OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 April 2016 commencing at 10.00 am and finishing at 4.15 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 Alison Rooke Councillor Les Sibley District Councillor Monica Lovatt District Councillor Susanna Pressel District Councillor Nigel Randall
Co-opted Members:	Moira Logie and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Hannah Iqbal and Julie Dean (Corporate Services); Director of Public Health

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

17/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for absence were received from District Councillors Martin Barrett and Nigel Champken-Woods and from Keith Ruddle.

18/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest submitted.

19/16 MINUTES

(Agenda No. 3)

The Minutes of the last meeting held on 4 February 2016 were approved and signed subject to the following amendments:

- Minute 8/16 'Closer to Home – Health & Care Strategy' – penultimate sentence in paragraph 5, to read as follows (amendments in bold/italics):

  'Dr McManners asked if the Committee wanted engagement with the public to be 'joined up' in one local area about everything – or would it want it to be repeated in ***each locality?'***

- Minute 12/16 – South Central Ambulance Service NHS Foundation Trust (SCAS) – third sentence, paragraph 2:

  'The Trust was working ***with the Department of Health to consider how*** £1m ***could be reinvested*** into the ***service*** to cover the fines and to address the reasons behind the penalty.'

  There were no Matters Arising.

20/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following people addressing the Committee. All had requested to speak at the start of the item concerned:

Agenda Item 7 – Councillor Hilary Hibbert-Biles, (Local Member) and Dr Jonathan Moore (Chipping Norton Health Centre);

Agenda Item 8 – Councillor David Nimmo – Smith (Local Member); and Cllr Ian Reissman (Chair, Townlands Steering Group); and

Agenda Item 12 – Councillor Jenny Hannaby (Local Member).

21/16 OXFORDSHIRE'S HEALTH & SOCIAL CARE TRANSFORMATION PLANS

(Agenda No. 5)

A Panel attended to update the Committee on the development of system-wide Transformation Plans and also to respond to questions from members of the Committee. It comprised of Stuart Bell, Chief Executive, Oxford Health (OH): Andrew Stevens, Director of Planning & Information, Oxford University Hospitals NHS Foundation Trust (OUFT): Dr Joe McManners, Clinical Chair, Oxfordshire Clinical Commissioning Group (OCCG): and John Jackson, Director of Adult Social Services, Oxfordshire County Council (OCC) and member of the Transformation Board. A presentation was given by Stuart Bell.

Stuart Bell, responding to a question about whether there was a sufficiency of trained people to provide health care, agreed that there was a need for more trained personnel and support staff, for example, volunteer drivers. He stated the Board's belief in the importance of creating career structures and the development of apprenticeships. John Jackson added that the practical issues inherent in finding a sufficient workforce to do the job had been recognised at the onset of the Project – and there had been some success in attracting more social care providers into the county – but he had warned that the introduction of the living wage was viewed as a potential problem for the future.

A member asked whether there was sufficient money for the technology required for the project. Stuart Bell responded that much of the technology was about people purchasing their own Health apps to download onto their mobile phone. To this end the Board were working with the Oxford Academic Health Scientists Network on attracting investment into the capability of linking information into the system. He added that the Board was holding discussions with a number of partners and investors in this field with a view to linking into and developing this field. Mr Bell accepted that not everybody accepted new technology, but it was surprising how many older people did – and this acceptance could make the difference between people staying in their own home or having to leave it. An important thread of the project was the concept that care needed to be made much more personal and adapted to people's own circumstances.

A member of the Committee expressed the view that more work needed to be done in the sphere of sharing information on patients between different healthcare professionals or departments to avoid conflicting, and therefore confusing advice. Dr McManners responded that the system needed to be sufficiently flexible to offer a grade of different interventions to assist patients, adding it was more about partnership between the patient and the professional than patient responsibility. The new proposals allowed the patient to self - report and to observe and take action if required.

A member expressed the view that issues in the national agenda such as the scrapping of nurses' bursaries by 2020 and the issues currently in the media regarding GPs contracts could all have an impact on the local workforce and attract funding problems in the future. Mr Bell agreed that any issues of this kind could not be ignored, but there were always opportunities to attract funding and get the best out of a situation, for example, nurses training could be supported by Trusts in return for an agreement that they will work for the Trust for a set number of years.

A question was asked about how robust this Plan for Oxfordshire was in the midst of discussion about the overall structure of local government within Oxfordshire. Dr McWilliam stated that it would be important to design the best systems whose principles did not depend on organisational structures within the NHS or local government, but would be robust.

