OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 17 November 2016 commencing at 10.00 am and finishing at 2.15 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price 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 Pressele Councillor Janet Godden (In place of Councillor Alison Rooke)
Co-opted Members:	Moira Logie
Officers:	
Whole of meeting	Julie Dean and Katie Read (Corporate Services)
Part of meeting	Director of Public Health

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 documents prepared by West Oxfordshire District Council in relation to the Deer Park Surgery, Witney (Agenda Item 7) and agreed as set out below. Copies of the agenda and reports agenda, reports, schedule and additional document are attached to the signed Minutes.

61/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for absence were received from Keith Ruddle and Anne Wilkinson. Cllr Janet Godden attended in place of Cllr Alison Rooke.

62/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Cllr Andrew McHugh declared a personal interest in Agenda Item 7 by virtue of his recent involvement with Horsefair Surgery, Banbury, as practice manager and also by virtue of his employment by the NHS supporting vulnerable surgeries in Swindon.

Cllr Jane Doughty declared a personal interest in Agenda Item 7 by virtue of her membership of the Deer Park Medical Centre, Working Group as set up West Oxfordshire District Council.

63/16 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 15 September 2016 (JHO3) were approved and signed subject to the addition of Cllr Jenny Hannaby (attending in place of Cllr Alison Rooke) in the list of voting members present at the 15 September 2016 meeting.

The Minutes of the meeting held on 30 September 2016 (JHO3) were approved and signed, subject to (changes in bold italics):

Page 23 – address by Keith Strangwood - sentence 1 - 'the petition had accrued round ***18,000*** signatures (and not 3,000) signatures to date'; and sentence 3 to be amended to read as follows:

' He added his view that the advertising for the ***vacant posts*** was 'more than inadequate' as it had only appeared in ***NHS Jobs*** and no other site, ***up until the end of September, and the first serious attempt at advertising in the British Medical Journal did not happen until August 2016.'***

Page 23 - address by Dr Peter Fisher – sentence 3 to read as follows:

'The hospital had been allowed to develop an integrated service with the ***area's GPs. This was no longer as effective since many consultants had been moved to the JR.*** He added that it was very significant that the number of ***applicants for posts as Clinical Research Fellows in Obstetrics had fallen since the beginning of 2015, but advertisements for a different type of middle grade staff had not been placed until April 2016.'***

Page 27 – first sentence, paragraph 3 – to substitute the word 'issues' with 'evidence'.

64/16 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 7 and 8:

Item 7 - Understanding GP Surgery Closures

- Brenda Churchill – Chair of Deer Park Surgery Patient Participation Group; and
- District Councillor Julian Cooper - Chair of Deer Park Surgery Working Group as set up by West Oxfordshire District Council.

Item 8 - Oxfordshire Transformation Plan and Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire & Berkshire West - Updates

- Roseanne Edwards – Newspaper Health Journalist, Banbury Guardian
- Clive Hill – Chipping Norton Action Group
- Dr Elizabeth Peretz – Member of the Public
- Keith Strangwood – 'Keep the Horton General'

65/16 FORWARD PLAN

(Agenda No. 5)

The Committee received the draft Forward Plan (HWO5).

The Chairman advised that, as the 'Toolkit' assessment for Deer Park Surgery had only just been received from the OCCG, members of the Committee would be meeting with OCCG representatives to look at the assessment privately in December. She also reported that there would be a special meeting of the Committee to consider the Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire West in December[1].

The Committee **AGREED** that it would be more useful if the Health Inequalities report was to be submitted to a meeting of the Committee in approximately 6 months' time, together with an update on expected actions from organisations.

66/16 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 (JHO6).

[1] (Since this meeting, it had been agreed that the Committee would not convene a special meeting in December, but would scrutinise the formally published STP when it was released in the New Year, rather than the draft copy made public on Reading Borough Council's website on 16 November).

Rosalind Pearce undertook to send a copy of the feedback from various groups held by HWO relating to GP provision to Katie Read who would then circulate it to all members of the Committee.

With regard to the article included in HWO's Activity Update entitled 'Reaching People', a member commented on the low number of people consulted by HWO about their experiences of Health and Social Care services in Oxfordshire. Rosalind Pearce responded that HWO always wanted to speak to more people but only had a limited team of 2 outreach workers with which to carry out such work. However they were redesigning the way they communicated with people and aimed to balance quantity ('yes/no' responses) with quality responses.

