OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 June 2018 commencing at 10.00 am and finishing at 4.15 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Monica Lovatt (Deputy Chairman) Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Laura Price Councillor Alison Rooke District Councillor Neil Owen District Councillor Susanna Pressel Councillor Nick Carter (In place of Councillor Kevin Bulmer)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle

Officers:

Whole of meeting	Strategic Director of People; J. Dean and K. Read (Resources)

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.

23/18 ELECTION OF CHAIRMAN

(Agenda No. 1)

Councillor Arash Fatemian was elected Chairman for the duration of the Council Year 2018/19.

24/18 ELECTION OF DEPUTY CHAIRMAN

(Agenda No. 2)

Prior to appointing the 2018/19 Deputy Chairman, the Chairman, on behalf of all members of the Committee, led a vote of thanks to the outgoing Deputy Chairman, District Councillor Monica Lovatt, for all her hard work and support during 2017/18.

District Councillor Neil Owen was appointed Deputy Chairman of the Committee for the duration of the 2018/19 Council Year.

25/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 3)

Councillor Nick Carter attended for Cllr Kevin Bulmer, District Councillor Phil Chapman for District Councillor Sean Gaul and apologies were received from District Councillor Nigel Champken-Woods and Anne Wilkinson.

The Committee recorded its disappointment that South Oxfordshire District Council had not been represented for a number of recent meetings.

26/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 4)

There were no declarations of interest submitted.

27/18 MINUTES

(Agenda No. 5)

The Minutes of the last meeting held on 19 April 2018 were approved and signed subject to the following amendments:

- Minute16/18, Care Quality Commission Local System Review - Page 6, paragraph 2, sentence 1 – to delete the words 'the provision of beds' and to substitute with 'any beds were closed';
- Minute 17/18, OCCG: Key and Current Issues' – Page 9, paragraph 2, sentence 2 – to delete the word 'the';
- Minute 20/18, Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account – page 13, penultimate paragraph – delete the words 'to return to' and substitute with the 'email members of the Committee with their priority areas as they were finalised';
- Minute 21/18, 'HOSC and Health 'Ways of Working Workshop report and draft principles' – Page 14, penultimate paragraph prior to the resolution – to amend to (amendments in bold italics):

  '***Cllr Laura Price*** then proposed, and ***Cllr Glynis Phillips*** seconded, that the Planning Group be held in public session. This was lost by 3 votes to 7. The Chairman ***then*** proposed, and was duly seconded, to formally adopt the recommendations contained in the report.

Matters Arising

The Chairman agreed that issues in relation to Wantage Hospital, which were referred to at the last meeting, could be raised again under Agenda Item 9 – OCCG key and current issues.

28/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 6)

There were no requests to address the Committee or to submit a petition.

29/18 FORWARD PLAN

(Agenda No. 7)

The Committee **AGREED** to include the following into an updated Forward Plan and to request the Officers to schedule a prioritisation session at the next meeting in September:

- To revisit the MSK Services following the findings of the Working Group (February 2019);
- Health Inequalities update (in 6 months time);
- Winter Plan;
- GP appointments – to include representation from the GP federations; and
- To prioritise School Health Nurses and the Health Visiting services and the reorganisation of the Oxfordshire Health & Wellbeing Board;

30/18 UPDATE ON OXFORDSHIRE WINTER PLANS 2017/18

(Agenda No. 8)

At the time last year's Oxfordshire Winter Plans were presented to the Committee in November 2017, the Committee asked to review their subsequent effectiveness. Members considered the report JHO8 from the Oxfordshire Clinical Commissioning Group (OCCG) which contained an evaluation of last year's Plan.

The Chairman welcomed OCCG's Chief Executive, Lou Patten and Chief Operating Officer, Diane Hedges; Karen Fuller, Deputy Director, Adult Services, Oxfordshire County Council (OCC); and Sam Foster, Chief Nurse, together with Sarah Randall, Deputy Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust (OUH), to the meeting. Stewart Bell, Chief Executive, Oxford Health and Dr Kiren Collison, Clinical Chair, CCG joined the Panel to respond to questions later in the session.

Diane Hedges introduced the report JHO8 which covered all angles of the urgent care pathway. Although the focus was on how urgent care supported patients, the report also covered the whole range of options for patients, such as the option to call the 111 service which was supported by clinical advice, the Out Of Hours (OoH) service and the Minor Injuries Units (MIU). It also covered examples of interventions made to try to encourage people not to use the urgent care services, such as the pilot use of the SoS bus in Oxford, the use of the OoH service for patients requiring repeat medication and the use of advice from pharmacy services direct from the 111 service

so as not to take up GP time. A wide range of approaches were also being used, such as safe havens for people suffering from mental health illnesses. She stated that the GP Access Fund should increase access to these.

