Home Care market. The OCCG did support financially the 76 beds 'released' in November 2015 and Adult Social Care absorbed the costs. It was believed that the releasing of the 76 beds was a pilot.

The question for me now is whether the Committee sees this as a substantial change. If the 'Toolkit 'assessment made by the Trust states that this is not a substantial change, I would disagree and I would suggest therefore that these proposals should go forward and be put into the forthcoming consultation. The release/closure of beds will have an impact on beds'.

Paul Brennan, in responding to Cllr Mrs Heathcoat's statement, commented that he had been involved in a number of conversations with adult social care colleagues regarding this to ensure that any changes were supportable. And no-one had been able to identify an impact on social care costs. He asserted that, apart from the 55 already in situ, there was no intention to purchase any more beds. He added that the Trust was investing £4.1m on services to support patients in their own home which included social worker support. The OCCG had funded part of the Hub work to the amount of £900k and the OUH had funded the balance. The OUH was also pump-priming that funding. By moving out of the bed base, all monies would be invested up front and there would be no impact on nursing homes.

In response to a question asking how the closure of 118 beds was being managed, Mr Brennan explained that the OUH had appointed 50 staff and OCC has awarded the reablement contract to OUH at a fixed cost, to which OUH would add to if it was found to be necessary. The Trust was investing £1.6m in the development of an Acute Hospital at Home service and was also investing in a discharge service (45 nurses, medics and therapy staff). Patients would be managed on a Treatment Pathway. Dr James Price further explained that arrangements would be made for those patients suffering with transient episodes who would usually require prompt assessment. He added that hospital care for frail elderly patients with social and psychological problems could be risky and it did not benefit them overall. Moreover, an in-flow system-wide access to hospital when necessary, together with a capable team situated in the community (including families) was very important, and would make for very good decision making. He added that the current arrangements across the system were not as good as they needed to be. Capable people were required to make a diagnosis and deliver a treatment plan as quickly as possible. The paper laid out a whole range of options and support arrangements with patient care, SHEDS (Supported Hospital Discharge Service), multi-disciplinary teams and community based teams to aid better outcomes and a better patient experience. Dr Price commented further that much thought was being put into rebalancing physical space. Historically there had been too many overnight beds for patients, even when it wasn't in their interest. A rearrangement of clinical support was required to give better care. In working with patients, carers and families, patients could be supported better and at the same time better support could be given to those who did benefit from being in hospital. Furthermore, it could be particularly difficult for many patients in hub beds and in intensive support settings, or who were in the last year of their life. For the above reasons, this was a very strong model, supported by local clinical opinion and by the National College of Physicians and the future Hospital Commission. A member

of the Committee asked if there was a precedent. Dr Price responded that there was national evidence that such services were successful, and also local examples had supported the principles, for example, Abingdon EMI (Emergency Multi - Disciplinary Unit) and the assessment unit at the JR Hospital.

Paul Brennan stated that it was his view that this was not a substantial service change because patients would still access health care in the same way – there would just be a change in the care pathway. He stated also that the direction the Trust was going in was consistent with the national view and with the Liaison HUB strategy. He added that the changes would take 12 months.

A member commented that in the face of the closure of 118 beds, demand for services was growing, waiting lists were longer, and ambulances queuing up at Accident & Emergency. She asked why a report had not been written from a GP's perspective – which would serve to give a feel for the Committee of the patient pathway. Paul Brennan responded that the report sought to explain this with the description of the creation of the Unit at the JR Hospital. He added that GPs had already stated they wanted access to acute professionals when needed, to help support them when dealing with patients at home. It was confirmed that GPs would have this access from November.

The Chairman referred to a further aspect of the proposals which was the purchase of care home beds at a high price than that offered by Social Services, thus causing possible blockages when patients were moved out of acute care, supported by adult social care. She stated that this had not been understood by the public and by the patients affected. The question of timing of the proposal needed to be considered in relation to the timescale for the Transformation Plan. The role of this Committee was to ensure that patients and the public alike understood the situation. She added that the Committee had asked that a substantial change assessment be completed by the OUH, although a completed version had not been received in time to enable the Committee to meet with the Trust prior to this meeting. Furthermore, the proposals needed to be considered in light of the Transformation Plan on which consultation had been delayed until early in the New Year. It was therefore

AGREED (nem con) that it was this Committee's view that this stage of the Rebalancing the System work was a substantial change of service and therefore required full public consultation. According to the terms of the legislation, the Committee should attempt to come to an agreement before referring it to the Secretary of State. Therefore, further discussion with the Trust would take place at a special meeting of the committee on 30 September 2016 in relation to the following issues:

- The impact of the Plan on other providers, including Social Care; and
- The Plan in relation to the forthcoming Transformation Plan consultation.