With regard to paragraph 2.4 'care in private care homes' a member asked if HWO intended to extend their reach into care homes. Rosalind Pearce responded that HWO was seeking to establish an 'enter and view' facility so that the perspective of patients and managers could also be gleaned. She added that it was important to look in more depth about why some homes were retracting from local authority contracts and if there were sufficient local authority places in homes. She added that HWO was developing a relationship with the Care Quality Commission, who was keen to hear feedback from residents, carers and family to whom HWO had spoken to in the homes in which were inspecting. She informed the Committee that HWO had prioritised their work with care homes for 2017.

Rosalind Pearce, in response to a query, commented that, to her knowledge, a hospital parking permit scheme had been introduced at the Oxford hospitals.

The Committee **AGREED** to receive the report and to thank HWO for their very high quality work and for responding to issues the Committee was raising.

67/16 UNDERSTANDING GP SURGERY CLOSURES

(Agenda No. 7)

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

Brenda Churchill expressed the concern of the Deer Park Surgery Patient Participation Group that most of the meetings relating to the closure of the Deer Park Surgery, Witney had appeared to have taken place behind closed doors, there being no reference to any discussions in the minutes of this Committee. She added that to close a well-loved surgery that, in their view, served them well and would expand next year did not make sense in the knowledge that other surgeries in the town did not offer the same services. There had been no consultation with patients on the decision to close, no environmental impact study, no risk assessment and no consultation with other doctors in the town who were expected to take 3,700 patients living in Witney. She added that by March 2017 there would be 200 more houses built in the Deer Park Surgery catchment area and an estimated 600 more patients would be seeking a doctor in Witney. She also made reference to the plans to build another 1,500 houses in Witney next year. She asked where they would they all go? She asked also that this Committee scrutinise the decision for closure and that it

concludes that it is a substantial change to medical services for all of the 26,000 residents of Witney.

Julian Cooper, speaking on behalf of the West Oxfordshire District Council Working Party, urged the Committee to agree that the decision to close the Deer Park Surgery, Witney, was a substantial change in circumstances for one of the main communities in Oxfordshire. The reasons for this which he put forward were that:

- The proposals to build an additional 2,000 houses in Minster Lovall, Brize Norton and Witney did not appear to have been taken account of. There was considerable doubt at the District Council that the practices within Witney had the capacity to absorb these 4,000 patients;
- The Working Party has concluded that the wrong assessment of the age profile had occurred, adding that a considerable number of patients (approximately 60%) on the register at the Surgery exceeded the age of 65;
- The main form of communication had been advertisements in the local press;
- This part of Oxfordshire had lost Burford Hospital in the last 20 years and the further loss of this health infrastructure undermines the commitments given by the Health Authority to this part of the County.
- He concluded by stating that other communities within Oxfordshire could be left defenceless in the future if this is allowed to go through.

The Chairman stated that the Committee was aware that the OCCG had extended the contract for GP services at Deer Park until March 2017. She added that a completed substantial change assessment (the 'Toolkit') had been received from the OCCG. This would now require an informal meeting of the Committee to examine the completed toolkit with OCCG representatives and for the full Committee to then take a view as to whether it was a substantial variation of service to merit public consultation.

The following representatives attended for this item:

- Dr Joe McManners, Diane Hedges and Julie Dandridge – OCCG
- Dr Paul Roblin – Local Medical Council
- Rosalind Pearce, Healthwatch Oxfordshire

Diane Hedges introduced the paper (JHO7) giving some information on where it featured within the context of the Oxfordshire Transformation Plan. Whilst recognising that primary care in Oxfordshire had much to be proud of, she emphasised the major challenge was that more people were living longer and thus more support would be needed for longer. Julie Dandridge added that GP practices were independent contractors and the OCCG commissioned many of them under a national contract. It was recognised that GP practices were under pressure both nationally and locally for a number of reasons, including more patient requiring a same day appointment and GP recruitment and retention. She stated that the OCCG had invested £4m into GP practices to improve their sustainability; and more appointments had been offered as a result of the GP Access Fund. She also highlighted additional funding, available from 1 November 2016, which allowed the OCCG to provide additional support to practices.