Diane Hedges also informed the Committee that, as potentially expected, the 4 hour target for people waiting in Accident & Emergency (A & E) had not been met and the service had been escalated to the highest level. In January/February, when pressures had been felt nationally, operations had been cancelled and Trusts had been requested to re-think their approaches to elective operations. It had been the worst winter in terms of weather nationally with huge numbers of patients waiting to be treated. However, in adversity, alternative solutions had been found to assist in different areas of work, for example, in the approach to home care. Patients had been assessed on an individual basis to enable them to move from their hospital beds more quickly. More care home beds had been bought and the number of community beds had been extended to avoid risk, wastage etc.

Lou Patten also highlighted another example of real success which had been the implementation of much tighter assessment systems in hospital and community hospitals, with less duplication, which had resulted in good use of community hospital beds. Assessments of Delayed Transfers of Care (DToC) patients who had occupied a hospital bed for 7 – 21 days, were linked to the home circumstances of the patient in the first instance, which had resulted in strong progress in this area. OCC had led this work which had gleaned a better response and had encouraged people to work together. A working party team was already reviewing this shift in emphasis to the individual as against the bed, and the social and therapeutic impact of this; and was looking at what was learnt, with a view to reorganising the approaches to winter pressures for 2018/19.

Questions asked and responses given were as follows:

When and where were the extra beds planned and where were the evaluations of action taken so that this could be measured against in the future? Sam Foster responded that this would be undertaken in September in order to measure capacity. A Committee member stated that a clear understanding of which funding streams each intervention drew upon would also be required, for example, the Better Care Fund, the OCCG or OCC pots etc. In addition, learning about how effective the additional clinical resources given by the South Central Ambulance Service (SCAS) had been, together with information about whether it had been a one off pot of funding to try a different way of working. Also, how learning would take place from this experience? how were staff feeding into them? were they joint plans? and what roles were available for staff to apply for if they were moving from one position to another? Diane Hedges responded that the extra resourcing had gone into the procurement of urgent 111 services to provide for clinicians. Learning had taken place on which area of clinical service had had the best impact within workforce constraints. The Accident & Emergency Development Board had considered how to best access GP hubs and whether they could increase capital access and clinical advice. She added that it had been a challenge, as it was in every area, to supply sufficient numbers of clinicians.

A member asked how many patients did the plan equate to? Sam Foster responded that collecting and measuring data as a system was quite tricky, but the figure tasked with equated to 44 beds or beds equivalent. Some guidance would be coming in relation to this work. A member commented that whatever method of evaluation was chosen, it would have to have scientific rigour;

The representatives were asked why they were not able to do what they had achieved so successfully in previous years and what challenges did they face in putting it together? Lou Patten responded that the situation had been very different this year. Significantly more comprehensive reflection had taken place and there had been more emphasis on the empowering of clinicians. The challenges associated with funding streams was that they often came late.

A Committee Member asked where the third - party providers came from and what was the cost of backfilling job vacancies? Diane Hedges responded that the CCG had a good relationship with Age UK. Sam Foster commented also that Age UK had proved to be very helpful in their support for OUH in getting patients back into their own beds at home. The Trust was looking to work with additional agencies. She undertook to let the Committee have the costs involved.

Sam Foster was asked how long non-urgent surgery had been postponed for and when did they plan to catch up? She replied that non - urgent surgery for patients had been cancelled across the Trust at the behest of national NHS. These patients had now been caught up with and there were now no long waits. Diane Hedges stated also that some patient beds had been cancelled due to workforce pressures. Sam Foster referred also to the national shortage of registered nurses, of whom more were leaving than joining the service (the Board papers provided more detail than they had in the past in relation to staffing, also giving more clarity on where the vacancies lay and on recruitment). The focus was on staffing for theatres and emergency departments. The Trust currently had 250 offers out to overseas nurses. There had also been joint recruitment to vacancies within the system which had proved to be successful in accordance with the initial working party. Success had also been achieved with the numbers of temporary workers who had been made permanent. This had also incentivised large numbers to work extra hours in order to keep maximum capacity open. The Working Party had also ensured escalation if it was deemed necessary and it was also working towards paying support workers more money. Its focus was on the optimum safety, as it was aware that temporary staff came with risks. In addition, a significant amount of monitoring of emergency plans was undertaken to ensure that the situation in relation to elective and unplanned operations was in a better fashion than last year.

A member asked if any analysis had been undertaken into what constituted an emergency at A & E; and was there any evidence of a definition/categorisation of presenting which might be included in a business case on how A & E could be developed in the future. Also, was the 4 - hour target realistic nowadays – could it be achieved or should it be scrapped? Sam Foster explained that patients were triaged immediately on entry. If they were brought in by ambulance, then they were triaged as a priority. If they presented with a relatively minor clinical problem, they were placed in GP streaming. The latter service was up and running at the John Radcliffe Hospital and numbers attending had increased. She undertook to bring back to

Committee a case mix with information on where they had been treated. The mix of patients did tend to change in the winter with more presenting with influenza and respiratory disease etc. She added that there was a significant amount of focus currently on trying to do things differently in A & E departments and decisions were generally made on the next steps within 30 minutes, thus improving performance statistics to 90%. There had been no further 12 - hour trolley waits in April. The system was not quite there as yet and there was a need to ensure the Winter Plan was part of the Urgent Care improvements. Sarah Randall commented that evidence had seen improvements which had the most impact on those patients with extended stay (7 – 21 days) in hospital. Evidence had proved that the local health economy statistics were at their most satisfactory where hospitals had lower occupancy rates, which were in turn cheaper. The work being undertaken on reducing the 4-hour target and helping extended stay patients to return to their own homes had given the system a head start in comparison with other areas (10 – 20% reduction). This was equivalent to a 44 bed reduction. There was a will to achieve this target but the 4-hour target was very complex and necessitated high impact action being taken as a system - and sometimes required more work to get it organised.