51/16 OBSTETRICS AND THE STRATEGIC REVIEW - THE HORTON HOSPITAL

(Agenda No. 8)

Prior to consideration of this item, the Committee was addressed by the following speakers:

Catharine Gammie – speaking in behalf of Victoria Prentis MP

Firstly the decision to suspend obstetric services at the Horton Hospital was made with no consultation at all. Victoria Prentis's staff were made aware of the OUH's plans at a meeting of the Horton on 20 July. It was thought that the object of the meeting was to discuss the Transformation Plan proposals affecting maternity provision at the Hospital and Victoria could not attend the meeting. At no point did anybody forewarn her of the imminent announcement relating to the temporary closure of obstetrician provision. The Trust's decision affects not only her constituents in North Oxfordshire, but those beyond her own Parliamentary constituency boundary, for example, the Cotswold Birthing Centre in David Cameron's former constituency transfers 50% of emergency closures to the Horton. Yet at no point did the Trust inform them of their plans.

Secondly, no effort has been made to engage with clinicians or the public. There is considerable bad faith locally and this is exacerbated by a total lack of engagement. The consultants feel excluded and do the Banbury GPs, many of whose patients would now have to decide whether to give birth in the midwife-led unit or to make the 90 minute journey to the JR Hospital. Together the GPs wrote to the Trust in advance of the Extraordinary Board Meeting to express their opposition to the proposals. Their letter expressed many of the concerns they expressed to the Independent Reconfiguration Panel in 2008 ie. safety, sustainability and the reduction in access to base health care and choice for their patients.

Thirdly, the decision to suspend obstetric services is not evidence based. Despite asking to see the risk assessments on many occasions, it was not until this Committee's Agenda was published was there one in the public domain. She has grave concerns, that without controls and contingency plans, there were a number of 'high risks' on the register, including the timeliness of the transfer of patients; the impact on the JR Hospital's maternity service and the retention of staff. Whilst she recognised that without sufficient obstetricians the service was not safe, the transference of mothers who had encountered complications during or post-labour when that transfer would take at least 45 minutes in an ambulance, not taking account of loading and de-loading the patient was extremely worrying.

In conclusion she expressed her fear that lives would be lost and urged this Committee to do everything in its power to intervene and hold the Trust to account. He understood that when there was an emergency, there could not be a statutory consultation process, but the decision needed real scrutiny. She asked the Committee to refer the Trust's actions to the Independent Referral Panel as a matter of urgency and at the same time to ensure that the Trust remained under pressure to recruit, either by being more creative with the advert and job offer, or by outsourcing responsibility to dedicated recruitment consultants. Despite being told consistently that this is will be a temporary suspension, she stated that it would be and there would be a domino effect which would be a fatal blow to the future provision of acute services at the Horton General Hospital. She called for the Committee to ensure that a full obstetric service resumed in the New Year.

Keith Strangwood

Keith Strangwood referred to a third option that he had put forward to the Trust on behalf of 'Keep the Horton General' which was that instead of transferring the obstetric service to the JR Hospital, to keep the theatre open at the Horton so that elective caesarean operations could be carried out by senior gynaecologists. He expressed his concern that unlike the Horton there were no beds at the JR Hospital and to transfer patients from the Horton would cause an overflow. Mr Strangwood commented that the efforts of the OUH to recruit and employ obstetricians was 'ridiculous'. He expressed his belief that the OUH had manipulated the situation and urged the OCCG to utilise the facilities offered by the Horton to take the pressure off the JR. He also expressed his concern that patients could suffer and a life could be lost.

Cllr Lawrie Stratford

Cllr Lawrie Stratford, a former member of HOSC and a resident of Bicester North where many of his constituents resided, were, or had been Horton patients, including himself. He stated that during the past number of years, the Horton had been a recurring item for this Committee. Back in 2008, following a very substantial review of NHS proposals for the Horton by the Committee, the Independent Reconfiguration Panel was asked to examine the proposals and report back to the Secretary of State. One of the key proposals at that time was, and he quoted:

'Obstetrics, gynaecology, and the special care baby unit.

