OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Tuesday, 7 March 2017 commencing at 10.00 am and finishing at 4.07 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Les Sibley District Councillor Nigel Champken-Woods (Deputy Chairman) District Councillor Jane Doughty District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Jenny Hannaby (In place of Councillor Alison Rooke) Councillor Ian Corkin (In place of Cllr Andrew McHugh)
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Resources Directorate)
Part of meeting	Strategic Director for People & Director of Public Health; Director of Law & Governance

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 and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

13/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Cllr Ian Corkin attended for Cllr Andrew McMcHugh and Cllr Jenny Hannaby for Cllr Alison Rooke.

14/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

15/17 THE OXFORDSHIRE BIG HEALTH & CARE CONSULTATION: PHASE 1

(Agenda No. 3)

The Chairman introduced the item stating that Phase 1 of the Big Health & Care consultation was only the start of the consultation process. She outlined the order of business for the day which comprised the following:

- Dr Joe Mcmanners, Clinical Chair, OCCG, together with David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group (OCCG), to present the proposals;
- Members of the public to speak to the Committee;
- Representatives from Healthwatch Oxfordshire, Berkshire, Buckinghamshire & Oxfordshire Local Medical Committee, Oxfordshire County Council, Vale of White Horse District Council and West Oxfordshire District Council to address the Committee;
- The above Health Executives , together with those from the Oxford University Hospitals NHS Foundation Trust (OUH) to answer specific questions from the Committee on the content of the proposals and their impact on patients, the public and the local health service;
- Committee members to consider their views and feedback on the consultation proposals.

The Committee's discussion and feedback on the proposal; and the outcome of the meeting would formulate the Committee's formal response to the consultation which would be submitted prior to the close of the consultation on 9 April 2017.

The consultation document was attached to the Agenda at JHO3 together with a web link to the supporting documents, including the pre-consultation business case and travel analysis.

Written submissions from the following organisations and Members of Parliament had been received and were attached to the Agenda and to the Addenda for the meeting:

- Oxfordshire County Council Cabinet
- A joint submission from Cherwell District Council and South Northamptonshire Council
- West Oxfordshire District Council
- Oxford City Council
- Northamptonshire County Council's Health Adult Care & Wellbeing Scrutiny Committee
- A joint response from Warwickshire County Council's Adult Social Care & Health Overview & Scrutiny Committee, South Warwickshire CCG & South Warwickshire Foundation Trust
- Victoria Prentis, MP for North Oxfordshire
- Andrea Leadsom, MP for South Northamptonshire
- Robert Courts MP for Witney & West Oxfordshire
- Healthwatch Oxfordshire

The Chairman stated that there had been complaints from local MP's and from action groups about the two phase consultation despite it being made clear that the Committee had required a consultation by January this year. She reminded all that the consultant-led obstetric service at the Horton had been temporarily withdrawn and bed closures at the John Radcliffe Hospital had occurred prior to the Oxfordshire Transformation Plan (OTP) consultation being ready. The Committee had deemed it unacceptable that these substantial changes should go for a year or more without consultation. She added that it was already clear that the success of the proposals depended upon the impact on community services, home care and GP provision, but a date for the Phase 2 of the consultation was not yet known and not likely to be until the Autumn. By then, it was her view that the OCCG would have experience of managing change and perhaps a fuller picture would be more apparent. This, she added, could be a positive advantage.

Prior to their presentation, Stuart Bell (OH) pointed out that the Oxfordshire Transformation Board (OTB) comprised representation from Health, Oxfordshire County Council, Healthwatch Oxfordshire and the Local Medical Council. He emphasised that it was not a statutory body but was a group which facilitated the coming together of key local partners for the purpose of developing ideas and planning services. It predated the Sustainability & Transformation Plan (STP), which again, had no statutory powers, but would likely become a means by which NHS England could channel resources. Consultation needed to be undertaken by a statutory body which was why the OCCG were leading on the consultation. Dr McWilliam added that the OTB acted in an advisory capacity and it was not leading on the consultation. Thus its proceedings did not represent the views of Oxfordshire County Council, Healthwatch Oxfordshire, or the views of the Local Medical Council. Oxfordshire County Council had produced its responses to the consultation on a separate basis.

