# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Friday, 31 May 2019 commencing at 2.00 pm and finishing at 4:23 pm

**Present:**

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| **Voting Members:** | Councillor Arash Fatemian - Chairman<br><br>District Councillor Neil Owen (Deputy Chairman)<br>Councillor Mark Cherry<br>District Councillor Tim Hallchurch (in place of District Councillor Sean Gaul)<br>Councillor Hilary Hibbert-Biles<br>Councillor Jeannette Matelot<br>City Councillor Nadine Bely-Summers<br>Dr Alan Cohen<br>Barbara Shaw<br>Councillor Liz Brighouse OBE (In place of Councillor Laura Price)<br>Councillor Liam Walker (In place of Councillor Mike Fox-Davies)<br>Councillor John Howson (In place of Councillor Alison Rooke) |
| **Co-opted Members:** | Dr Alan Cohen and Barbara Shaw |
| **Officers:** | |
| Whole of meeting | Julie Dean and Martin Dyson (Resources); Rob Winkfield (Adult Social Care) |

*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.*

## 26/19 ELECTION OF CHAIRMAN FOR THE MUNICIPAL YEAR 2019/20

(Agenda No. 1)

Councillor Arash Fatemian was elected Chairman of the Committee for the 2019/20 Council Municipal Year.

## 27/19 ELECTION OF DEPUTY CHAIRMAN FOR THE MUNICIPAL YEAR 2019/20

(Agenda No. 2)

District Councillor Sean Gaul was elected Deputy Chairman for the 2019/20 Municipal Year.

## 28/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Cllr Liz Brighouse attended for Councillor Laura Price, Councillor Tim Hallchurch for Councillor Sean Gaul, Councillor John Howson for Councillor Alison Rooke and Councillor Liam Walker for Councillor Mike Fox-Davies. Apologies were received from Councillor Paul Barrow, Councillor David Bretherton and Keith Ruddle.

## 29/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

There were no declarations of interest submitted.

## 30/19 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 5)

There were no requests to address the Committee.

## 31/19 OXFORD CITY COMMUNITY HOSPITAL
(Agenda No. 6)

Prior to the start of the discussion to Chairman invited Rosalind Pearce (Healthwatch Oxfordshire) up to the table to air the views/concerns of patients and public of Oxfordshire. She stated that community hospitals had a big part to play in the heart of communities, who were now faced with two temporary closures at this and Wantage Hospital and four fewer beds. Rosalind Pearce stated that it was the view of Healthwatch that the time had come for the system leaders to work out exactly what was the role for community hospitals in the future. Furthermore, patients and members of the public needed to know, via this Committee, how the system would cope with fewer beds and what the future of bed provision was.

The Chairman thanked Rosalind Pearce for her address and welcomed the following representatives to the table:

- Dominic Hardisty – Director of Community Services and Deputy Chief Executive Officer, Oxford Health Foundation Trust (OH)
- Pete McGrane – Clinical Director, OH
- Tehmeena Ajmal – Service Director (OH)
- Louise Patten – Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG)
- Lucy Butler – Interim Director of Adult Social Care, Oxfordshire County Council (OCC)
- Benedict Leigh – Deputy Director of Commissioning, OCC

Pete McGrane began by informing the Committee of the following:

- The City Community hospital, like other community hospitals, had two main focuses, firstly for people with sub-acute mental health needs and for

rehabilitation (ie. for mobility, nutritionally and for generic rehabilitation purposes) after a stay in acute hospital;