- Replace consultant-led obstetrics and gynaecology services with a midwifery-led maternity unit;
- Transfer obstetric-led services and the special care baby unit to Oxfor Women's Centre;
- Transfer emergency and inpatient gynaecology services and care to Oxford Women's Centre.

Cllr Stratford asked if there was some familiarity with the above proposals and stated that the detail IRP report response , made in 2008, made several references to 'could put mothers and babies at risk' whilst transferring them to Banbury from the Oxford area. It was summarised as follows:

'The IRP does not support the Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the Special Care Baby Unit at the Horton Hospital. The IRP does not consider that they will provide an accessible or improved service to the people of North Oxfordshire and the surrounding areas.'

Cllr Stratford also stated that to help demonstrate this point a 'test run' was organised where two HOSC members were 'rushed from Banbury to Oxford' to ascertain the 'safety' issue. The test was undertaken in a blue light car as an ambulance was not readily available and it took place on a Wednesday afternoon. The outcome demonstrated that it was not a viable or safe option. Since 2008, there was an estimated 20% more traffic and considerably more roadworks especially around the City. He concluded that if it was not safe then, how could it be safe today? He

therefore urged Health to ‘think again’, adding that it was his view that people had lost faith in NHS management. He added that Health had to greatly improve its engagement with residents and patients in the north of Oxfordshire if it was ever going to regain their trust going forward.

Cllr John Christie

Cllr John Christie addressed the meeting in his capacity as a County Councillor for Banbury Ruscote and also as Chair of the Banbury Locality Group of County Councillor who were united in support of the Horton. He stated his view that residents were concerned that the underfunding of the NHS was putting at risk vital acute and maternity services at the Hospital, as outlined in the earlier presentation on the STP. He added that it also made clear that the projected 2% annual growth in the NHS budget was insufficient, and implied cuts to services as well as efficiency gains. He reported that what residents did not understand was how cuts to the Horton were even being considered when it had existed for over 140 years, and in light of the population growth in demand for services in Oxfordshire. In addition to this, they could not understand it in the face of the ‘atrocious’ nature of current access to Oxford from North Oxfordshire, and when the JR site itself was being restricted. He concluded by stating that residents saw the emergency cessation of maternity consultant provision at the Horton as ‘the thin end of the wedge’ which could lead to permanent cuts under the STP. They were concerned that the current staff training and recruitment exercise would fail without some innovative approaches to staff redeployment across both sites which may include incentives. He ended by stating that there must be more ways of ensuring the continuation of such vital services.

The Chairman welcomed Paul Brennan and Andrew Stevens to the meeting to explain why the temporary removal of the consultant-led service would be implemented at the end of October.

Mr Brennan recognised the value north Oxfordshire residents placed on the Horton, but the Trust did not want to be put in a situation where it would be held responsible for patient safety. The Obstetrics service carried out very complex work and emergency work and a senior doctor was required to be in situ 7 days a week, otherwise it was deemed unsafe.

With regard to the recruitment and employment situation, Mr Brennan explained that on 3 October there would be 3 doctors in post. One had resigned and was leaving in November. The number of doctors required to maintain a safe rota for individuals who would have the opportunity for exposure for training at the JR also was 9. Furthermore, due to the low number births since March 2015 (1,466) it had been found that there was insufficient exposure for doctors who needed to keep up their exposure to complex births. Given these numbers, this service was suitable for a midwife-led service, of which there were 3 across the County. Thus a decision had been made at a meeting of the Trust to temporarily close the Obstetrics Unit on 1 October, and to open as a Midwife-led Unit. In the meantime, the Trust had been continuing with their efforts to recruit doctors and had recently offered 4 doctors a consultant post. All had indicated their wish to take up their offer but not all resided in the UK and 2 were not registered with the UK Medical Council. The Trust was trying to support then, but there were limitations with what they could do. Any new doctors

would require a 6-8 week induction and would need to be overseen by senior clinicians at the Horton. He added that there was currently a new advert out and then a further one would go out following its expiry.