The Committee were then given a presentation by Dr Joe McManners, Clinical Chair, OCCG and David Smith on the proposals. It was confirmed that feedback from the Phase 1 consultation would be considered by the OCCG Board on 25 May, and the final decision on a way forward made no earlier than June 2017.

The Chairman thanked Dr McManners and David Smith for the presentation and invited the following members of public to make their address to the Committee:

Mrs Ginette Camps – Walsh, speaking as a member of the public informed the Committee that she had received no response from the OCCG with regard to her complaint about being given no choice of hospital or consultant when referred for surgery by her GP. She felt it was OCCG's deliberate policy not to allow patient choice for referrals for some clinical specialities. This required further investigation as it affected a significant number of patients, and may have detrimental effect on health outcomes - it may even contravene NICE guidelines. Mrs Camps-Walsh concluded that there was, in her view, a danger that more centralised commissioning across Buckinghamshire, Oxfordshire and West Berkshire, as part of the STP process, may lead to a reduction in variation, which would in turn lower standards.

Keith Strangwood, speaking on behalf of 'Keep the Horton General' campaign urged the Committee to reject the split consultation as it would render consultation with the public 'worthless'. He added that the huge public concern regarding patient safety, together with the letters received from local MPs had not had any effect on the OCCG.

Clive Hill, speaking on behalf of the Chipping Norton Action Group spoke about the 'illogical' nature of the two-stage consultation and the confusion it has caused to members of the public. He cited the example that Phase 1 was looking at the Horton Maternity Unit, yet midwife-led units elsewhere would be considered in Phase 2. He expressed concern that the OCCG claimed to have listened before finalising options in the consultation, but they did not listen to the concerns of the Chipping Norton Action Group, and, in fact, no conversation event had been held in Chipping Norton. He expressed the Group's fear that community care would be down-graded, and the service would disappear, with patient safety being compromised by the use of care from unqualified family and friends, due to the closure of community hospital beds. He urged the Committee to use its power and responsibility to ensure that the proposals were safe and workable and not to 'let communities sleepwalk to a disaster'. As part of the consultation he called for a full and open investigation into the outcomes of the changes made at Chipping Norton Hospital to NHS staffing and management.

Mark Ladbrooke, speaking on behalf of 'Keep our NHS Public' highlighted a number of problems in pushing the proposals forward, principally, the risk involved in not running old services in parallel with new proposals / pilots. He stated that Simon Stevens, Chief Executive Officer, NHS England, had recently announced new criteria for proposed NHS changes. He called for the planning of services to demonstrate sufficient alternative provision, including GP provision, to be in place alongside or even ahead of bed closures, together with a new workforce in place to deliver. He urged the Committee to ensure the application of some clear tests to ensure safe delivery of this process given that OCC was projecting a shortfall of staff and in light of the recruitment and retention problems currently being experienced in primary care. He pointed out that the workforce as a whole would need to grow by 7.5k and 29% of workers change jobs at any one time.

Chris John Whitburn speaking on behalf of the retired members of Unite urged the Committee not to accept the proposals contained within the consultation. It was his view that care at home would be a 'minefield' for frail older people. He used the case of his elderly relative to demonstrate that domiciliary care visits are not long enough to deliver the care required and do not factor in travel time for care workers.