- It was located on the Churchill Hospital campus at the Fulbrooke site. Ward patients average stay was 25 days and medical cover was provided by sub-contract with colleagues from Oxford University Hospitals Foundation Trust (OUH on both a planned basis and an ad hoc basis, if more medical input was required);
- Half the patients came from the local postcode area and the other half from further afield within the county and admissions were on the next available bed in the County's community hospitals in order to ensure an adequate flow;
- Staffing for the hospital was based on the Shelford model tool which addressed the numbers of registered/unregistered numbers of nursing staff required. However this varied depending on whether patients had higher dependency levels, thus requiring additional support. One registered nurse was required for every 6 patients within the environment;
- Recruitment of registered nursing staff was a challenge for OH – conversations had taken place at Board level and with other partners during August/September last year. The Trust had carried 6.4 fte staff vacancies through last winter. The ability of the Trust to still look after the patients during this time was a testament of the ability and hard work of the staff and agency staff to keep the ward open;
- At the beginning of April this year, of these 6.4 fte, 3 members of staff had given notice of their plans to leave thus raising the vacancy factor to 8.7fte. Efforts had been made since August last year to look at other options, along with other colleagues, ie. at secondment of staff, the securement of more agency staff and consideration of what more could be done in relation to substantive recruitment to keep the ward open;
- Pete McGrane emphasised the professional view which was that the patient was placed at significant risk when there was no continuity of care and in times of crisis – best outcomes relied on this. If a member of staff was unfamiliar with the environment it was difficult for them and provided strain, which in turn increased the risk;
- When the point was reached in mid-April where the Trust could no longer ensure one substantive member of staff on duty at each shift it was decided that the ward should close temporarily on 31 May. The Trust had been left with no other safe option than closure and to regroup to work with other colleagues across the system in order to look at options;
- Recruitment had proved to be successful when students had worked at the Trust, but not so with national advertisements, open days etc, in line with contextual regional variances. There had been more success with the above for the mental health wards on the site, but not on the community ward. Traditional methods of recruiting did not work any more; overseas recruitment had dropped dramatically from 9k in 2016 to 200 and many had left the profession.

Questions from members of the Committee and responses received were as follows:

A member asked if OH had discussed whether there was a possibility of a nursing contract with OUH, given that there was a clinical sub-contract in place and given that

OH provided physical care to older people, commenting that if there was a larger critical mass this might assist. Pete McGrane responded that historically the Trust had tended to consider its own staffing arrangements and to address its own challenges. The deputy directors had been involved in work across the system via the BOB STP work on how to make better use of staffing. There was an ongoing dialogue with the acute Trust, but in reality the OUH was in a very similar position with regard to recruitment. He added that the Trust did not have sub-contractual arrangements with OUH. There was a framework arrangement with agencies which OH used to provide cover for community hospitals. However, there were difficulties in getting staff members to work across sites. There had been a pooled arrangement with the acute trust where staff could be employed on a flexible basis, which had led to challenges, but which had proved to be successful over the winter months. Speaking with partners in recent weeks all were having trouble recruiting. Problems had been experienced with staff movement across the sites. He emphasised that currently it was a staff market and employers had to be as flexible as possible. As a result, he had met with the Chief Nurse and Deputy at OUH in order to look into the possibilities of this. All had agreed that a different approach was required to include the interlinking of staff across the county.

A member asked what efforts were being made to increase the numbers of nurses coming through training if that had proved more successful that job fairs? Pete Mc Grane explained that the Trust had experienced success with training, in fact this aspect had proved to be the most positive. The Trust had embraced the Nurse Apprenticeship Training Scheme (NATS) and it was trying to attract more students into nursing training. In fact, OH had the highest results nationally in relation to its training programme and its recruitment programme had greatly improved. The problem was that if the numbers of nurses on a shift fell below a certain level then supervision and training from registered nurses on the job could not take place – and a good supervision experience often led to more people advancing to registered nurse status. Also, the lead - in time from recruitment was 3 months. The challenges faced in the City featured unique aspects – nurses tended to want to work in physical health. The Trust was constantly trying to secure longer term commitments from agency staff (classed as ‘lines of work’) but this was a negligible part of the workforce – which was not changing. In his view a temporary closure was an opportunity to re-consolidate towards working with patients across the system.

A member asked what was happening to the residual staff during the temporary closure - and were they on stand-by? Pete McGrane stated that no doubt those residual staff were very disappointed at the steps being taken. However, they had been equally reassured on a personal basis that patient safety was being considered. Oxford Health was in active consultation with those staff on the best options open for them. Some had wanted to go to work at Witney and Abingdon Community Hospitals – and it was felt by the Trust that every individual’s decision was of the highest importance, indeed, their skills could be expanded by working elsewhere. He added that there was a possibility that some of them may be working with colleagues at the Churchill Hospital. He gave his reassurance that those staff on temporary re-deployment would be recouped once the ward re-opened.