With regard to a comment from a member about the need for patients to obtain care in a home situation, rather than in a care home, Sarah Randall responded that the question of providing ‘in house’ carers was being looked at in the OCC review. This was currently a large area of learning within Social Care, as well as that of system working with OUH and Age UK on patient outcomes. This was in a bid to take services away from a hospital situation and to centre the service around the patient themselves and what other support they had around them. She added that this would also have a positive impact on the DToC situation. She stated that the policy of Adult Social Care was to support the patient within their own home as much as possible, using facilities such as extra care housing, care support at home and using community support at home. She added that locality bases were working very actively together.

In response to a question about whether a proportion of patients were being regraded from one of requiring an emergency operation, to a non-emergency status, Diane Hedges gave her reassurance that it was not about regrading, but more about giving the correct advice to services. The CCG was looking to only having a reasonable number of people referred to urgent care, via the emergency services, and were asking clinicians to support that approach, by giving their clinical view. Lou Patten stated that there were strong indications in other areas, with similar demographical linkage, that this approach was both workable and cost-effective. Diane Hedges added that a whole range of emergency areas were now using clinicians and GPs, by, for example, increasing the level of GP involvement into the 111 service, GP support to the Out of Hours practices and hubs, and the offer of additional week-end appointments at surgeries. This had often caused a stretch on daytime services, tensions in the system, pressures on OH and on OCC funding. This work had been brought together by GP Federations, the Local Medical Council, OUH and the CCG. Lou Patten added that GPs had to offer a broad range of clinical competencies and it was necessary to comprehensively evaluate where this precious resource was being placed, and how it helped patients in the system.

A member asked if the extra GPs were being brought in from outside or whether they were already in the system. Diane Hedges and Lou Patten responded that the additional resource was often managed by a group of practices together, but it was in the province of the GPs themselves to manage their own resources. They had provided these additional resources either by extra recruitment or by operating leaner practices.

A member asked if a patient's medical record could be instantly accessed by staff on admittance from another hospital. Stewart Bell responded that currently a number of different systems were in play. An Oxfordshire care summary was in place to view essential information such as patient notes from other systems. Not all were available, but good progress was being made to achieve this, for example, the OoH's service was able to access GP records.

In response to comments from a member, Diane Hedges endorsed the importance of sustaining primary care. The nature of primary care was changing. Nationally, the introduction of different sorts of skill mix to surgeries in order to maximise GP time was under investigation, such as the introduction of clinical pharmacists to attend to, for example, the multiple medications for older people. Also the numbers attending Minor Injuries Units had reduced during the winter period and there was a need to understand why this was happening and what injuries patients were presenting with in order to make the best use of the service and the maximum use of services already in place.

Lou Patten added that GPs already had a good idea about how they could enhance their capacity and now it was about listening to the GP Federation Alliance, together with Oxford Health, for possible formal collaborative integration of services. In response to a question about why the GP contribution to the Winter Service Plan was not sustainable all the year round, Dr Collison explained that in primary care different levels could approach the problem ie. in the practice itself, at cluster or locality level. At local level there were possibilities, such as the introduction of nursing practitioners to take some of the GP load, or the movement of some of the GP's paper work into the back office. There was a significant time reduction at cluster level which could be achieved, for example, the looking after older people in a more proactive way. At locality level, urgent access partners were available, together with visiting services. Notwithstanding this, there were many gaps in GP workforce and aspects of the job were being looked at to provide the variety which GPs were looking for, for example, rotation around different areas of the job.

Lou Patten was asked if it would be possible to develop a model which would result in a radical reduction in the numbers of patients attending A & E. For example, some local communities could perhaps pilot schemes to this end. She responded that she sat on the regional A & E Board and agreed that it was about understanding the population, getting into the communities, looking at what voluntary services were available and then assimilating the key factors. This could then be brought to five key priority areas.

At the close of the session, the Chairman thanked all representatives for their attendance and their input and requesting the following:

(a) keeping evaluation reports and future plans focused and brief, and with the inclusion of some measurable impacts and targets and some indication if where original GP hours came from;
(b) more information on the plans going forward for GP contribution, including what would be a measurable impact in percentage terms;
(c) information on whether there was an issue around 7 day working in some localities and where was it not happening? Why was this? And what impact it was having in the areas where it had been introduced;
(d) more information on whether Oxford City was the best place for the SoS bus and not Banbury? Was this service better suited to the city where there were greater numbers of people, in order to discourage people from going to A & E?
(e) more information on who the third party providers were in relation to the 111 service and how Age UK assisted in returning patients to their own homes?
(f) some detail on the additional costs of backfilling staff vacancies with agency staff and whether private providers had been used; and
(g) more detail on hospital bed closures.