Councillor Hilary Hibbert-Biles, speaking as local member for Chipping Norton spoke of her 'proud moment' when she attended the opening of the new hospital unit at Chipping Norton in 2011, adding that this was a hospital that 'worked well'. She expressed the concern felt by the surrounding villages about the possible closure of the hospital. Residents looked to the hospital for their care, adding that it did not make sense to close beds when more would be needed under the plans, not fewer, and Chipping Norton and Banbury were both growth areas She also expressed concern at the possible loss of the Midwife - Led Unit (MLU) at

Chipping Norton, particularly in light of the possible proposal to downgrade the Horton to a MLU, plans for which would be contained in Phase 2 of the OTP. Councillor Biles called for more paramedics and ambulances for transporting mothers and babies to the John Radcliffe hospital, highlighting the anxiety felt by the mothers who were not aware that there were problems beforehand. She concluded by emphasising the need for a consultation that was not split, that contains more options and alternatives and the need for the OCCG to heed the impact of the proposals on GP surgeries when it was already difficult for patients to obtain an appointment..

The Committee then heard statements from the following representatives on behalf of their organisations:

Dr Paul Roblin - Chief Executive, Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee

Dr Roblin declared that he was a Governor on the Oxford University Hospitals NHS Foundation Trust (OUH) Board, acting in a 'critical friend' capacity. He agreed with the perception that the case for change was powerful, however it was his view that inadequate detail had been given regarding what would substitute for the bed closures. The two-stage process presented a problem in that the solutions were not well developed or articulated, either from a financial or operational point of view, despite having theoretical support. These needed to be in place before any closures took place. He stated his personal support for the principle of 'the best bed is your own bed', but the concept of 'when beds are short, cut them' was counter intuitive and if deemed inadequate could generate criticism or even legal action. He viewed the development of care outside hospital as risky, but accepted that funding needs to be released from the acute sector and an element of faith is needed. He endorsed the view that alternative services should be in place before other services are stopped. He added his recognition that the OUH had tried to obtain an obstetric workforce for the Horton, but it was for the Committee to decide if the efforts made were enough.

Eddie Duller, OBE, speaking on behalf of Healthwatch Oxfordshire (HWO), commented that it was not reasonable to make a decision until both consultations had concluded. HWO had an idea of the sorts of questions being generated from members of the public - they appeared puzzled and not to understand the broad statements coming from the clinicians, some of which were contradictory. He stated that more detail was required on how the overall staffing levels were going to be projected, as splitting could result in rises of administrative and technical support costs. He added also that the public wanted an explanation of how the proposals related to them individually. He raised the problem of travel for patients transferring to Oxford from the Horton and about the parking situation worsening at the John Radcliffe site. Mr Duller also questioned what specialist services would be available at the Horton and to what extent certain procedures would be made available at the Horton. The meaning of 'ambulatory emergency care' was queried and the hours this care would be available? He concluded by asking if Health had developed a detailed plan and if they had, would they make it public?

Diane Shelton speaking on behalf of Cllr Jeanette Baker, Cabinet Member for Leisure & Health, West Oxfordshire District Council (WODC), stated that WODC supported the aspirations of OCCG to transform services, recognising the increase in demand for services. The Council understood that the proposals were based on clinical realities which mitigated access to high standards of care. However, it was believed that without the information contained in Phase 2 it was difficult to understand the specifics of the proposals. She highlighted the current difficulties with patient parking at the John Radcliffe Hospital which would be likely to increase if more patients were to be transferred to Oxford from the north of the county. Furthermore, in view of the forthcoming growth in population of West Oxfordshire, WODC strongly supported the continued provision of the Midwife-Led Unit at Chipping Norton Hospital and its First Aid Unit, both of which patients could reach relatively close to home. She added that representatives from WODC had attended the consultation events but had not felt part of the proposals, despite the provision of a large amount of local evidence for inclusion. WODC wanted to be part of the development of proposals and would devote time for this involvement. She asked the OCCG not to exclude the district councils, particularly as they held membership in the Health & Wellbeing Board and its sub group, the Health Improvement Board.