Mr Bell was asked if there would be sufficient time for the public to be allowed the opportunity to influence plans, given that there would be a consultation at the end of the summer. He responded that there had already been some work with service

users at local level, adding however that more discussion and planning would need to take place on this.

The Chairman thanked all attendees for the excellent presentation. On behalf of the Committee she asked for more information to be given by the OCCG on what would be delivered locally in relation to home/bed based care. – and gave permission for details of this Committee to be included on the Transformation Board's website.

22/16 REBALANCING THE SYSTEM - UPDATE

(Agenda No. 6)

The Chairman welcomed the following representatives from Oxford University Hospitals Foundation Trust (OUH) and Oxfordshire County Council to the meeting:

- Pau Brennan and Lily O'Connor – OUHFT
- John Jackson and Karen Fuller - OCC

Paul Brennan gave a presentation on the pilot to tackle Delayed Transfers of Care (DTOC). He reported, to date, there had been a 30% reduction in delays against an expectation of 25%.

Challenges highlighted in the presentation were:

- Workforce recruitment and retention – some staff tended to find a combination of high cost housing, the cost of living, transport movement around the City a disincentive and move away;
- The 4 hour standard in Accident & Emergency – reaching the desired level of 70% was moving in the right direction, but not as quickly as was hoped;
- Re-ablement care was still posing a challenge, demand being greater than capacity;
- Readmissions had been higher than expected.

Lily O'Connor gave a flavour of how the Hub staff (comprising Occupational Health, Physiotherapy, Social Workers, Contracting, Financial Assessment, Nursing staff, Administration, Medical staff) were working interactively – and were meeting on a formal basis once a week. The Hub was staffed at weekends by nursing staff and Oxford Health Medical Assessment staff. She reported also that there had been a number of readmissions at the start of the project. However, as the Hub had gained in confidence, communication with the Care Homes had improved, and many patients had either been placed in Homes close to their own homes, or been given rehabilitation enabling them to go back home with reduced packages of care.

Karen Fuller spoke of issues which were being dealt with by staff at the Hub, including assistance with obtaining legal power of attorney consent. From an Adult Social Care point of view, there had been a number of key benefits to working at the Hub, such as staff being able to conduct daily tele-conferences to discuss clients, to which key organisations would contribute. This enabled the flow of patients to be managed better. There were good, positive outcomes owing to a robust multi-disciplinary team assessment. Intensive rehabilitation, in conjunction with social workers, enabled patient pathways to change. There was also good communication between organisations which enabled staff to focus resources to the most appropriate point.

In response to a question, it was confirmed that there had been a sufficient number therapists recruited.

In response to a question about funding of the project, John Jackson reported that funding had been via the OCCG, who were currently looking at continuing the project beyond April 2016 at a reduced level.

A member asked how nursing staff in care homes coped with patients with very complex conditions. Lily O'Connor explained that Hub staff went out to homes to support this category of patient when required, and worked alongside staff. There was also a care home support service who worked with other staff in the Home to aid the management of such conditions on a long term basis. Any problems with patients' medication were dealt with on an individual basis via liaison with this service if more support is needed. In all, Lily O'Connor stated that staff in care homes were gaining in confidence, given that they had never been exposed to this situation before. A sense of trust between the Hub and the care homes was more apparent and there were signs that they were working with a problem rather than contacting the emergency services to send the patient into hospital.

In response to discussion around patient deaths, the Committee was informed that patient deaths were automatically reviewed. They were also informed that this patient group were usually more frail and older. It was the view of the speakers that death in a home environment was invariably more dignified.

In response to a question concerning the number of acute beds that had been released to date, Paul Brennan reported that 76 beds that were not in use, had been released, but not closed, as it had been agreed that this would be a consultation issue, as referred to earlier by Stuart Bell. The intention was to maintain the released beds, though it would be highly likely that there would be a recommendation that they be permanently closed at the consultation stage.

A member asked if the released, acute beds had been made available for winter pressure use. Paul Brennan responded that beds often did not require acute care and that a focus was needed on patients who were on an ambulatory pathway, who only needed them for a few short hours before going back home. John Jackson added that if more capacity was taken for the purpose of winter pressures then this would have an impact on funding. With regard to the funding of beds, Karen Fuller added that working together with the social care placement officer had been beneficial, giving an opportunity to negotiate a price when necessary and not pay higher prices. Paul Brennan added also that overall, the cost of support was less than the cost of running an acute bed, thus the cost of running 76 beds had been less.