31/18 OCCG KEY AND CURRENT ISSUES

(Agenda No. 9)

Lou Patten and Dr Kiren Collison, Chief Executive and Clinical Chair respectively, CCG gave an oral report on the current key issues for OCCG. They were also accompanied by Stuart Bell, Chief Executive, Oxford Health (OH).

Lou Patten reported on the following:

- The CCG was now involved in estates and infrastructure in conjunction with the County and district councils via the Growth Board and meetings related to the Oxford/Cambridge expressway. A fruitful meeting had taken place with West Oxfordshire District Council looking at both planning and infrastructure;
- She had met with the Deer Park PPG to obtain their views on processes and transparency for when the CCG decided the trigger points at which GP practices and GP providers were required to look at how else to provide for a growing population;
- Work continued with providers to discuss how the plans for winter pressures could be executed, at the same time embedding the CQC work, but also ensuring that services were tailored to localities. Details of how the Government monies must be spent were yet to be worked through and the Committee would be kept updated. She reported that she had informed the regulator that if there was not a similar injection of monies for Social Care, then Oxfordshire would struggle to provide what was required. In response to a comment from a member about the lack of national guidelines on this matter, and if Oxfordshire was to become a pioneering authority in this regard, more money would be required from the DoH, she stated that she had asked for some money to oversee it, to accompany the money the CCG would commit for managerial resource. She added that the end result would be a transparent look at how the CCG saw resources and how it was taking forward the market for new GPs.

Questions and responses received were as follows:

Lou Patten was asked about CCG input into the expressway consultation. She responded that she had heard at the Growth Board that the Police and Ambulance flows would be favoured by very good transport links and intended to query with NHS England how it would affect patient flow. A member informed the Committee that the proposal for the corridor was about to be announced and urged the CCG to consider the time-scale in respect of consultations. Stuart Bell pointed out that one of the most important implications arising from this venture was to consider the more strategic planning of services for Health and their sustainability, for example, for cardiac services.

A member asked whether the population planning ought to have a 20/30 year time-frame, rather than a 5 year one adopted by the NHS; a point which had been made as part of the IRP submission in relation to the Deer Park Surgery closure. Lou Patten responded that, in order to conduct a dialogue, planning needed to be about understanding the type of local populations and evidencing their needs. Only then could the physical infrastructure needs be looked at. Stuart Bell stated that there was a need to consult other organisations such as Oxford Health and the GP Federations about the locality in which to place services, for example, x ray services. In addition it was necessary to know the proportion of patients currently attending Oxford who could go to local centres.

A member raised the question of whether the beds closed at Wantage Hospital would be reopening in the near future, emphasising that it had now been 2 years since the temporary closure. She urged the OCCG to conduct the awaited review after the beds had re-opened, as the beds were needed within the community. She added her view that the issue concerned the building which, in her view, would require a full public consultation as a major service change. Lou Patten responded that there was a strong clinical case for patients not to be in bed for too long as it caused a rapid loss of independence. She added that consideration would be given in the system review to the use of hospital facilities to their best possible purpose and to suit the needs of the patients. The need was to develop something which was fit for purpose locally. She gave as an example of this the recent establishment of the rapid assessment clinical units at Townlands Hospital, Henley.

A member asked about the situation in relation to the Horton Hospital's Maternity Unit premises, commenting that, in their view, they were not up to specification. Lou Patten stated that the Horton Hospital had a very vibrant future and there would be facilities provided in the future for patients living in a locality which would be larger than Banbury itself. There would be an opportunity to bid for capital monies, which was a very convoluted process. It had been found to be very helpful if the bid for estates contained a description of how buildings would be utilised. She added her view that this needed to happen with speed.

Lou Patten and Dr Collison were thanked for the report and all were both thanked for their attendance.

The Committee **AGREED** to request the CCG to prepare, for submission to the next meeting, an outline timetable/Plan for the system capacity review, to include physical assets describing what the population needs were – and also to include, if it was deemed a significant change of service, the plans to consult.

32/18 CARE QUALITY COMMISSION (CQC) LOCAL SYSTEM REVIEW

(Agenda No. 10)

The Chairman welcomed the following representatives from the CCG, OH, OUH and OCC:

- OUH – Dr Bruno Holthof and Sam Foster – Chief Executive & Chief Nurse
- OH – Stuart Bell, CBE – Chief Executive
- CCG – Lou Patten – Chief Executive
- OCC – Kate Terroni, Director of Adult Services & Helen Sanderson

A briefing paper was attached at JHO10 and a presentation was given. The Committee thanked all for the useful paper, particularly because it contained specific examples.