Cllr Roger Cox, speaking on behalf of Vale of White Horse District Council, pointed out the importance of liaison with neighbouring areas because residents in the western part of the Vale relied on Swindon Hospital for their care. He highlighted how important it was for funding lines and responsibilities to be clarified before decisions were made. His view was that existing provision does not keep pace with Local Plans and the proposals for change need to be checked against projected increases. Cllr Cox stated that whilst he understood the rationale behind the Health proposals to centralise specialist services back to Oxford, the Committee should not lose sight of the excellence of Abingdon Hospital, adding that it was essential for residents and should be maintained. He called for a more joined up approach with district councils on health and wellbeing, particularly as local councils have a focus on health and leisure.

Following this address there was a short question and answer session with Dr Roblin and Eddie Duller OBE. Questions and comments from Members of the Committee were:

- Request for more information regarding estates and property;
- Concern with regard to the ‘silence’ on primary care, despite reassurances by OUH that increased care outside hospital would not fall on the GPs. There appeared to be some hope of investment, via the STP, in new models of care, but it would be difficult to find the funding in large amounts;
- Concerns about GPs being overworked and many taking retirement. Also patients unable to get a GP appointment;
- Concern voiced by Eddie Duller OBE that members of the public were uncertain about the content of the consultation because the language used was not easily understood;
- OCC should be more actively involved in evaluating of the impact of the proposals on care services. It was suggested that the second phase consultation should be jointly led by OCC and the OCCG;

- If hospital care at home should fail, would the burden fall on the GPs?
- It was difficult to see how recruitment and retention issues could be overcome in an area with high rates of employment;
- The impact of the plans on areas of high deprivation such as parts of Banbury.
- None of the plans appear to respond to the issues relating to growth areas;

Responses received from Dr Roblin and Eddie Duller OBE to the questions and comments above were as follows:

- There were many theoretical concepts around GP working at federal level, and uncertainty around the buildings they will occupy. In the past the NHS had raided its estates budget for revenue purposes. In reality extra money from the Government was easy to apply for, but not easy to acquire;
- It was Dr Roblin's view that decisions relating to change in primary care needed to be a matter for national decision/policy -making;
- Dr Roblin would be nervous to agree to bed closures and other facilities when it was unknown what the solutions entailed;
- Hospital care at home is bed-based care, which differs from the ambulatory care described in the proposals. GPs would not want to see this new type of care outside hospital delivered at a slower rate than necessary – it could increase the burden on GPs;
- Eddie Duller OBE was concerned about the impact on all parts of the county where there were pockets of deprivation. An update on responses to the Health Inequalities review report would be discussed at the next meeting of the Health & Wellbeing Board on 23 March. This was a report of great importance and must not be shelved;

Cllr Jo Barker, a member for Shipton South, Stratford District Council, spoke on behalf of Stratford's Health Overview & Scrutiny Committee, who was very concerned about the split consultation, which it felt was giving a disjointed, and even a flawed effect as a result. The Committee had invited the OCCG to come along to answer questions on the consultation, but, to date, no response had been received. The Committee were concerned that the Horton's MLU would not be available to Stratford's residents (approximated to 40 births a year) due to the downgrading of maternity services. She pointed out that it was often not known if a birth would become an emergency. The quality of care would become questionable and babies could be born damaged. She asked why, in light of the obstetric shortage, doctors and nurses could not be rotated around the Trust, as midwives were. By removing obstetric care, the Trust was making the service unworkable. Cllr Barker expressed concern that this had not been discussed across the borders. She concluded by recommending that the Trust takes a look at the Warwickshire's community nursing service as an example of good practice.

Cllr Ian Corkin gave his support to the submission made by Cherwell District Council who were, he said, committed to doing whatever was necessary to expose the inadequacy in the process. He added that what concerned him the most was the deterioration in outcomes for residents and their lives. His view was that the video contained within the presentation was 'slick, but lacked balance'. Mr Smith spoke of

60k patients using the Horton, per annum, under the new proposals, but Cherwell District Council believed the figure to be 90k (60k outpatients, and 30k day patients). The Horton estate would need to take 350 more cars per day when it currently runs to capacity. Furthermore, the pre-consultation business case made no mention of car parking, nor did it deal with the current situation at the Horton. He called for one unified proposal, so that decisions could be taken in full knowledge of the implications.