Mr Brennan reported also that the Trust had responded to public comment that the salary was too low and, for new advertisements, it was set at £62-76k and incorporated banding and premium rate payments. Also in response to public comment, the advertisement had been altered to include the possibility of the appointment being extended after one year. He explained that doctors needed to attain equilibrium of exposure and that, after that period, they would be moved onto larger centres. The recruitment cycle would be continued and if in the event that more doctors were recruited, the Trust would make their decision on 30 October to re-open the Unit on 9 January 2017 as an Obstetric Unit. In the event that this did not happen, then the Trust would continue to run a series of advertisements and if the correct contingent of doctors could be found, the Trust would re-open the Unit on 1 March 2017.

The Chairman thanked Mr Brennan for his report, commenting that the question of maternity services remaining open in the longer context were to be incorporated into a set of clinical options for the Horton to be considered by the Trust. This was not yet in the public domain and would feature as part of the Transformation Plan. She reminded members that today the Committee were only considering the immediate decision to close the consultant-led Unit on the grounds of urgency.

A member asked if the Trust had considered any other options to make the post more attractive. Mr Brennan responded that the Trust was paying more for the entry level of a consultant and was also helping to support doctors who required a visa. The Trust was also receiving help and support from local MPs on the latter. He pointed out, however, that obstetricians, were very specialised in terms of training and there was a general shortage of doctors. Currently there was a vacancy rate in trainees of 24%. There was no designated assisted training by the Deanery available at the Horton. He stated that he believed the Trust was doing everything possible to recruit obstetricians, although there had been recruitment challenges such as some not attending their interviews, or changing their minds after being offered the post in favour of going to larger Units.

Mr Brennan was asked about the alternative option as presented by the Keep the Horton General group. He responded that this would be costly (at a cost of £1.2m) and was not practical as many doctors at the JR could not be moved to the Horton because the training designation by the Deanery had been removed in 2013.

A Committee member expressed concern that one thousand new maternity cases would be relocated into the JR. Andrew Stevens responded that it was impossible to ‘grow’ birth numbers and there was a need to decide the safest course of action for women in north Oxfordshire. He added that part of the risk assessment was to look at additional capacity at the JR, as outlined in the paper. The risk assessment showed that the JR would be able to accept additional births. He also pointed out that the Trust had worked very closely with the planning authority and with statisticians and it had been ascertained that even with the level of population expansion, the birth rate would only rise by 10%.

In response to a question, Mr Brennan stated that the Trust would pay staff transferring from the Horton any excess travelling expenses incurred and provide designated parking permits for the period end of October to January, when it was anticipated that the Unit would re-open. Also, when asked about the knock on effect of the new arrangements on the gynaecological services, Mr Brennan explained that there would be an additional theatre to be staffed by a sufficient number of midwives.

A member asked if this emerging situation had been created in order to support long term plans for the Horton. Mr Brennan stated that this was not so, explaining that a difficult position had emerged in 2013 when training had been taken away, as outlined in the paper. He added that the Trust came up with an innovative solution to keep it running, via a Clinical Research Fellowship, but it needed to be recognised that its continued success had been due to EU doctors and nurses coming into the EU. Unfortunately, this pipeline had dried up.

Mr Brennan confirmed that there would be no change to the Special Baby Unit and screening would remain.

Mr Stevens, in responding to a question about whether a viable consultant-led maternity service at the Horton would be viable in the future, stated that there were concerns as to whether it is clinically sustainable for a variety of reasons. He added that if a viable option emerged, then there would have to be a trade-off.

Mr Stevens was asked if there was a hospital, consultant-led Unit closer to the Horton which would compare more favourably to the travel time to the JR. He responded that the Trust had undertaken some detailed modelling and, as part of this, had conducted discussions with hospitals in Warwickshire and South Northamptonshire. Mr Stevens commented that there was a need for the Committee to look at those options, adding that he had spoken to Northampton Hospital and midwives were speaking to all women giving birth, giving them the choice of where they wished to have their baby. He added that the Trust was currently working out the maximum number of women who may choose to give birth at the JR.

The Committee **AGREED** to request Mr Brennan and Mr Stevens to attend the special meeting of the Committee on 30 September in order to discuss further the following issues:

- timing issues of travel between the Horton and the JR in relation to safety;
- other options open to the Trust with regard to the successful recruitment of obstetricians; and
- why the number of births at the Horton had decreased in number from 1,700 to 1,466.

52/16 DIRECTOR OF PUBLIC HEALTH - ANNUAL REPORT

(Agenda No. 9)

The Committee had before them the Director of Public Health's Annual Report (JHO9). Members were asked to consider the key issues which they would like to take forward in the year ahead.