Questions from the Committee and responses received were as follows:

- Kate Terroni was asked if there was a clear business case to roll out Amazon Echoes to assist older people living at home. She responded that there was and this was an endeavour to avoid the need for carers for particular tasks;

- Dr Holthof was asked if the AGE UK provision for patients in hospital would be via new monies or would it be via existing contracted services with Age UK. He responded that the Trust would pay and no extra funding would be received for this additional service;

- A member commented that 48% was a useful statistic in relation to keeping people out of hospital and asked what the mortality rate was. Dr Holthof undertook to send a paper for information;

- In response to questions asking who was commissioning the Wellbeing Teams? who was funding the delivery of the service? and who was accountable for the recruitment of outside organisations and development of the service? Kate Terroni responded that OCC was funding the Wellbeing pilot and was accountable for the delivery outcome for the one - year pilot. She added that it demonstrated a new way of working locally and it was her view that it was accompanied by the right values and attitudes. Moreover, Adult Social Care was to set up some flexible home care services looking at a whole range of options for delivery. She added that the private sector would be encouraged to participate. Performance screening would look at workforce issues and an Officer would be attending a future meeting to present the outcomes and respond to questions;

- Kate Terroni was asked if OCC would be supporting the ongoing work to gain recognition for the inclusion of care workers into the definition of key workers. She responded that there was a need to work up a definition of key workers and would come back to Committee on this issue if required;

- Kate Terroni was asked if the potential partnership agreement with Cherwell DC might address the need for housing and recruitment of staff workers. She responded that Lou Patten and herself had met the previous day and had agreed that there was a potential to look at housing at local level, which could be quite exciting if the opportunity arose;

- In response to a question about how home care scheduling worked for self-funders, she reported that there was a very active and vibrant domiciliary provider market with whom they were working. She added there was also a willingness to help them to look at current service users and also at people who would potentially need care packages in the future in order to assist in the targeting of particular agencies to suit needs;

- In response to a number of questions relating to the quality checks that were in place for the carers of patients coming out of acute care, Sam Foster responded that nurses would be SEN trained with 2 years of training from the National Medical Council. Kate Terroni added that Social Care paid staff also had to be regulated regulated. Service providers would be expected to submit all appropriate data and would be expected to be working to assured models to ensure safeguarding issues were addressed. There were also some expectations put in place for volunteers. The Chairman added that this Committee would be picking up this up with the CGC at the September meeting. Helen Sanderson added that skills appropriate to the advised level would need to be up and running in Oxfordshire where system leaders were gathering an army of volunteers who would require training. OCC's Performance Scrutiny Committee was investigating this further;

- Stewart Bell and Dr Holthof were asked about the refreshed vision for the integrated Health and Social Care service, as monitored by the Health & Wellbeing Board (HWBB) whose constitution and methods of working was under review. Stewart Bell reported that both himself as Chief Executive of OH and Dr Holthof, as Chief Executive of OUH had now joined the Board as system leaders. The vision had been agreed at the special meeting of the HWBB on 10 May 2018. He added that a new Strategy for Older People would take time to construct and was expected in the Autumn. When asked about resilience and system level measurement, he reported that there were many measures in existence but so far there was no system method of measuring the patient flow through the system. Lou Patten added that the AQC Panel was to look at the evaluation of the programme. She pointed out that the revision of the HWBB would bring with it an opportunity to bring about a better informed, better experience of how it would deliver services in an integrated way. It would become all the more important to share ideas about how to configure itself, in particular

the promotion of integrated care in Oxfordshire in a much more focused manner. The HWBB would be the statutory vehicle with which to provide that and give it oversight. It was also an opportunity for a much more active discussion with the district councils on health matters and more focus on health at county level. Dr Holthof added that the four system leaders would be working diligently to re-design the governance, hold fewer meetings and focus on the right topics leading to the Board implementing some of the actions which would make a difference for patients;

- A member put forward their view that understaffing and under resourcing in the reablement service had been major factors in the problems experienced previously with DToC. Kate Terroni stated that it was important that reablement was part of the system. There had been a significant amount of good work to improve the situation and to ensure that it was not seen in isolation in relation to the delivery of the contract. This was an important issue for system leader discussion. Sam Foster responded also that an example of some improvement work undertaken internally was a peer review with some of the patients to ascertain that a community hospital bed was not always required and patients were able to go home earlier when discharged to reablement teams;

- In response to a question from members asking if housing for key workers was being investigated, Stewart Bell cited a piece of work entitled 'Homes First' had been undertaken with Adult Social care and Age UK to get patients home first. Its aim was to reduce the burden of domiciliary care. He added that sub-contracting with OH had enabled delivery of 96% of the contract, but it should be kept in mind that demand had significantly outweighed capacity.

At the close of the discussion, the Committee **AGREED** to request to view:

(a) the framework for the measures that would be put in place; and
(b) any examples of best practice from elsewhere which had been used to cut delays.