Cllr Susanne Pressel, speaking on behalf of Oxford City Council, stated that there were many good components contained within the proposals, but, in her view, the NHS generally needed more funding. She also called for more to be done to reduce health inequalities. She asked for information about where the new sites would be located for the new, larger premises required at the John Radcliffe. Cllr Pressel also recorded her concerns about the future of Accident & Emergency, mental health services and public health services. She referred to page 47 of the Addenda that gave a summary of what Oxford City was calling for, which was a sustained focus on delayed transfers of care which 'did not appear to be working', and improved, integrated health and social care services. Cllr Pressel called for improved Health Centres which were fit for purpose and investment in key housing to help the recruitment and retention problems.

Councillor Mrs Judith Heathcoat, Cabinet Member for Adult Social Services, who was accompanied by Kate Terroni, Director for Adult Services, Susan Halliwell, Director for Planning & Place (interim) and Hannah Farncombe, Deputy Director, Children's Social Care, made the following statement to the meeting:

'On 21st February Cabinet received a paper title "Response to Oxfordshire Clinical Commissioning Groups Consultation on the Oxfordshire Transformation Programme for NHS Services.

I wonder, if you'll bear with me whilst I make an introduction which will allow me to give not only Cabinet's view and therefore a political view on the Oxfordshire Big Health and Care Consultation: Phase 1but also put in context where we are today.

As you are all aware, our officers have attended general meetings with OCCG and I have sat with the Leader and senior officers on the Transformation Board – a non-decision making body. Our officers have been able to present specialist advice when any one single proposal would have implications for us within Adult Social Care, Public Health and Children's services. By law we must work with the NHS. It must be remembered that this authority is a consultee and we've been able to examine proposals thoroughly and importantly take account of the views of the public and the impact the proposals will have on our services. I can fully understand as can the Cabinet the public's grave concerns on this consultation.

The report received at Cabinet was an assessment by the Council's Leadership Team and detailed the impact the proposals may have on our services and on the public.

Cabinet members made many comments and the points raised were:-

The disturbing situation of knowing that this is only the beginning of the process – this is of course Phase 1 of plans and there is to be a Phase 2 later this year. It is proving impossible to separate and understand the total impact of plans - Phase 1 on Phase 2 and vice versa. Reference was made to the less than transparent proposals for communities and the public especially for the public in the North of the County. It was recognised that the interplay between a BOB STP and an Oxfordshire consultation remained unclear and confusing for everyone – professionals and public. With the splitting of the consultation into the 2 Phases there is no coherence to allow for a full picture to be drawn on the future of maternity and children's services.

Cabinet members continued to comment on the fact that there will be a "domino effect" on other services. If there is a diminution in one service this tends to lead to a diminution in related services. Changing maternity services, intensive care services and the bed stock at the Horton will have effects on other medical services – anaesthetics, paediatrics, accident and emergency and these impacts are not covered by the consultation.

By reducing hospital bed numbers across the County I should also like to state that to a have a truly sustainable transformation plan for the future, consequences from Phase 1 need to be examined. Beds can't just be cut and shifted – there needs to be investment in other aligned services to support the impact that these proposals will have.

As the Cabinet Member for Adult Social Care the proposals are very concerning as they do not contain detail for us to understand the full impact on adult social care – no modelling has been done that reflects the assumptions have been made with regard to patients' length of stay, or their acuity – so there is no ability to translate bed numbers into estimates of patient flow.

Equally, the expected housing development across the county, the changes to travel plans for patients, staff and visitors shows a lack of understanding that there will automatically be an effect not only on traffic flows but also on the already congested hospital car parks. More and more patients will either arrive late or will miss appointments!