Dr McWilliam was congratulated on a very interesting, easy to read and comprehensive report.

In relation to alcohol related hospital admissions and illness, Dr McWilliam was asked what was in place to educate the public in relation to the dangers of alcohol. He responded that Public Health Officers addressed it to the best of their ability, it was also part of the schools' curriculum and part of the school nurses remit. He added however that drinking rates among young people were falling, along with teenage pregnancy numbers, but both needed to be kept under surveillance. Public Health advocated a growth in referrals, but also a good and timely service. The key element of the new service which had been put in place was that of outreach for people in psychological distress. School health nurses also dealt with mental health problems and help was on hand for children suffering from stress. However, it was his view that services were still not dealing with this aspect quickly enough and there was a need for him to keep a watching brief.

Dr McWilliam was asked to expand on what services were in place for children aged 15 – 19, in light of the recent surge in mental health issues experienced by this age group. He reported that the Care Quality Commission had highlighted the matter of increases in waiting list times and assessment at first appointment. The Chief Medical Officer had highlighted a more stressful lifestyle as the cause for this and had advised young people to come forward earlier in life if they were experiencing problems. He added that the Child & Adolescent Mental Health Service (CAMHS) provided access to school counsellors and school nurses had been invited to attend a conference on alcoholism which was held every two years. He also added that he had been very pleased with the outcomes of the alcohol prevention project when Oxfordshire Fire Service had been involved.

At the request of the Committee, Dr McWilliam gave a flavour of the areas in which Public Health had been involved over the last year. This included:

- A breast feeding project in Brighton with an aim to increase support in areas where there was a low uptake.
- A person had been employed to telephone primary care patients with the aim of encouraging them to take up their health check.
- School nurses were keen to know what outcomes they should meet and were thinking of a way to use these to target help where it was needed most.
- Pegasus Theatre had staged some excellent plays on Health issues.

A Committee member asked about Health services and transport (in the face of reduced bus subsidies) for older people in villages in light of the closure of some GP practices. Dr McWilliam agreed that there big issues for Public Health if the proposal to concentrate medical services in Oxford was to come to fruition. He reminded the Committee that practices were independent businesses and people were starting to shop around for services more frequently. He added that the advent of evening surgeries would attract more people in the future.

A member asked whether ‘shimmies’ (wired in equipment in new homes giving advice on local services) would come at a cost, or would they be free of charge. Dr McWilliam was unsure of whether there would be a cost. He commented that there was a need to raise this initiative in planning committees or as part of the Healthy Town initiative.

A member asked how it was ensured that pockets of deprived areas were included within Public Health initiatives. Dr McWilliam responded that Public Health initiatives were available across the board. However, the bigger issue was more about how the NHS met the needs of the population. There was discussion in the report about whether there is sufficient differentiation in how services were delivered in these areas. This would be included in the Health Inequalities Commission report later in the year.

A member of the Committee wondered if the TP and STP were intending to deliver a link with local planning to deal with prevention and Health inequality issues and with low target groups. He referred to the distribution of indicators contained within the report for disadvantaged groups, and in particular, those for children with mental health and behavioural issues and the inherent difficulties with data collection. He applauded the Director and his Team for trying to get into these areas. Dr McWilliam responded that it was down to all parties to ensure that the Plan was differentiated down to all groups in the population and how they would be served. He added that Health Inequalities was another focus. He pointed out that it was disadvantageous that the data was only available at the top levels and there was a need to drill down to a local level, for example, on relation to mental health.

A member asked if the Public Health status had grown and was more visible now that it was situated in the ambit of Local Government. Dr McWilliam responded that at the moment it still had a ring-fenced grant worth £32m, with a guarantee that this would remain until the end of 2017/18, after which it was not known whether it would be ring-fenced.

In response to a question about whether Public Health would be underspent again this year, Val Messenger, Deputy Director of Public Health, came up to the table to report that there was a possibility that there would be an underspend of £125k this year, but the level of a grant would be reduced next year. Public Health was trying to make the budget more sustainable so that it would not have to make any further service changes next year.

The Committee was pleased to see more actions taken during the year documented in the report, and that they were undertaking some good campaigns. Even more information on these, together with a view on what the Team had achieved would be welcomed in the future. The Director responded that the Team were trying to gain an overview of the health of the whole ‘body politic’ of Oxfordshire and trying to make Public Health the ‘soul’ of Oxfordshire.