Paul Brennan, in response to a question, reported that 17 nursing homes had been used across the county and the number of beds used had been just over 70. Every effort had been made to cite a nursing home close to the patients' own town/village and there had been no issues reported over choice.

In response to a question concerning notification to the regulator of clinical incidents, Lily O'Connor explained that the rules and procedures had remained the same and had not been undermined in any way to suit the circumstances.

Lily O'Connor gave her assurance that lessons would be learned as part of the final evaluation.

John Jackson clarified the position with regard to the impact on Health & Social Care of people working in retail, for example, being paid above the living wage. He stated that there was a need to look further at the impact of this if a negative situation was to occur, adding that 2% had been set aside in the County Council's budget to meet the costs of the national living wage.

The Chairman thanked Paul Brennan, Lily O'Connor, John Jackson and Karen Fuller for their attendance and Paul Brennan for the presentation.

23/16 IMPLEMENTATION UPDATE - HENRY CORNISH CENTRE, CHIPPING NORTON

(Agenda No. 7)

Prior to consideration of this item, the Committee was addressed by Cllr Hilary Hibbert-Biles, in her capacity as Local Member for Chipping Norton, and Dr Jonathan Moore, GP at the Chipping Norton Health Centre. The major points of their addresses were as follows:

Cllr Hilary Hibbert-Biles

- The 2011 contract had made clear that the beds were defined as 'sub-acute' and did not have intermediate care status. The change constitutes a down-grade;
- In her view, this Committee had not supported the residents of Chipping Norton in relation to this issue;
- Nursing staff did not wish to TUPE over to the Orders of St. John;
- There was concern that the Unit was not accepting referrals for people who had known clinical needs during the transition. This constituted a waste of staff expertise;

Cllr Hibbert-Biles called for the Committee to consider this as a substantial change in service, consultation for which had not occurred, and asked that it refer it to the Secretary of State for Health as a consequence. She also called for the Unit to be included in the forthcoming community hospital review.

Dr Jonathan Moore

- Expressed his appreciation for the large investment made in 2011 when the old hospital centre had closed down. The Hospital now had a Maternity Unit, a Minor Injuries Unit, Physiotherapy services, Outpatients and X ray facilities.. To complement these facilities, a sub-acute unit had always been expected and it had been disappointing to GP staff, in particular to a new GP with an interest in hospital care, to find that the Community Hospital had been downgraded without sufficient consultation;
- There had always been a need for sub-acute beds and there had been no alternative model of care provided; and

- The numbers of beds were shrinking and as a result there was an inadequate background provision of care in the community.

The Committee had before them a briefing on the implementation of the new arrangements at the Henry Cornish Care Centre ICU. On 26 January 2016, the County Council's Cabinet had approved Option A for the ICU which involved the ICU continuing, the full 14 bed service being provided by the Orders of St John Care Trust (OSJCT). The paper addressed the staffing issues, including the TUPE transferred staff, implications for service users and the plan moving forward.

Due to difficulties in recruiting staff in the west Oxfordshire area, a transition plan had been put in place that involved staffing the ICU with a combination of transferred nursing staff and Health Care Assistants, agency nursing staff and OSJCT care staff. All community and urgent care services would be available as usual during the transition period and there would continue to be medical and therapy cover available to the Unit at the same level as currently provided. The transition plan would focus on providing the service to those predominantly with rehabilitation needs. The service would therefore not be accepting referrals of people during the transition period who had known clinical needs, as it was essential that safe care was provided. The timescale for achieving these aims depended on the recruitment of nursing staff and it was envisaged that it would take approximately 3 months to recruit staff and a further period of 1 – 2 months to fully mobilise the nursing led service.

The Chairman welcomes Sara Livadeas, Strategy Director and Patsy Just, Assistant Operations Director, OSJCT; and John Jackson, Director for Adult Social Services, OCC.

John Jackson introduced the report about an issue which had been discussed on a number of occasions at this meeting and the Committee had previously asked for an update report on implementation. Mr Jackson asked to respond to a number of points made by Cllr Hibbert-Biles and Dr Moore. These were as follows:

- OCC Cabinet had already made the decision on 26 January 2016 on the process of implementation;
- Points had been made during the consultation which had directly addressed the allegation made by Cllr Biles and the Steering Group that the service had been down-graded. No person had written to his department specifically concerning the allegations. He invited a response to it, stating that the consultation information was still in place on the OCC website;
- Improvements to the Intermediate Care Unit had been made by OCC alongside considerable investment made by the NHS into the other facilities offered, as set out above. He paid credit to the efforts made by OSJCT to provide a full complement of nurses in the implementation time-scale.