I seconded a proposal by Councillor Hibbert-Biles at Cabinet to amend the recommendations before us to read:

- Welcome the opportunity to comment on this consultation, acknowledge the difficulties faced by NHS services locally as present in the OCCGs case for change, but on balance not to support the proposals based on the lack of information on the impact on council services "and that of the public" '.

Questions for Councillor Mrs Heathcoat and associates covered the following areas:

- Whether OCC was condemning the consultation proposals as 'unsafe' and expressing a preference for them to the deferred until they could be joined up with Phase 2 of the proposals.

- The added pressure on council services, particularly when OCC are facing issues with recruitment and care at home, with contracts having been given back and providers having gone out of business.
- OCC's a consultee role and the need for the Council to take a key role in the consultation.
- Whether the Government should be asked for money to pay for transitional funding for Adult Social Care.
- The recruitment and retention issues in the care workforce and the influence OCC has over private providers. Is it a question of the timing of implementation? What can be done when employment rates are so high in the county?
- The Committee has for two years tried to raise awareness of the need to include Health & Social Care into development plans. How are you dealing with this?
- None of the existing processes are being triggered to identify need, but now is the time to be planning for that growth. Cherwell District Council and the Vale of White Horse District Council have already raised concerns that none of the plans flag up future growth;
- Whether there is sufficient information available in the split consultation for the impact on care services to be known;
- The number of intermediate beds in care homes available to be able to move people out of hospital;
- Are there problems being caused by district councils not adapting homes quickly enough to support discharge from hospital;
- The recent rise in delayed transfers of care and its link to a lack beds and a lack of reablement services.

Responses given were as follows:

- The proposals are not unsafe, but consideration should be given to the impact of the proposals on adjoining services that make up the whole system;
- The whole market support for care services is very fragile. Social Care services could not be cut without having an effect on all services;
- OCC has invested £400k into Social Care and 15 minute home care visits have been abolished the Cabinet was asked if it would support Social Care becoming a consultee so that it could become unfettered in its deliberations;
- Workforce issues were a real challenge and viewed as very important. In fact OCC pay the highest wages in the country for home care. Despite OCC's investment in the home care market to make it sustainable, providers were often leaving at short notice. By utilising initiatives such as value-based recruitment and assured provider cost contracts, a 10% increase in home care had been achieved. It had plateaued now and it was hard to say if this was sufficient to meet the need;
- The Government had allowed more money for Adult Social Services by allowing Councils to raise their precept by 2-3%. OCC had chosen to raise it by 3% over a period of 2 years which would allow more investment into services;
- Oxfordshire strongly aligns itself to the principle of care in one's own home, but, for this to happen successfully there needs to be a number of ingredients

to fulfil it: the right workforce, the ability of GPs to become involved etc. Employment is very high in the county and OCC is open to suggestions and ideas about how to tackle it further;

- It has been difficult to get future medical needs in development plans and more could be done. OCC is beginning to get engagement via, for example, place reviews. Health have been invited to attend the next meeting of the Growth Board and it is hoped to strengthen their role via the Board;
- As far as the sufficiency of intermediate beds was concerned, this was a very complex subject and carried out with a multiplicity of agencies. There are peaks and troughs in delayed transfers of care, but there has been much closer working between Health and Social Care and statistically the delays have decreased in Oxfordshire;
- Health cannot expect to put plans into place without the impact being felt by Adult Social Care and care homes. It was therefore important for Health care and care homes to work closely together to ensure the right care is being put in place;
- Timely adaption of homes can be a problem. There was only a small number of people waiting for adaptions to their property, but they tended to be long waits. Detailed discussion was currently taking place on a pilot scheme which could provide holding places in extra care housing for people waiting for adaptions;
- The reablement service had been taken over by the Acute Trust on 1 October 2016.