A member asked how temporary was temporary? Pete McGrane responded that he was very aware of the anxiety caused by this and the strength of feeling this

generated and every effort was being made to improve the situation. However, the stark reality was that he could not say whether there would be a definitive solution to it, due to the local context. He was intending to come back to Committee in September in order to give an update on the situation and the intervening time would give the Trust an opportunity to re-group to look at means of securing staff.

In response to a question about whether OH had gone out to India to recruit staff, Pete McGrane stated that there had been a campaign to attract potential staff overseas in the past but in reality this had not proved as successful as it had been for other Trusts. He added that the acting Director of Nursing had been looking at the BOB footprint to seek information about where staff had been recruited from, and had found that some 300 staff had been recruited from India. The Trust was looking to take in 15 members of staff from there on an on-going basis. However, there was a need to think creatively on how this could be done across all of the community hospitals. The pipeline for staff overseas was not significant at the moment.

A member asked if there were limits put on the use of agency staff in Trusts. Pete McGrane stated that health providers often found themselves squeezed between two regulators regarding safe levels of staff. The CQC and NHSE both monitored this aspect and as a Trust, the primary responsibility was on the well - being of the staff . Dominic Hardisty stated that OH had spent £25m on agency staff in the last financial year and, as a result was in a £3.8m deficit.

A member asked how did OH reconcile the problem of taking staff from one environment in order to support another – and the threat this may cause to the former? Pete McGrane stated that this was a very real challenge in relation to quality issues - in fact the Trust had been trying for four years to sort this problem out. Work by system leaders was underway on the question of where the greatest need was and this needed to be accelerated. In addition, answers were required to questions such as why was working on this small ward considered so unattractive. He added that it did not help that the hospital was situated separately from the rest of the campus on the Churchill site – and isolation was a problem. The wards for older people and for people with mental health problems was a bigger peer group and tended to work together. There was also a canteen on site where these wards were situated which made the culture more attractive. If staff wished to work with people with mental health problems then they would automatically go to the Fulbrooke Centre to work - and those nurses wanting physical health wards had many options to choose from.

Pete McGrane, in answer to a question about whether those patients who were being re-located were being taken away from their family and friend support systems, stated that the last of the patients who were to be discharged were going that day, according to the usual clinical planning procedures. He assured the Committee that the Trust was working with the family/friends of those affected patients that were being moved to other community hospitals.; and added that if it was possible to find a solution, for example, a hub or a rehabilitation setting, then this would be done.

In relation to the communication issues between the Trust and this Committee, Dominic Hardisty gave his apologies stating that it had not been as it could have been, but it was due to the need to balance difficult demands and constraints. He re-

iterated that the prime focus had to be on patient safety and on staff working for the Trust, at all times. Furthermore, the ebb and flow of workforce pressures had reared up at different times. The Community Hospital had first flagged this as a particular risk with the Committee last summer, but this had been managed through the summer and winter periods as a result of extraordinary efforts on the part of staff members to avoid closure. Unfortunately, when it became apparent that three members of staff were leaving, it had been decided that it was no longer sustainable to carry on. At this point Pete McGrane had discussed the matter with system partners and two weeks was given over to seeing if anything could be done. On 8 May the Board finally made the decision to close temporarily and this had been conveyed to this Committee, and a tool-kit completed. He added that it was apparent that this was not what was wanted by this Committee and to this end, learning was needed. On the Trust's part, it was felt that it could not risk de-stabilising the situation by putting it into the public domain earlier. There was a balance between what could be communicated, what could not, and the ongoing discussions with system partners. He offered detail on this if the Committee needed it.