Sara Livadeas stated that the Unit had only been open for just over 2 weeks and thus it was only very early days. The OSJCT had not been able to begin the recruitment process until after the consultation had ended and the decision made. She pointed out that 3 part-time nurses had transferred from Oxford Health to OSJ and 80 hours of cover would be provided from Health Care Assistants. Whilst she understood any concerns, the nurses on duty would provide a stable staff group, aided by an agency

nurse, to give cover at all times to those patients reliant on services available other than clinical nursing care.

A member of the Committee asked why OSJCT had not started a dialogue with OCC regarding staffing during the course of the consultation. Sara Livadeas responded that it had been decided not to do this in a bid not to want to pre-empt the outcome of the consultation.

Points made and views expressed by members during debate were as follows:

- The people of Chipping Norton had been promised a 'sub-acute' service which would be run by the NHS. Now it was not the case and recruitment had proved difficult. There should have been a plan put in place for what may happen and then contracts could be adjusted accordingly if necessary;
- The mapping of the ICU facility, staffed by OSJ nurses, should be mapped against other provision to ensure transparency.

John Jackson responded that, as part of the communications about the new service, OCC had published a large amount of information on the OCC website. Detailed information had also been given on the specifications of both NHS and OSJ provision, and had been compared with each other. He added that it had proved particularly difficult to recruit nurses in the west oxfordshire area due to it being predominantly rural and housing prices and rents being relatively high. He referred to a crisis in the recruitment of nurses which, he warned, might become an emergency in the future, if something is not implemented nationally.

Committee accepted the need to recruit additional permanent nursing staff for the 3 month transition period.

In addition, Members received confirmation from the Director of Adult Social Services that the Intermediate Care commissioned beds would be included within the county-wide Transformation consultation to be undertaken in the autumn of this year, as set out on page 3 of the Transformation Plans report.

24/16 TOWNLANDS HOSPITAL, HENLEY ON THAMES - UPDATE

(Agenda No. 8)

Prior to consideration of this item the Committee received an address by Cllr Ian Reissman of the Townlands Steering Group, and by Cllr David Nimmo-Smith, local member.

Cllr Ian Reissman

Cllr Reissman began by congratulating all who had been involved in work on the new Townlands Hospital, saying that it was a major achievement in securing local delivery of these much needed services. He expressed the concern, however, of the Townlands Steering Group that the OCCG decision, which was made in September 2015, not to provide the beds as originally planned but to operate the Ambulatory Care Model, had not been shared with the Group sufficiently to provide reassurance that the health needs of patients who had been using the bedded service in the Peppard ward were being met. Cllr Reissman commented also that he believed that

the closure of beds would lead to higher DTOC statistics. He stated that the community were keen to see an effective process of monitoring and scrutiny of the new model of care. He added that the paper presented by the OCCG to this Committee provided an overview of many of the key issues but asked that the Committee ensure that details were provided by the OCCG in the following areas:

- Details and location of the Integrated Locality Team which would be based at Townlands as key components of the RACU and the Multidisciplinary Team;
- Provision of a clear plan for the Rapid Access Clinical Unit (RACU) including the opening dates and staffing arrangements;
- Evidence that home care packages were available both now and when the RACU opened with the inevitable increased demand;
- Details of the operation of the beds leased from the Care Home including levels and qualifications of staffing, co-location of the beds and spot purchasing arrangements;
- Provision of a clear, specific, measurable set of Key Performance Indicators to include an explanation of how these had been arrived at , and the dialogue with the community; and
- To request the OCCG to engage properly with the Townlands Stakeholder Resource Group (TSRG) and co-operate with the OCCG to reconfigure the TSRG and have clear and constructive Terms of Reference. The CCG was asked to respond to the proposals and adopt as many of the proposed Terms of Reference as possible.

Cllr David Nimmo-Smith

Cllr Nimmo-Smith supported the comments made by the previous speaker address. He too congratulated all involved in getting the new hospital opened and looked forward to the care home opening soon. He hoped that the Henley experience would be taken into account as plans were developed, and consultations held, as part of the County's Transformation Plan, which in turn fitted into the national health agenda.