Dr McWilliam clarified that OCC has a statutory duty to work in partnership and co-operate with Health and does so through various strategic boards (e.g. the Health & Wellbeing Board), by having joint budgets with Health and by commissioning services from Oxfordshire's Healthcare Trusts. Health and OCC had worked to integrate services as best as they could and had a good record of working in the best interests of the residents. What could not be known was how this translated into a second consultation. He reminded the Committee also that there was a forthcoming election and it would be a matter for the next Council to consider how it wished to work with Health.

The Chairman summed up the concerns expressed by speakers and via questions so far for the OCCG and OUH to answer during the afternoon session. These were:

- Concerns regarding the split consultation;
- Concerns about the impact on other services;
- The importance of dealing with health inequalities known about in areas of the county, notably in Banbury and Oxford which have been flagged up by the Committee and in MPs letters;
- The lack of consultation with neighbouring counties and districts;
- Complaints about the timing and location of consultation meetings, e.g. in Chipping Norton;
- The impact of car parking at the Horton Hospital and the Oxford hospitals;
- Uncertainty about the level of care and impact on the public of the changes to maternity services at the Horton if the downgrade to a MLU is made permanent in Phase 1; and

- The plea from the MPs that Phase 2 should be a joint Social Care and Health consultation.

Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust and Chairman of the Transformation Board; David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group; and the following Health representatives ;

- Bruno Holthof – Chief Executive, Oxford University Hospitals Trust
- Dr Tony Berendt - Medical Director, Oxford University Hospitals Trust
- Catherine Stoddart – Chief Nurse, Oxford University Hospitals Trust
- Dr Joe McManners – Clinical Chair, Oxfordshire Clinical Commissioning Group
- Dr Paul Park – Deputy Clinical Chair, Oxfordshire Clinical Commissioning Group
- Dr Kerin Collison - Deputy Lead for West Oxfordshire Locality, Oxfordshire Clinical Commissioning Group
- Ally Green, Head of Communications and Engagement, Oxfordshire Clinical Commissioning Group

attended to answer specific questions from the Committee on the content of the proposals and their impact on patients, the public, and the local health service.

Before responding to questions Dr Joe McManners responded to comments made earlier in the meeting noting that they were part way through the consultation period. The OCCG had noted down the views expressed and they would prove useful in their deliberations. They had been asked why it was not a joint consultation with Oxfordshire County Council and he made it clear that they would welcome this in Phase 2. They would offer that to OCC and welcomed the opportunity to take a proper look at health and social care integration.

The OCCG had been advised in advance of questions collated from the Committee which provided a framework for the session. Responses were received based around the following headings.

<u>Proposed bed closures</u>

Health representatives were asked to explain the rationale/wisdom of closing beds at the JR, in the context of 95% occupancy this winter, where people were left lying on trollies not being cared for or treated. Tony Berendt referred to the delayed transfers of care where people were trapped in hospital because of the failure to put care packages in place or to have domiciliary care available in a safe place. He pointed out that the elderly particularly those with dementia are easily distressed by change and there is constant change in acute hospitals. It is better to move them to a more friendly, homely environment. The number of beds corresponded to the numbers of delayed transfers of care. Asked about ambulance service waiting times at hospitals he advised that he was unable to provide information for another service, but was not aware of any particular issue. The Chairman indicated that this data should be provided to the Committee.

When asked about the impact of bed availability for planned surgery the Committee was advised that the availability of beds was not the major factor determining

planned surgery. Of more importance was the referral for treatment and availability of doctors and surgery time. Medical developments meant that fewer beds were required. Responding to a suggestion that the freed up beds be used to provide more services it was explained that it was not simply a case of having as many beds as possible. Those beds needed to be staffed appropriately and it was not the right response to use beds simply to hold patients. They referred to the brief suspension of elective surgery which had been a nationally imposed requirement. It had not been implemented at the Churchill or the NOC as neither of these two were set up to deal with acute illness.