Julie Dandridge emphasised that the OCCG would only decide to close practices where there were concerns about quality and patient safety. Deer Park Surgery, Witney was not one of these surgeries – the OCCG had believed that they could find a provider, but this had not been possible. An extension to the contract had been given until 1 April 2017 and OCCG were working with the existing provider to ensure that patients who had not yet transferred to other practices were identified and supported to do so.

Dr Paul Roblin stated the view of the Local Medical Council was that the problems experienced by GPs were national ones, adding that the main reason why practices were closing was because the financial equation did not work. The percentage of NHS funding had fallen from 10.4% to 7.5% in 2014/15 and Simon Stevens had recognised that GPs had been neglected. As a consequence surgeries could not get replacement partners and the alternative was either salaried GPs or locums. He added that GPs opting for the salaried role would come at a cost as they would not be part of a funding stream. He added also that the financial value attached to initiatives to remedy the deprivation of funding for GPs was not forthcoming. As a result, GPs were retiring early. Dr McManners acknowledged the comments made by Dr Roblin and agreed that it was a national issue. He stated that constructive solutions needed to be identified to address this; one of the ways to sustain general practice in the county was to consider forming larger scale practices and sharing staff and overheads.

A member asked Dr Roblin, if in his view, anything could be put in place to prevent the use of locums. He responded that market forces drove this, but Jeremy Hunt MP had asked local primary care services to report on this issue.

A Committee member asked how the OCCG responded to anticipated health needs in respect of new housing developments. It was stated that NHS England was a statutory consultee in planning applications. Dr Roblin agreed that a potential solution to the problem was the involvement of the NHS in a more co-ordinated way as developments were being planned. The Chairman added that this HOSC had raised this question with NHS England Property in the past and had expressed its hope that responses could be made in this way in the future. Julie Dandridge added that the OCCG was currently working with South & Vale District Council on growth in Didcot, but would welcome more links with district councils. Dr McManners referred to the new Community Infrastructure Levy (CIL) which would offer opportunities not seen before.

In response to a question about why a mechanism had not been put in place to help surgeries to avoid closure, Dr Roblin responded that the solution to it lay in the hands of the Government, NHS England and NHS employers. He added his view that the problems should have been seen in advance, but they were not for a number of reasons.

Dr McManners stated that the OCCG was looking at a number of new models of care in practice around the country in the form of multi-disciplinary or super practices. He believed that new roles, such as the Advanced Nurse Practitioners, would improve patient experience. Consideration was being given to how the concept of the GP

could be preserved with its maintenance of a comprehensive care of a patient, with the introduction of the new roles.

A Committee member asked for more detail on how quality was measured in general practice, as it was not apparent from the papers. Dr Roblin responded that General Practice had worked under a fairly comprehensive framework called 'Quality and Outcomes Framework', which was still in place, but might be superseded.

In response to a question asking if GPs generally would wish to concentrate on their medical role rather than surgery business, Dr Roblin responded that this did divert attention away from the patients as a sizable chunk of the day was spent in dealing with business. The new models of care would enable GPs to spend more time with their patients. Julie Dandridge confirmed that there were different options available to GP practices in terms of dealing with administration.

A member commented that it was difficult for the Committee to scrutinise issues such as the imminent closure of the Deer Park Surgery, Witney, when there was a lack of detail to drill down into. It therefore had to take many factors on trust. It was also pointed out that the Committee did not have a proper understanding of the issues relating to the Deer Park Surgery because details of the clinical model for the surgery were not known. Diane Hedges responded that in relation to Deer Park Surgery, the OCCG was bound by procurement law. She was able to say, however, that the single response received to the tender was not one that the OCCG could support. She undertook to share the tender documents with Committee members, but not the provider's tender submission.

A member queried why the procurement process for retendering GP services at Deer Park Surgery was so short and questioned whether this had limited the opportunity for potential providers to come forward. Julie Dandridge responded that the OCCG had met the recommended procurement requirements and undertook to share the advice she had received from OCCG's procurement team.

Diane Hedges highlighted that one problem the OCCG was wrestling with was how to encourage GP practices to change from working as autonomous businesses to working with others. She added that the model for general practice had to change because per capita funding for each year was a problem, and not one that the Government could solve alone. The OCCG was exploring different models and viable solutions and aimed to take ideas to GPs in December.

Members were disappointed that no particular vision for a sustainable primary care system had been demonstrated. Julie Dandridge responded that a paper on the Primary Care Strategy was to be brought to the next meeting of the Committee on 2 February 2017 where this would be shared.