He stressed that the new facilities were, in his view, a great improvement, but the OCCG report accompanying this Agenda gave the impression that all teething problems had been resolved. He pointed out that this was not the case, the community required answers to their questions about integration with Adult Social Care and home care packages.

Cllr Nimmo-Smith added that the Henley and district community did not see the newly formed stakeholder group as being the answer and made a plea to the OCCG for sufficient local community involvement. He commented that getting things right in health care was important to the users of the new facility and for the Oxfordshire model.

The Chairman invited Cllr Lorraine Hillier, Mayor of Henley, to state her views. She commented that the OCCG had pledged in September 2015 to work with the community. The three, two hour meetings which had been held to date, had, in the Stakeholder Group's view, little value. She added that the media coverage had been negative because of the failure of the OCCG to address the communication

problems; and asked therefore for clear Terms of Reference for the proposals from the OCCG.

The Chairman welcomed Dr Andrew Burnett, Clinical Locality Director for SE Oxfordshire and a local GP, and Peter McGraine, Clinical Director of Older People's Directorate, Oxford Health to the table. Andrew Burnett stated that the hospital was now open with excellent facilities. The expanded Minor Injuries Unit, the Physiotherapy service and the Out of Hours service were now in place, adding however that there were still issues with regard to the re - provision of the full X Ray service because the wiring had proved unavailable (it had been ordered in 2014). In addition the RACU was not yet in place, but the plan was always that this Unit would open later. He further reported that consultants were keen to come along to work in the new hospital.

Dr Burnett added that the consultant-led Unit providing rapid access via a combination of doctors and the community teams was a respected and well-established model, which would serve to keep people in their own homes as much as possible. He refuted the issue that the closure of beds would lead to greater DTOC statistics, stating that, conversely, having more beds increased DTOC figures. The modern approach was to close beds and to help patients to go home or out into the community for rehabilitation care.

Pete McGraine reiterated Andrew Burnett's views stating that the facilities were excellent offering a podiatry service, a speech and language service, a therapy service and Out of Hours care. He reported that the public had been invited to visit the site when it opened and feedback had been very positive. Now that the older hospital had been removed, the full visual impact was being appreciated. He further reported that he had met with the media and talked through the benefits, advantages and challenges still faced, for example with the X ray facilities. Oxford Health were working very closely with colleagues at the Royal Berkshire Hospital. It was both difficult and a challenge recruiting suitable staff with suitable expertise for the RACU, adding that it was an emergency discipline providing preventative care in a responsible way. He supported the fact that the RACU was always going to be established after the other facilities. Staff groups were working in the community and those who were focusing on ambulatory care were currently being trained ready for the RACU's opening. He reported also that locality teams were not to be placed at Townlands now. He recognised the issue of timely availability of home care across the county and acknowledged that KPI's had not yet reached the agenda at meetings.

The Chairman, speaking on behalf of the Committee, thanked Dr Andrew Burnett and Pete McGraine for the update. She stated that this new model of health care was to become the norm, but the message did not appear to be being communicated sufficiently well. She added that engagement with the stakeholders and the town about the new model of care and the facilities offered was not strong enough and needed to improve.

25/16 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 9)

Eddie Duller, Chair of Healthwatch Oxfordshire (HWO), was invited up to the table to deliver his update on the activities of HWO. He reported that the restructuring of the organisation was now complete and HWO were relocating during the following month. He also stated that they may be able to continue the Hearsay! programme later in the year.

A member suggested that the NHS response to HWO's recommendation (a) on the Discharge Report which stated that 'the discharge summary was being redesigned with input from clinical staff including GPs, pharmacists' should also include summaries from carers and patients.

A Committee member asked for more information in the section on 'what we have heard', page 37, mental health services – first bullet point – 'widespread concerns have been expressed about how difficult it is for people to access mental health services when needed in a timely and effective manner. They report seeing increasingly unwell people who are turned away from services as the threshold to access mental health services rises ever higher.' Mr Duller agreed to send more information with regard to this.

Members asked if it would be possible for HWO to be a little less anecdotal and to give more concrete evidential information, It was agreed, however, that it was useful for the Committee to see a picture emerging from the community of any problems .Mr Duller agreed to this.

Mr Duller was thanked for the report.