The Chairman responded that the Committee accepted the duty to patients and staff, but it did not accept the lack of communication with the Committee. He reminded those present that Trusts had signed up to ways of working with the Committee, in the form of a Protocol, following a workshop. There were processes that all Providers were aware of. The OCCG briefed the Committee regularly on what was likely to take place, for example, on vasectomy services. He expressed the Committee's concern that OH was not making a strong and positive case in relation to this temporary closure, particularly in light of the ongoing temporary closure of Wantage Hospital, which had still not re-opened nearly three years later.

Councillor Liz Brighouse, speaking as local member for the Churchill Lye ward commented that she had spoken regularly to health staff living locally and it was her view that she had not met one worker who would intentionally vote with their feet to destabilise the situation. They worked all hours.

Louise Patten stated that as a commissioner she was confident that everything had been done and all avenues explored to try to avoid the temporary closure. Moreover, a significant amount of liaison with OH had taken place prior to this day on the issues involved. She accepted that the decision made for immediate closure had been appropriate. Furthermore, the OCCG would be closely monitoring the situation in relation to the beds transfer. Going forward, there was a need to consider all the options open to them with regard to the re-opening of the beds on the Oxford site and maintaining urgent care across the system. She added that OCCG would be working with OH and OUH as co-partners, to take a different look at what possible innovations could be made. Options then could be put forward to decide its future. Going forward there were wider, complex, issues regarding the future of community hospitals and the workforce. She stressed that this would not be about whether community hospitals should exist, it would be about what services should be provided for the population, and then to work out what was possible given the workforce issues. She added that there certainly was a significant workforce problem and there was a need to look at that. There was also a need to look at services for patients at home. This would be a solid piece of work which would take in population growth. Louise Patten

urged the Committee to understand that this was not phase 2 in a different form, it was looking at needs, growth and the significant workforce challenges this brought.

Lucy Butler endorsed all that had been said by partners in relation to patient safety, the impact of taking 4 beds out, and the work which was required generally by system leaders going forward.

Benedict Leigh commented that the nursing factor was not just an NHS challenge, it also impacted on nursing homes, it being difficult to recruit substantive, skilled nurses, particularly for people suffering from dementia. Moreover, the private sector could offer salaries which the NHS was unable to. He added that two years ago there were, on average, 15 applicants from nurses per month, last month there were none. Moreover, he stated that the situation would become increasingly difficult. He undertook to bring a report to the appropriate Committee(s) on the impact on social care, stating that there were patients in community hospitals who ideally could be at home, if there was a sufficient workforce to allow this.

In response to concern from the Committee that OH had underplayed the issues – and that there was a reluctance to put it into the public domain, Dominic Hardisty stated that there was a myriad of pressures on many NHS wards in the present time. The Trust did not wish to put it into the public domain when the outcomes of the decision were not crystal clear. There was only a certainty that the temporary closure was a necessity until April, which was the time when it was brought to HOSC.

A member asked how this closure of a hospital situated in the centre of Oxford would impact on the ‘hospital at home’ service, which, she understood, was difficult to access. Dominic Hardisty explained that patients were not admitted to the ward based on where they lived, rather, they were admitted to the first available bed. There were twelve countywide admissions, which would not cause additional pressure on any one area. This also meant that the ‘hospital at home’ service would be able to cope with it.

Dominic Hardisty assured the Committee, in response to a comment, that the closure was not a cost-saving exercise in terms of staff hire. Pete McGrane added that in the City the nursing agency uptake was as low as 66% and therefore there was no guarantee that these would be forthcoming if there was a reliance on flexible workers. It was not a reliable source. Moreover, the community hospital had kept going to date by NHS staff being diligent, flexible workers and a small amount of long – line workers. Pete McGrane confirmed that the changes in the numbers of registered nurses available to work in April meant that closure was a necessity and finance and funding did not feature as part of the discussions at that point.

In response to a comment from a member of the Board that there was little understanding by the public about workforce pressures, the Chairman stated that this Committee was not in any doubt about the work pressures, it being a universally accepted truth. However, it still needed to be looked at by the Committee in the future. Tehmeena Ajmal commented that the Trust was still learning as a community hospital in relation to what short-term beds were required for winter pressures, and it was therefore right for the Trust to do all that was possible to look at the pressures.