Rosalind Pearce called for patients to be put at the heart of the changes.

All were thanked for their attendance.

68/16 OXFORDSHIRE TRANSFORMATION PLAN AND SUSTAINABILITY & TRANSFORMATION PLAN FOR BUCKINGHAMSHIRE, OXFORDSHIRE & BERKSHIRE WEST - UPDATES

(Agenda No. 8)

Prior to discussion on the Oxfordshire Transformation Plan (OTP) and the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP), the Committee was addressed by the following speakers:

Roseanne Edwards, speaking in the interests of electors in Banbury, put forward the view that the public did not want the BOB STP, adding that the BOB STP Plan ordered that at every stage, communications experts were to be employed 'to dress up the bad news as deliriously good'. She commented that the Trust had made temporary, changes at the Horton 'to make the STP easier to push through' which demonstrated 'how damaging and dangerous the STP would be.' She recounted some recent stories reported to her in the last week which demonstrated to the Committee and NHS managers, who ultimately bore the responsibility, that the consequences of STP wold be 'unjustified and completely unacceptable.'

She asked what about post STP? commenting that managers did not know as it was untried. She asked then 'what about Plan B? and if there was a way back 'when it proved unworkable.' She urged the Committee to act in the interests of electors and refer any Horton Hospital downgrading to Jeremy Hunt, adding that the loss of the Horton's maternity, acute medicine, paediatrics, trauma and Accident & Emergency would cause 'utter chaos'. She also stated her view that the John Radcliffe could not cope at present, and it too would have to reduce beds under the Plan. She added that 'as a foundation trust it would soon be offering 49% of beds to private patients'.

Dr Elizabeth Peretz stated her belief that the Committee would be asked to endorse 'devastating' cuts to the Health service, via the STP and OTP and emphasised that these plans must be made available to the public to comment on. Also that they should be presented as a whole system as there would be no other way to see if they were sustainable or not. She also asked that the Committee seek clarity and assurances about the finances, and in particular, the timetable for signing off contracts, to ensure that they do not sign off any binding contracts before the final consultation document is brought before the public. In conclusion she called for an NHS that is both fully funded and public.

Clive Hill urged members of the Committee to remember that the primary role of this Committee was to 'strengthen the voice of local people' and its job to challenge OCC and the OCCG. During the course of his address he related some of his concerns about the proposals to be contained in the STP and OTP to a number of measures taken by OCC and the OCCG to, in his view, 'downgrade' the Chipping Norton Hospital. He urged the Committee not to be railroaded and to study the situation at Chipping Norton. He also put forward the view that the Chipping Norton Hospital had all its needs on one site, ie. beds, consultants, clinics, physiotherapy, maternity, the GP Surgery and Pharmacy; adding that it did not require reinventing, but the beds needed to be reverted back to NHS beds.

Keith Strangwood urged the Committee to take action and use its power to refer to the Secretary of State any attempts to downgrade the Horton Hospital's facilities once the final STP and OTP documents came before the Committee.

At the request of the Chairman, the Oxfordshire Transformation Plan (OTP) was taken first. Diane Hedges and Dr Joe McManners attended from the OCCG, Stuart Bell from Oxford Health (OH) and Andrew Stevens from the Oxford University Hospitals NHS Trust (OUH).

Diane Hedges introduced the paper (JHO8) which laid out plans to conduct two public consultations on OTP proposals. She emphasised that the purpose behind the OTP was to achieve more efficiency for the resources which were already in existence and not to make cuts. She reminded the Committee that people were living longer and, although resources were matching inflation, they were not matching the level of demand, which had increased considerably. She explained that the OCCG wanted to design services differently and, for example, use a different skill mix such as the emerging Advanced Senior Nurse Practitioners.

It was explained that the OCCG would be publishing a summary of the Plan before the end of the month, and the version of the full plan in early 2017. The reason for this was that the OCCG was currently going through a contracting round to agree funding over the next two years.

A member expressed concern about the decision to separate the consultation into two phases, particularly as the battle against changes to community services would be prolonged. The preventative work that OCC's Social Care were having to do due to cuts in local government provision was highlighted and concern expressed that local authorities were starting to drop out of the picture.

The Committee wanted to ensure that communities were made aware of the impact the proposals would have on them. Diane Hedges responded that the CCG would have wanted to address all the proposals in January, but a broader picture was required that would identify the future shape of services in each locality and the OCCG needed time to prepare this. She added that splitting the consultation would mean areas of greatest concern regarding patient safety could be covered in January.