33/18 HEALTHWATCH OXFORDSHIRE

(Agenda No. 11)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) attended to present the HWO update (JHO11). She also presented a short video which had been co-produced by the Luther Street Medical Practice Patient Participation Group (PPG), how the Luther Street Medical Practice staff, on the work of the Medical Centre's PPG. She stated HWO was working well with the PPG and that this was an example of the PPG going to where the patients were, rather than the other way around. The Committee thanked her for bringing the video to the Committee's notice.

In response to concern expressed by a member that 40% of children were known to have tooth decay by the age of 5 and the need to target this in areas of deprivation, Rosalind Pearce responded that a HWO report was due for publication at the end of

July which included a survey of care homes on dentistry provision for their residents. She added that in her view this was a classic area of joint responsibility for the Public Health and NHS areas. She also added her agreement of the importance of dental care beginning at a very early age.

A Committee member informed the Committee that there had been much concern expressed at a recent voluntary sector forum she had attended; and also expressed in discussion on the streets of Wantage, about the temporary loss of community care bed facilities at Wantage Hospital following its temporary closure 2 years ago.

A member supported the different approaches/interventions being taken in relation to people's health and wellbeing, such as the Health Checks project which targeted young men. Ros Pearce agreed that if HWO had not undertaken this it would not have reached these men in the normal manner. She also expressed the hope that others would learn from this approach taken by HWO.

Ros Pearce was thanked for her report.

34/18 UPDATE ON IMPLEMENTATION OF RECOMMENDATIONS FROM THE OXFORDSHIRE HEALTH INEQUALITIES COMMISSION

(Agenda No. 12)

In response to a request made by this Committee for progress on the review from the Oxfordshire Health Inequalities Commission to be reported every 6 months to ensure that health inequalities remained a priority, an update report was attached at JHO12. Dr Kiren Collison, Clinical Chair of the OCCG and Vice – Chair of the Health & Wellbeing Board, and a member of the Implementation Group which she also chaired, joined Dr McWilliam and Jackie Wilderspin, Public Health, OCC at the table.

Dr McWilliam introduced the item giving a brief overview of the process, reminding the Committee that the recommendations had no force of statute and some were very broad about society as a whole. Jackie Wilderspin spoke to the report highlighting the following key issues:

- A multi-agency group met quarterly which included membership from the district councils, OCC, OCCG and other bodies to consider how and who would take forward the recommendations of the Commission;
- Six priority areas had been highlighted and there was now a basket of indicators on 'Oxfordshire Insight''
- Little progress had been made on the setting up of the Innovation Fund as groups did not wish to duplicate what was already in existence;
- A workshop had been held to look at the reasons why benefits were not taken up, the outcomes of which would be taken to the Implementation Group to take forward;
- Good work had taken place on social prescribing which was OCCG led;
- Physical activity issues had been targeted and OXBAR had agreed to take them forward;
- A specific initiative on prevention issues had been taken on by the Oxford City Locality Group, working with Mental Health; and

- The Implementation Group was due to meet in July and wold be focusing on the list of recommendations, where progress had not yet been made.

Dr Collison commented that Health Inequalities should form a part of every workstream within Health and Social Care stating that there was a significant amount of work to do in relation to recognising its importance. She undertook to provide further information to members of the Committee in relation to recommendation 48 relating to the gathering of information on race.

When asked about how Health Inequalities for people suffering from mental health illness was being addressed, Dr McWilliam responded that this was included across the board, along with those for people with a learning disability (recommendation 39).

A member asked why the Commission did not address recommendations that related to the link between housing and health inequality, for example, to work more closely with housing associations in order to improve inequalities. Jackie Wilderspin stated that the report was a product of the evidence the Commission had taken from local data sources and responses received – and the links with housing had not been included in the report. Dr McWilliam added that Health had been a missing piece in local planning. However, its role was now much to the fore and was about to enter the workstream as a topic.

A member asked if there was anything that needed to be done to encourage people to provide the Implementation Group with the required information on factors which did not fit in with the familiar, such as transport. Jackie Wilderspin responded that the work was now progressing to the last few recommendations where there was a need to think about what to do if the knowledge was not there.

The Committee **AGREED** to:

(a) scrutinise the process again once the work on the priority areas had been completed with a view to using the Committee's influence to assist in the successful implementation of the recommendations; and
(b) in relation to recommendation 16, to suggest to the Commission that an additional clause be added in retrospect, that existing providers of social housing be brought into the Commission's orbit.

35/18 STROKE REHABILITATION SERVICES - PILOT REPORT

(Agenda No. 13)

Stuart Bell, Chief Executive, Oxford Health, presented a report (JHO13) which reported back on performance, outcomes and the next steps following the Stroke Rehabilitation Services pilot. He stated that the move had taken place in February from Witney to the Abingdon site. Since then it had been found that the length of stay had reduced which meant that patients were able to go home more quickly.

Attending alongside Mr Bell was Dr Robbie Dedi, Deputy Medical Director, OH and Sara Bolton, Allied Health Professions Lead, OH.