26/16 LEARNING DISABILITY UPDATE

(Agenda No. 10)

The Chairman welcomed:

Ian Winter CBE – Independent Chair, Transforming Care Partnership Board;
Ian Bottomley – Head of Mental Health Services & Joint Commissioning – Oxfordshire Clinical Commissioning Group (OCCG)
Sula Wiltshire – Director of Quality & Chief Nurse – OCCG
Helen Ward – Senior Quality Manager, OCCG
Lesley Stevens – Medical Director, Southern Health NHS Financial Trust (SH)
Kate Terroni – Deputy Director for Adult Social Care (Joint Commissioning) – Oxfordshire County Council

Ian Winter CBE addressed the meeting prior to the presentation. It was his view that successive governments had often failed in their quest to find a successful strategy for Learning Disability policy over the years. However, the latest Transformation Care Plan was a positive initiative in that it did not separate patients across the age ranges or by condition. He spoke about the importance of the Transforming Care Plan being underpinned by the Transforming Care Partnership Board. One of the issues for Oxfordshire was about the successful transfer of services to other providers. The role

of the Board was to ensure the safe and effective transfer and transformation of services by means of challenge, championing and collaboration. He hoped the Committee would reach some level of confidence in the action that was being taken.

Kate Terroni and Ian Bottomley then gave a presentation on the current arrangement with Southern Health and how the transition to other providers would be managed. Ian Bottomley referred members to Appendix 1 'Oxfordshire's Health & Social Care Transformation Plans' which was set out in the Addenda to the Committee.

A member asked if the general community health services, as health care providers, would have the appropriate expertise to deal with people with conditions such as autism. Ian Bottomley responded that resources were already in place to provide a service, in the form of the existing contract which would be rolled over. He stated that there was no imposed solution – all had to be fully engaged and inform the OCCG of general risks and of financial risks. Moreover, the OCCG needed to be satisfied that providers were able to do the job. The contract was already provided by the existing community services located at the John Radcliffe Hospital. Here there was a good liaison service in place for people with a learning disability because staff and ward teams had a familiarity with the patients.

In response to a question asking how would intelligence be collected in order to access data, Ian Bottomley stated that the OCCG's working approach would be to identify the outcomes for meeting the health needs for a person with autism or a learning disability, and then to monitor how well the patient had done against those outcomes. Moreover, there was also a need to monitor how well the OCCG was picking up this condition generally, by asking the question of how the organisation might assess whether somebody had got autism. Sula Wiltshire explained further that the commission had made recommendations in relation to the investigation of deaths. She explained that there was an acceptance that good data on people with a learning disability was not apparent and there was therefore a need to know how to secure intelligence in order to determine how robust professionals were, for example, on how incidents were interrogated.

A member stated that it was reassuring to hear that the OCCG aimed to keep staff engaged as a priority, asking if anybody would be monitoring engagement criteria with patients – and would the criteria be set locally or nationally? Ian Bottomley responded that learning disability was not an exact, scientific diagnosis. In general it was known what future demand would be for adult and children's services but mental health, and particularly autism assessments were more difficult. The big challenge was to design a way of assessing which related to professionals looking for signs under the principle 'behaviour always means something'. The specialist aspiration was that everybody would go through the front door of Health. Dr McWilliam commented also that learning disability and autism were not concepts that could be nailed down using socially constructed, imposed definitions. To try to apply to very strict quality standards was 'slippery', and then to be asked to measure it, 'difficult'. At some time the Panel would try to transform services making it routine care rather than specialist care. He added that it was difficult to define what they were going measure, and then to put into contracts at this time, as there were legal contracts to unpick.

A member asked the Panel to expand a little more on what the vision was for the future of in-patient support within Oxfordshire and how spot-purchasing would go forward. Kate Terroni explained that originally there were 8 spot purchases which had reduced to 6. These were managed by a multi-disciplinary team of nurses and clinicians to enable staff to be supported and to keep a person in that environment. Now that there was a move to fewer beds, some patients would be placed as near to home as possible, and with a consistency of staff for in-reach and support, with a view to re-integrating the person into the community. She added that there would only be a small number of circumstances when beds would be required. Ian Bottomley added that in circumstances when there was a need for crisis provision, it would be managed by nationally imposed targets. The aim was to end with a model which only used beds when required, and for as short a time as possible. He added that the OCCG would be monitored on a reduced number of beds during the lifetime of this contract.

A member asked if there would be a point of contact with a member of staff for patients. Kate Terroni explained that professionals would look at the individual to assess whether they would suit that particular placement.

When asked what the CCG was expecting out of mainstreaming, Ian Winter stated that the aim was that people with a learning disability and autism should receive the same access to broad health care as a person without the condition.