A Committee member responded that there was a need to challenge the NHS to be more realistic about prospective time periods for consultation. She cited the temporary closure of Wantage Hospital, which remained closed whilst consultation periods were deferred, and the temporary closure of the obstetric-led service at the Horton Hospital, pointing out that the NHS was asking a lot of communities given the scale of public passion for local services. Stuart Bell commented that the Midwifery and Physiotherapy Units at the Horton Hospital, and all community hospitals, would be continued.

A member stated his concern about the 'decoupling' of the OTP consultation emphasising the need to rebuild trust amongst the public in the north of the county and for them to be given the opportunity to respond to the proposals via a focussed

consultation. He also commented that there were areas where better care outcomes could be delivered, for example in critical care. It was his view that the OCCG could explore ways of giving GPs more experience in other areas, as a means of attracting more to the profession.

Stuart Bell emphasised the importance of doing more work in the primary care arena, meaning longer engagement was needed, to make it more resilient. . He reminded the Committee of its requirement at the last meeting that there be a consultation on proposals to reconfigure acute beds in January, whatever the situation was with the OTP. Furthermore, he gave his reassurance that the NHS was acutely aware of the impact of social care on Health.

A member of the Committee expressed her concern about whether there would be sufficient funds to provide the extra staff needed. Diane Hedges stated that this information would be in the consultation paper and would be made clear.

Diane Hedges was asked when the GPs would be consulted on the Plans in view of how much they were expected to be involved. She explained that a representative from each locality was on the OCCG Board and each locality was conducting discussions with GPs about the implications and impact of the proposals on their patch.

Members expressed concern about the absence of primary care proposals in the plans for consultation and the apparent lack of join up with GPs. Dr McManners stated that primary care was being viewed as an enabling work stream and therefore it was essential to try to sustain models already in place and not to have new structures. He added it was about trying to include capacity, stating that the OCCG would have a primary care strategy very soon to discuss with GPs. Stuart Bell confirmed that proposals in phase 2 of the consultation would focus on services that link the most with primary care.

In response to fears from a Committee member that a decision had been taken already to remove all services from the Horton Hospital, Andrew Stevens referred to the paper presented stating that splitting the consultation would enable a greater public focus on OUT's proposals. He reassured the Committee that no decision had been made on any of the options for acute services as yet.

Members of the Committee then, in discussion with Diane Hedges and Andrew Stevens **AGREED** to approve the consultation Plan as presented and to **AGREE** that the OCCG should proceed with phase 1 of the consultation in January and requested that:

- With regard to options relating to obstetric/midwife-led units in the north of the county – if any proposal impacts on any surrounding services, then information on this should be included in the consultation;

- Options around the closure of any other service at the Horton Hospital be included and considered together, for example emergency abdominal, viability of paediatric care, Accident & Emergency – and if they are not included in the first phase, then nothing in the first phase would prejudice the second phase;

- Proposed delivery of planned care at the Horton would be included in the consultation paper and the impact of changes in GP delivery would be made clear;

- That the geographical detail be easily identifiable so that the public can be clear about proposed changes to be made to services in their locality; and

- Clarity on the meaning of 'ambulatory' care.

The Committee was then given a presentation by Ian Cave, Sustainability & Transformation Plan Programme Director, updating members on the latest situation with the STP in which he emphasised again that it was not about cuts, but about being more efficient. He reported that a summary of the Plan would be published in early 2017 – and explained that the aim of the recent contracting round was to engender a clearer position. Ian Cave was joined by Gary Ford, Chairman of the STP Oversight Committee and Diane Hedges, Chief Operating Officer & Deputy Chief Executive, OCCG.

Gary Ford stated that, as a clinician, he was keen on establishing a prevention programme and achieving better collaborative working across services in the Thames Valley region where this would add value.

Dr McWilliam clarified that confusion had occurred with regard to the role of Oxfordshire local authorities in the whole process. As statutory bodies, local authorities in Oxfordshire and this Committee were not part of the STP process, nor signatories to the OTP. However, officers working across the system were continuing to work with colleagues in Health for the good of patient care. This did not presuppose any position of local authorities as independent statutory consultees on these Plans.