Cllr Rooke reported that some members of the Committee had made a very interesting visit to the Stroke Unit and had found the staff to be very engaged in their work. Questions asked and responses received were as follows:

In response to questions from members regarding a recent Healthwatch Oxfordshire report which had stated that a number of patients at Abingdon were waiting for a discharge package for occupational therapy and physiotherapy; and 70 patients were waiting for assessment, Sara Bolton stated that therapy was provided on the Unit and exercises were also given for patients to do at home on leaving the Unit. She added her awareness that there were waiting times in the Community Therapy service, stating that the Team would provide more information to the Committee on this subject.

In relation to a question asking at what point did a patient begin to deteriorate without physiotherapy, Sara Bolton stated that it depended upon the individual's treatment plan. If a patient required therapy immediately following discharge then it would follow through as a seamless process. Sometimes hospital patients were given extra therapy. Dr Dedi added also that even without therapy, the level of functioning deteriorated the longer a person was in a hospital bed. Therefore, getting these patients home would improve their situation.

In response to a question about whether there had been input from families /carers regarding the travel aspect of the move, Dr Dedi stated that there had been no specific complaints or consistent carer feedback regarding the transfer. The patients were made aware of the benefits of co-locating which were that they would be better cared for and would be moved back to their home more quickly.

A member asked about the costs of recruiting nursing staff. Sara Bolton responded that the Trust continued to have a very active recruitment process which had been extended to embed agency staff further into the Team. This, however, was not a long - term plan. Also, in response to a question about how many staff had left the service as a result of the transfer, how many had transferred and how many had returned, Sara Bolton stated that she did not have the current details with her of who had left the service. However, four support workers had discussed a transfer to Abingdon which would create a good Team.

The Chairman requested at this point that representatives returned to a future meeting once the evaluation pilots had been completed, adding that the Committee would be interested, in particular in the patient feedback and the impact of the closure on Witney Hospital, on, for example, staffing.

A member asked if being treated whilst in hospital strayed into a grey area with regards to means testing. Dr Dedi responded that stroke specialists/therapists were present at the Unit. Specialist therapy was not related to means testing. Therapy reduced the need for ongoing care and should minimise the need for ongoing treatment.

The representatives were asked when the pilot was scheduled to end and what criteria was in use to measure success. Dr Dedi responded that the Trust had been confident at the start of the scheme and even within a few months it had been

demonstrated that outcomes had been met and it had showed its worth. He added that there were many reasons for continuing with the pilot, and to continue with the arrangement thereafter.

The Chairman stated that a further report on the outcomes would be useful for assessment purposes. Dr Dedi responded that those receiving intense and regular therapy were difficult to measure as the numbers were too small. However, the Trust would be measuring staff, friends and family outcomes and clinical outcomes; and would also be reporting against the national data. In relation to a comment from a member stating that expediency would be welcomed as it was understood that the Oxfordshire Community Therapy Unit was causing many problems, Sara Bolton reported that the CCG was in the process of commissioning a stroke review to determine whether the correct rehabilitation model was in place, which included OCE.

At the close of the session, the Committee **AGREED** that it was encouraged by the early indications, but needed to see the outcomes-based data of the pilot and the service's impact on the County before taking a final decision. It therefore reserved the right to finalise the review until a presentation was given on the final data, as indicated above.

36/18 TRANSITION OF LEARNING DISABILITY SERVICES

(Agenda No. 14)

Following the transfer of specialist learning disability health services from Southern Health Foundation Trust to Oxford Health in July 2017, Sula Wiltshire, the OCCG's Director of Quality and Lead Nurse attended to present an overview report (JHO14) of the transition which included a consideration of whether lessons had been learned. She was supported by Chris Walkling, Senior Commissioning Manager for Mental Health at the CCG and the co-chairs of the Oxfordshire Transforming Care Partnership Board, Gail Hanrahan (Oxfordshire Family Support Network) and Paul Scarrott (My Life My Choice).

She introduced the report by stating that the OCCG had undertaken this piece of work at the request of this Committee, its focus being on quality and safety from the users and carers' perspective. She informed the Committee that this had been very much a shared piece of work with Southern Health, Oxford Health and 'My Life My Choice'.

Paul Scarrott informed the Committee that he had sat on the Board during its consideration of the transition and its view was that the transition had gone smoothly, with no staffing problems encountered. The Oxfordshire Family Partnership Network had been successfully embedded within the process which had involved families and users in the process. It had also co-chaired the Board. The Network had been part of the whole of the process, for example, viewing and commenting on, if necessary, letters to families prior to despatch. This had been very good from the Network's perspective.

The Chairman stated that this information was very reassuring and positive, asking if Oxfordshire was the only place who had experienced this level of involvement. Gail

Hanrahan explained that this had been a difficult process to be a part of initially, given the mistrust from families following Conor Sparrowhawk's death. She added that it had been a risk of reputation for their organisations to be a part of the process. She added however that there would always be a mistrust of the NHS, given the recent Leader's report and the Mazar's review. A benefit had been the learning for the NHS that the involvement of families was required when changes were made to a service. As a result of this involvement there was now more trust in the process and knowledge that the views and input of families were required to create a more level playing field.