The Committee also complimented him on the interesting section on Health Checks. Dr McWilliam responded that it had been noted by the OCCG that this was a good programme and would be delivered in the future using OCCG money, though this was unconfirmed as yet.

The Committee **AGREED** to inform Cabinet that the Director and his Team were to be congratulated on the report for the above reasons.

53/16 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 10)

The Committee had before them the report (JHO10) by Healthwatch Oxfordshire (HWO). Tracy Rees, Vice-Chair of the HWO Board attended in place of the Chairman, Eddie Dyer whilst he was on leave. She was accompanied by the new Executive Director, Rosalind Pearce, who had only just taken up her post. Rosalind Pearce explained that initially she intended to follow the current programme, but was working with the Board on it. She added that although the overarching Policy would not change, it was intended that there would be an increased HWO presence in different parts of the county with a view to meeting and listening to the views of the patients and public. She also intended to develop the current reporting mechanism with agencies of the third sector and stated that she would like to be more proactive with HWO's 'enter and view' role, in order to gain a clearer idea of issues and to aid horizon scanning.

There was a discussion on the study being undertaken by HWO on Minor Injuries Units (MIU) and what equipment was available to them. Rosalind Pearce commented that it was the view of HWO that MIU's needed to promote more information about what services could be offered at these sites and agreed to follow it up. Tracy Rees added that the primary focus would be on the Abingdon MIU, as its situation and issues were mainly similar at all the sites around Oxfordshire.

A member suggested that HWO and HOSC might work together utilising the roles each had. As an example, it was suggested that as Oxfordshire had a new contract for school nurse provision, it would be helpful if HWO could talk with some young people who had experience of the service in order to produce some feedback for the future scrutiny of this service by the Committee. Rosalind Pearce commented that HWO were keen to work with young people, and were already doing some work in schools. She undertook to let the Committee know what could be done at the next meeting.

A member commented how effective and helpful HWO had been when contributing to the pre-consultation engagement meetings on the Transformation Plan. Rosalind Pearce responded that high on HWO's agenda was to work actively with the OCCG on this, sharing knowledge on the engagement process, but at the same time maintaining their independence. She added that there was to be a HWO/Voluntary Sector conference towards the end of January to ensure that these organisations get a voice in the engagement process. Tracy Rees flagged up the need for information to be in plain English, to provide translations and for there to be good information on the website, to ensure people had all the tools to enable them to make up their own minds.

The Chairman thanked Rosalind Pearce and Tracy Reese for their attendance at the meeting.

54/16 CHAIRMAN'S REPORT

(Agenda No. 11)

The Chairman introduced her latest report (JHO11). She highlighted the report on the closure of the North Bicester Surgery and the action taken by the Committee. This entailed asking the OCCG to complete a Toolkit assessment, in order to glean the information required, and then meeting with the Patient Participation Group (PPG) attached to the surgery, local councillors and OCCG representatives to hear the issues.

Katie Read, Policy & Partnership Officer, asked the Committee if this approach could be established as a process to be followed with similar issues in the future. Dr McWilliam pointed out the GPs were a commercial enterprise and the process was more about ensuring that NHS England had the processes in place to deal with issues around surgery closures. He questioned whether the Toolkit process added anything to the process of patient care.

Katie Read clarified that elements of the Toolkit assessment, which were normally initiated by Health organisations if they were unsure as to whether a change in service was substantial or not, could be used to find out how many people would be affected by a change in service, for example, so that this could inform similar issues as they emerged.

Some members of the Committee suggested that important messages around changes in Health care from NHS England and the OCCG were not being communicated sufficiently well enough. For example, residents were not aware that once they had re-registered with another surgery, following the imminent closure of a surgery, they could not attend their previous one. Local Councillors had distributed letters to residents in their local areas in Bicester, reminding them that they must register with another practice.

The Chairman informed members that the Committee's visit to the Hub was to be arranged shortly.

55/16 FOR INFORMATION ONLY

(Agenda No. 12)

The Committee was briefed on 'Healthcare & Justice Commissioning for Prisons and IRC in Oxford – Deaths in Custody' - as requested at the previous meeting (JHO12).

At the request of the Committee, Katie Read undertook to seek information on what issues caused the deaths in custody and what the Service were doing to reduce suicides, and to circulated this information to all members of the Committee.

in the Chair

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JHO3

Date of signing