In response to a question about what ambulatory care meant, Dr McManners explained that currently GPs could assume a stay in hospital for their patients which would be a few days whilst tests and treatments were completed. The Plans worked on the premise that all assessments would be completed quickly to enable patients to go home more quickly.

A member asked where public engagement would be on the STP, particularly in light of the statement 'public consultation where required'. Stuart Bell explained that there was little in the forthcoming Plan that had not been discussed in this Committee over the last year. He was pleased that now there was an opportunity for people to realise that.

A Committee member asked why there had to be an STP and why couldn't Oxfordshire continue to work with partners in spite of an STP? Gary Ford responded that the aim was not to increase bureaucracy, but that collaboration should already be taking place and the STP would clearly capture the benefits of working together. Mr Bell commented that the STP had no formal status and that it was a process to which a number of national bodies were accountable to the Government. It required the NHS to both describe and give a good case for how challenges were

approached, such as how to put a limit on resources. If the STP was not to be rolled out, then the ability to access a fund would be declined. He added that given the circumstances the NHS faced, it was important to take a planned and integrative approach. The Chairman felt it important that the Committee spent some time to establish how it all fitted together in a special meeting.

A member commented that it would be excellent to utilise the very good skills staff at the Horton Hospital possessed in Trauma Treatment and the 111 service. Diane Hedges responded that the STP was indeed about prevention, including linkage with the 111 service. She explained that the NHS would continue to meet the care needs of patients, but how they were met would change. Efficiencies did not mean cuts, ie. a withdrawal of service.

A Committee member asked if areas within the Buckinghamshire, Oxfordshire and Berkshire West (BOB) footprint had large debt and whether under the STP this would make Oxfordshire liable for such debts. Stuart Bell responded that the STP was relatively positive in this county. There was a need to look at how some issues were addressed locally. Other areas, such as workforce development, would be addressed across the piece. He confirmed that the 2% efficiencies each year expected from the NHS would continue throughout implementation of the STP.

A member commented that diagnostic services at Hubs needed to be underpinned by access to acute services and this was proportionate to the level of deprivation in a community. If most of the acute activity was to be centralised in Oxford, he asked what about the needs of the most deprived areas in Oxfordshire as a whole? Diane Hedges agreed that there were greater needs found in areas which would be best addressed targeted investment in community services. She added that there was a need to consider the outcomes of the Health Inequalities Commission.

In response to comments from Committee about the problems of accessing care centrally from Oxford for some patients, Gary Ford commented that a much better patient experience could be had for certain groups of patients from the EMU's in Abingdon and Witney, for example. Moreover, pharmacies could be used more frequently than they were. It was about having the right quality of care in the right place. Diane Hedges stated that more links were needed with local communities.

A member asked if it was considered in the NHS that public consultation was required on the STP and what engagement with Adult Social Care had there been in relation to the STP. Diane Hedges responded that public consultation would be required for the OTP, but with regard to the STP there was an uncertainty. Gary Ford responded that some of the general elements of planning contained in the STP had already been repeated at meetings, but there was a need to look at what the focus was and its key areas of benefit.

Dr McWilliam responded that OCC, as a formal consultee, would be responding with regard to the broader issues of the proposals for Adult Social Care. He confirmed that implications for pooled budgets and any other aspects of Adult Social Care would be discussed over the coming months. The Chairman added that this was an area that the Committee needed additional information on.

The Chairman thanked all for attending and suggested that a special meeting be held to look at the STP document, which it was understood, was now in the public domain.

69/16 COMMUNITY NURSING

(Agenda No. 9)

Sula Wiltshire, Director of Quality & Innovation and OCCG Chief Nurse and Ros Alstead, Director of Nursing & Clinical Standards, Oxford Health attended for this item. Sula Wiltshire introduced the report (JHO9) which provided an overview of community nursing provision and the 2015/16 review.

The Committee heard that there were 325 district nurses in the county and these were based in GP practices. They worked in teams and were managed by a senior district nurse and a senior matron provided general management support. Some worked closely with primary care services mainly focusing on housebound people. There was a big demand on the services from frail, elderly and housebound people with respiratory and cardio - vascular conditions. There was also a cancer service and they also provided insulin at home, along with bladder care and care for people suffering from leg ulcers. Some patients were being looked after by a relative, and there were standard procedures around how often they were to be seen and how well they managed their own care.