Moreover, as system partners we do whatever we can whenever it is recognised that there was a pressure.

Members asked if the system partners had already been working on it, why could the staffing situation not have been sorted out for May to September, thus avoiding closure? Lou Patten responded that the temporary closure would take place, and there was a need to explore, and then address, the bed-day requirements, which in turn was linked to a larger piece of work of system re-design. As part of this a specific look at what was required in terms of preparation for times of the year when this would be needed.

The Chairman commented that the Trust had known about the problems for a while and had not taken steps to change a strategy which was not working. He added that management had reduced other work they were doing in order to try to find alternatives. Moreover, they had been engaged with the problem in a more meaningful way by trying, for example, the apprentice training programme. Management did all it could to try to be flexible in order to attract staff. If 2/3 members of staff decide to leave, then solutions had to be found very fast. Dominic Hardisty added that the problems had been communicated in the Trust Board reports which were in the public domain. He added that the Trust had a range of programmes on recruitment and retention – but sometimes they don't work.

Cllr Liz Brighouse, speaking as local member for the area in which the community hospital was situated, commented that it was the perception of members of the public living in that area that there was an absence of anything strategic on the part of the NHS in the way buildings, staffing, planning was handled in relation to the hospital. It had closed a number of times over the years. It was her view that there was an opportunity here to look at how and where these services were funded in a strategic manner and not in an ad hoc way.

In relation to the Committee's perceived lack of communication with this Committee, Dominic Hardisty re-iterated that the decision to close had been made by the Trust Board on 8 May and that was when it had been communicated to HOSC. This was no more of a surprise to the Trust than it was to the Committee.

A member asked Dominic Hardisty if the Trust had shared their concerns with regard to staffing with partners. He confirmed that all partners shared their concerns in relation to all parts of the system in weekly meetings - and that the Trust had shared that there was a risk in its ability to keep the ward open. In response to a question as to whether Adult Social Care were aware of the problems being experienced, Benedict Leigh confirmed that it had been discussed at meetings of the Chief Operations Managers – and Adult Social Care was aware of the risk. However, ADC on hindsight, was aware that an error had been made by not informing HOSC at this point.

The Chairman asked Lou Patten for her thoughts on what would be the next steps from May to September for the OCCG. She explained that work would take place with OH to work up various options, for example, to address the bed – day equivalents for urgent care. She added that as a commissioner she had heard from a group of clinicians in Oxford City and an opportunity would be taken to look at a different kind

of service which would form one of the options. She assured the Committee that there would be a transparency with the discussions. Lou Patten added that generally there had to be a solution to the workforce problems in Oxfordshire as a whole – and it was clear that they had to be looked at in a different way. There would be a wider piece of work in relation to this coming soon, the scoping of which was to take place within the next few weeks. Lou Patten also commented that there were other issues on the table apart from those considered today with regard to the Hospital, such as the level of noise. She added that on reflection, these issues should have been looked at earlier, and, as a system, we shall have to reflect on that.

At the Chairman's request, Lou Patten **AGREED** to send regular monthly progress reports on the last day of each month, to Sam Shepherd, who would circulate them to all members of the Committee.

The Committee then adjourned from 4.05 – 4.20pm to receive legal advice in relation to possible actions to be taken.

On its return the Committee **AGREED** the following (unanimously): to

(a) approve a motion of no confidence in the management of Oxford Health and its understanding of the agreed principles between Health providers and HOSC which had been signed up to: and

(b) instruct the officers to write to all the Oxford Health Board members expressing the Committee's lack of confidence and inviting the Chairman of the Board, together with a non-Executive Director, to attend the first HOSC meeting following the Board's consideration of the letter in order to discuss its:

(1) understanding of the working principles; and
(2) future strategy as regards to City Community Hospital.

## 32/19 CHAIRMAN'S REPORT

(Agenda No. 7)

The Committee noted the Chairman's report.

..... in the Chair

Date of signing .....