Sula Wiltshire then gave a presentation the Commissioners' response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust.

The Chairman thanked Sula Wiltshire for the presentation.

Lesley Stevens explained that one challenge was that this was the first real examination of deaths in the community. In the past there had no clarity of guidance about who should investigate and no criteria to apply in particular settings. It is a huge amount of work as there are no tools to apply in the community sector. The data for 50% of the cases was required for the work.

A member asked who was doing the work – and would it have been undertaken if Oxfordshire had not teased out the data. Sula Wiltshire responded that it would not have been undertaken and it was the Health Economy Group who were doing the work. They were due to be trained very soon. She explained that the Group would pick up the recommendations from the thematic review and compile a number of questions to be explored. For example, was the liaison good for that person? Was there a delay in diagnosis?

A Committee member asked if a change in Board leadership had been considered, given the need for a dispassionate eye for how things needed to change. Lesley Stevens responded that it had been considered, in fact much scrutiny around the leadership had taken place, however, Monitor was the body to take such a decision and an Improvement Director would be working with the Trust. She added that there was confidence in both the Director and the Board and a wish that they should stay. She added further that the Trust had been the subject of a significant amount of

external scrutiny to date and had received reassurance about improvements made and the safety of services.

The representatives were thanked for their attendance and for allowing a frank, open discussion.

27/16 QUALITY REPORTS

(Agenda No. 11)

Oxford Health Financial Trust (OH)

The Chairman welcomed Ros Alsted, Director of Nursing & Clinical Standards and Jane Kershaw, Acting Head of Quality & Safety, Oxford Health Financial Trust (OH).

The Committee had before them a summary version of the Quality report. A finalised, detailed report had been circulated to members that day. Ros Alsted reported that the summary had focused on prioritisations. She pointed out that representatives had recently attended Committee to discuss the findings from the Care Quality Commission (CQC). Eleven were evaluated as good, one was outstanding and four required improvement.

Jane Kershaw reported that the Trust had identified for priority areas in 2015/16 and were also keeping the same ones for next year. The four priority areas were as set out in the report.

A Committee member asked about the problems being experienced both nationally and locally regarding the recruitment of nursing staff. Jane Kershaw responded that the overall majority of staff in lower paid work were not clinical members of staff. She added that that there were multifactoral reasons why the problems were unique to Oxfordshire, such as high property and rental costs, but the Trust remained very focused in trying to attract people into the workforce. It had achieved relative success, particularly in respect of the recruitment of nursing staff. She added that in one year's time the bursary system would change, but any problems would not emerge for 4 years. In the meantime, efforts were being made to recruit and retain staff by working together to ensure career pathways were in place, for example. This was an important priority for the Quality account.

The Committee **AGREED** to note the priorities and objectives proposed for the Quality Account in 2016/17.

Oxford University Hospitals Foundation Trust (OUH)

The Chairman welcomed Dr Tony Berendt, Director of Quality, and Claire Dollery, Deputy Director of Quality, OUH.

Dr Berendt gave his apologies for the full Quality report arriving too late to be despatched with the papers for this meeting, but stated that he was pleased to be given the opportunity to discuss the report.

Dr Berendt, during his report to Committee, commented that discharges to GP care had more than doubled. He also stated that the work put into the DTOC programme could not have taken place without all the input that Health and Social Care colleagues had put into the system.

He reported that a public engagement event, to which both governors and staff had attended, had been held on the Quality account, when an overview of the previous year's account and a reflection on outcomes had taken place. A session had also been held on intended priorities for the coming year. The Trust was doing a piece of work on improving the discharge process as part of DTOC work. Part of this was to empower patients and families to ask the right questions. He added that he would be happy to give an update in progress. He undertook to let the Committee know of future patient and public dates in respect of the Quality account process. The Committee welcomed this, commenting that this would ensure a much smoother process for major programmes and their implementation.

Dr Berendt referred to a one day training programme for staff on Compassionate Care which had been arranged and delivered by the Chief Nurse and the HR Department. Patient participants would be encouraged to relate their own experiences, with the aim of helping staff to more consciously empathise with what is occurring. He added that the plan was to broaden this out still further in the future to pick up other medical staff.

In response to questions about incidents of maladministration, Claire Dollery reported that she had worked this year to identify those which were of high risk. For example, a programme to identify any time-critical medication and means by which staff could learn about these and put them into practice. Dr Berendt added that errors in prescribing medication via different kinds of nursing error.