Ros Alstead was asked if she regarded 325 district nurses as sufficient and if there were any plans to cut numbers further? She responded that there had been an increase in demand given the demographics in the county. More staff would be needed in the future, including community nurses. She emphasised that this was a service which was not being reduced, but the needs of the service had risen considerably, hence the review. She added that the Care Quality Commission (CQC) had rated the service as good overall and had in general found staff to be very compassionate and caring.

A member asked how strong the link with GP Locality Teams was. Ros Alstead responded that work was currently underway within the integrated locality team to determine what needs to be provided at a GP level, or cluster level or at a more specialised level.

Ros Alstead continued that there were two elements to the review. It focused on finding different ways to provide integrated work with GPs and how to release time by changing practitioners and working more efficiently. Options considered and measures taken were detailed in the report.

A member asked if district nurse work was allocated by a team. Sula Wiltshire responded that this was via a conversation between the GP and the district nurses at primary care team meetings. She added that social workers, the practice manager and health visitors may also be involved in those meetings.

Ros Alstead was asked how the service worked with Carer's Forums. She replied that community services could not run without the support of family carers. Individual support was given to carers regarding treatments, for example – and community

nurses worked with carers to educate and support them. She added that it was important to ensure people with caring responsibility had the capacity of assessment and the ability to make judgements.

A member asked if there was an issue with morale within the profession and, if so, how could it be improved? Ros Alstead responded that morale was variable, stating that there were times when community nurses found their workload more difficult to tolerate. It was important to try and understand where the issues lay and to address them at a local level. She was also aware that district nurses often spent time delivering care outside their contracted hours and this was an issue.

A member asked if timetabling was sufficient to look after patients appropriately. Ros Alstead responded that the time slots worked well - a large amount of thought went into it and the CQC had complimented the Trust on this. However, she stated that it was not a perfect science and sometimes there was a need to complete a holistic assessment on a person. :

She added that the new integrated locality teams will bring a multi-disciplinary element in which may benefit the service.

A member commented that district nursing should therefore feature quite highly in the forthcoming Transformation Plan asking were there sufficient numbers to support it? Ros Alstead responded that there was a need to do more work with the nursing workforce to help them understand the benefits of working in the community. The profession also needed to ensure that there were sufficient opportunities for undergraduates to have a lengthy experience of working in the community, which was a good and satisfying career. She referred to a specialist practitioner course at master's level which provides training for very bespoke support for acute nurses to work independently in the community. She highlighted that opportunities for handovers would require structural support.

Ros Alstead was asked what her experiences were of recruitment and retention of district nurses and how involved had she been in the development of the Transformation Plans. She was also asked if the service would receive more money to allow patients to have their care at home? Ros Alstead replied that recruitment and retention within the county was not an easy problem to solve - many issues were as a result of the high cost of living in the county. The profession faced a variety of vacancies across the board.

Ros Alstead was asked if the service made use of agency staff. She replied that it did, but only targeted staff who were prepared to work with the service over a period of time held a caseload. Sula Wiltshire added that recruitment and retention issues were their biggest challenge, whilst trying to create the reality of a 'workplace without walls'. They had looked at examples in Holland where the community care model was rooted. Hospital was not the best place for patients, the aim being to make their stay as short as possible.

A Committee member commented that the Kings Fund had claimed that there were 50% fewer district nurses than there was 12 years ago. Given the drive for greater partnership working, she asked whether the service could be extended to encompass

work with social landlords and Age UK etc? She also asked if there were sufficient hospice places in Oxfordshire. Ros Alstead responded that the number of district nurses in Oxfordshire differed to the national figure. She added that some areas did not fund the district nurse programme, but it was felt in Oxfordshire that it was important to support it. With regard to partnership working, there was already vital partnership working in place with the voluntary sector and GPs via the integrated locality teams. The expectation was that there would be an increase in partnership working with a variety of organisations. Regarding hospice places, Sula Wiltshire stated that people do prefer to die at home, and community nurses worked closely with MacMillan nurses to facilitate this.

The Chairman thanked Sula Wiltshire and Ros Alstead for their attendance.

70/16 CHAIRMAN'S REPORT
(Agenda No. 10)

The Chairman introduced her latest report (JHO10).

The Committee **AGREED** to note the Chairman's report. It was noted that the next scheduled meeting of the Committee would be all day meeting.

71/16 FOR INFORMATION ONLY
(Agenda No. 11)

..... in the Chair

Date of signing