A Committee member thanked Gail Hanrahan and Paul Scarrott, on behalf of the Committee stating that there was a need for more of this method of involvement within the NHS when difficult changes were proposed. Sula Wiltshire was asked if there had been any interaction the ongoing health inequality work within the County. She responded that, as a result of the Mazar's report, a joint report had been undertaken between the OCCG and OCC's Safeguarding Adult Board. As a result, a sub-committee had been created reviewing mortality and morbidity. This had been set-up prior to the formal requirement to look at it. She reiterated the importance of learning lessons. For example, it had been found that people with a learning disability and/or autism were not invited to breast/bowel screening examinations. In general, hard work was in progress with local providers and there was a passion to improve the lot for these people, as they were the most vulnerable in our society. She added that it was about how to strengthen services around it and create a bigger footprint. As the services were quite specialised, the Safeguarding Board was working with colleagues in Buckinghamshire and Berkshire looking at how to strengthen the expertise of providers in this area. She added that the Chair of the Health Inequalities Steering Group had also taken up the offer of help and co-operation in this regard. She was unsure about whether Professor Griffiths had taken evidence from for the Commission report, but undertook to find out.

A Committee member commented that more funding had been made available by the CCG for the transition of the service and asking whether the contract value had been increased. Sula Wiltshire responded that that the local authority held the contract for Southern Health and it was clear where these resources would like to be placed. It was about ensuring that when and where investment was received, the desired outcomes were realised. Chris Walkling added that the contract would include a secure learning disability service as there was concern in the whole of southern England that patients often stayed longer in medium secure services with nowhere to go on to. Discussions were ongoing about developing the medium secure service locally on the same site, in order to increase provision.

A member asked if out of area placements were more expensive and logistically more complicated? Chris Walkling responded that a 'lift and shift' approach had been taken as part of the transfer. There were no local beds at the point of transfer and then, as part of the Transforming Care Programme, they were looking at developing services. Negotiations were in progress with a Hertfordshire NHS Trust in relation to out of area beds and specialist learning disability beds moving closer geographically, with Oxfordshire looking at developing short stay admissions. Numbers were relatively small for short stay, but no necessary lengths of stay were being reduced.

Gail Hanrahan reported that the Oxfordshire Family Support Network had been in contact to ask how the beds were being used, to ensure that an independent advice and support network was in situ. She added that currently they were working with two families alongside colleagues at Oxford Health in the Intensive Support Team. Parents were working with Oxford Health to ensure that any move back home was smoother. There had been some difficulty encountered in relation to where they would go when they returned. She added her view that there was a need for other services in Social Services and Social Housing to work together on this matter.

Paul Scarrott commented that a friend was experiencing difficulty in seeing their daughter in a home in Birmingham. However, now that she was back living closer, communication had been much improved. Chris Walkling responded that they were working more closely with family carers – and families went out to other areas to view what was being provided.

In response to a question about what additional help and support could be made available, Gail Hanrahan stated that the development of new services needed to be in equal partnership with families and carers. Her membership of the Board, together with that of Paul, had resulted in them feeling valued. They had been paid consultancy rates in recognition of their huge expertise as parents. The Board could not make any decisions unless they were present. Paul Scarrott added that it had been an excellent experience, in particular the experience gleaned when working with other people with a learning disability, and bringing what was learned back to the Board. A Member suggested that perhaps this was a learning experience which all needed to take on board when working with patient groups. HOSC ought to be asking why others were not using this valuable experience.

Sula Wiltshire was asked when the CCG would be moving on to the evaluation of the impact on patients. She responded that this was part of the improvements to the service, for example, the work ongoing in relation to access to health checks and inclusion as part of the screening programme to detect illnesses at an earlier stage. The CCG intended to track this via the Transforming Care Partnership.

The Committee **AGREED** to request the CCG's return, at a later date, to the Committee's Forward Plan in order to review the evaluation of the changes.

37/18 CHAIRMAN'S REPORT

(Agenda No. 15)

The Chairman addressed his report (JHO15).

At the request of the Committee he undertook to:

(a) raise formally with South Oxfordshire District Council the question of representation at this Committee;
(b) include in future reports a correspondence record; and
(c) circulate the Task & Finish Group report on MSK services to all members of the Committee. He took this opportunity to thank the three members of the

Group for their valuable work. These were Dr Cohen, Cllr Monica Lovatt and Cllr Laura Price.

It was **AGREED** to receive the Chairman's report.

38/18 DATES OF FUTURE MEETINGS

(Agenda No. 16)

The dates of future meetings are as follows:

(All to take place on a Thursday to begin at 10am, with a pre-meet at 9:15am for members of the Committee only)

20 September 2018
29 November 2018
7 February 2019
4 April 2019
20 June 2019
19 September 2019
21 November 2019
6 February 2020

..... in the Chair

Date of signing .....