A member of the Committee asked how many cases of sepsis was occurring via hospital acquired infection. Dr Berendt responded that the majority of the cases were community acquired cases. Claire Dollery added that there were two principal streams of work with the sepsis group, one was ensuring that the appropriate antibiotics were given in one hour; and use of data to identify the correct antibiotic.

A member commented that it was difficult for the Committee members to effectively undertake the job of scrutiny if documents were not received in time, particularly in view of their size. Dr Berendt responded that Quality priorities were set nationally and that the Trust's Quality priorities linked into those of lead organisations on patient safety, mortality etc and national priorities had to be met.

The Committee **AGREED** to note the priorities and objectives for the Quality Account in 2016/17.

28/16 CHAIRMAN'S REPORT

(Agenda No. 12)

Prior to discussion, the Committee were addressed by local member, Cllr Jenny Hannaby, in relation to the report of the confidential meeting held with representatives from Oxford Health with regard to Wantage Community Hospital on

14 April. The report informed the Committee of a briefing meeting attended by 10 members of the Committee regarding the imminent closure of Wantage Community Hospital on safety grounds, given the persistent recurrence of legionella in the hot water system of the hospital. This was being treated and there was no immediate risk to health. However, the treatment was not a long term solution and the whole system required re-plumbing in order to permanently eradicate the risk. The purpose of the confidential meeting was for Oxford Health to ask this Committee whether the proposed extension of the temporary closure of Wantage Hospital (to allow public consultation outcomes to shape the nature of capital works undertaken) constituted a substantial variation or not. The outcome of the meeting was that HOSC members recognised the closure of Wantage Hospital as a substantial change in service and noted the commitment by OCCG, OH and other organisations to a full Transformation consultation later this year.

Cllr Jenny Hannaby

Cllr Jenny Hannaby began her address by regretting that local members had not been invited to the confidential meeting with HOSC members. However, she had attended a briefing yesterday, in her capacity as local member. She stated that on making inquiries about the issues prior to the briefing, she had been informed that the hospital would close for 2 weeks, and later told it would be closed for 3 months. The staff had been very shocked when given the full facts. She added that this was the third time in 10 years that she had attended meetings to defend the hospital against closure. She informed the Committee that the problem had been prevalent for 4 years. It had been flushed out in the past and maintenance work had taken place. Friends of Wantage Hospital had given donations for some of this work. She reported that there had been 63 babies born this year at hospital, adding her view that OH should have corrected the problem permanently if it was a danger to patients. She further commented that purdah prevented a consultation on the closure which would have enabled members of the public to have their say. She requested the Committee to encourage OH to do a temporary closure of the hospital until a consultation was held – and to support the fight against permanent closure.

The Chairman responded to Cllr Hannaby on behalf of the Committee stating that, following their meeting with OH on 14 April, members were of the view that a proposal to close the Hospital permanently would constitute a substantial change of service and would require a full public consultation. Members had recognised the Legionella made it unsafe for the health of patients and therefore needed to be flushed out. She added that they were informed that the temporary closure would take place at the end of June.

Cllr Hannaby disputed that it was a temporary closure, informing the Committee that staff had been informed that the outcome of the consultation could be permanent closure. Hannah Iqbal responded that the HOSC members who had attended the meeting had been told that the outcome would not be decided until the consultation outcome.

Hannah Iqbal agreed that clarification on these issues would be sought in the form of a letter, adding that it was her understanding that Oxford Health had wanted to close

it temporarily in a planned, gradual manner and did not wish to be in a position where it would have to be closed as a sudden emergency closure.

..... Dr McWilliam advised that the Committee needed to make a judgement about whether they had been put fully in the picture. He suggested that the Committee should write a follow-up briefing to the Trust asking the appropriate questions.

It was **AGREED**:

(a) that the Policy Officer should write to the Trust seeking clarification of the issues raised; and

(b) to note the remainder of the Chairman's report.

29/16 FORWARD PLAN

(Agenda No. 13)

The Committee considered the draft Forward Plan.

With regard to a possible review into private nursing care homes, John Jackson advised that the Committee ask for a quality and monitoring report on private care homes.

It was **AGREED** that the Forward Plan be agreed and that patient transport ***and parking to hospital sites*** be reviewed***.***

30/16 FOR INFORMATION ONLY - BRIEFING REPORT

(Agenda No. 14)

The briefing report was noted.

..... in the Chair

Date of signing