Asked about the impact of bed availability on 4 hour waiting targets in A&E Catherine Stoddart advised that the target had been mixed over the winter, but had not been adversely affected by the changes in the way patients are managed. The walk in clinic for the frail elderly was far less traumatic than A&E. In the first week in February they had seen 159 patients who would otherwise have gone to A&E. They had also supported 31 people through Acute Hospital at Home and 221 through the Home Assessment and Reablement Team (HART). They had replaced acute inpatient beds with other provision.

Dr Paul Park, representing Banbury GPs, advised that the transfer of care into the community had been remarkably painless. The changes had been very effective at keeping people at home and in his experience had not increased GP workloads.

Responding to concerns that the level of recruitment would undermine efforts to reduce delayed transfers of care Catherine Stoddart acknowledged that recruitment was a challenge. Following recent efforts the HART team was now at 72 staff when 100 were needed in total. A group recruitment exercise had been very positive at the weekend. The HART service was able to flex up or down as required.

Dr Bruno Holthof responding to a challenge that beds should not be closed if alternative community provision was not in place, explained that last year beds had been released and OUH had invested £5m in out of hospital services such as the HART team. However the delayed transfer of care figures had gone back up to 180. There were too many patients in the system and the system should be releasing more acute beds to invest in out of hospital services Dr McManners added that it was about the flow of patients through the system and the system failing to have enough care at home provision.

Health representatives were asked about the justification for closing 146 beds based on two pilots yet to be fully analysed and in the context of releasing money for community services and in the face of a requirement to find £200m by 2020/21. Dr McManners replied that the numbers in hospital could only be reduced by investing in social care. A joint Health and Social Car consultation in Phase 2 could facilitate the necessary modelling. Working together it was possible to work out the gap in community provision, then it was about finding the money. The only way to do this was to save it from beds in hospitals and to reinvest in community provision. Without additional government money there was a fixed sum and currently this was being spent in the wrong place.

In response to concerns about parking problems at the JR and Horton hospitals Dr Bruno Holthof detailed work underway to develop a Master Plan for the Headington site. Proposals included Park & Ride facilities outside the ring road with links to the sites and plans for 5 multi-storey car parks, two at the JR, two at the Churchill and one at the NOC. OUH is engaging with local planning authorities to make these plans a reality. In addition the shift of some treatment and diagnostics to Banbury for people local to Banbury would save on number of journeys and free up parking spaces, as would the use of technology to reduce repeat visits, for example to receive results.

Committee members raised concerns about the effect of multi-storey car parks on the traffic congestion at the JR site and how the Master Plans would address inequalities in access. David Smith replied that the recent Health Inequalities report commissioned by the Health and Wellbeing Board made a number of recommendations that will need resourcing jointly with OCC.

Asked about parking at Banbury Dr Holthof advised that it was likely that any Master Plan would not be finalised until after a decision on the consultation proposals in June.

Proposals for redevelopment of the Horton

In response to questions concerning the impact of the Horton redevelopment on the JR, Dr Berendt commented that it had always been clear that staff could work at any site. The JR had coped well with the additional births since the Horton became a midwife-led unit (MLU). Asked about the safety concerns of consultants having to travel between sites, possibly when tired from long hours, the Committee was advised that there were no plans that doctors would work even longer hours.

Asked about consultation with workers and staff on the recent changes to maternity services at the Horton, Dr Berendt stated that as they were emergency changes they did not need to consult. Ally Green referred to public meetings organised in Oxfordshire and South Northamptonshire. The OCCG had also tried to respond positively to requests from Groups to attend their meetings and had varied the times of meetings and days of the week for the consultation events, which mostly were well attended. However meetings were not the only method of engagement.

Responding to a question about where the £14m - £15m funding for the redevelopment of the Horton Hospital would come from, Dr Holthof advised that there would be a 3-5 year capital plan for this. Asked how the Committee could be reassured that the redevelopment would happen, Dr Holthof added that they had already invested at the Horton in terms of chemotherapy and dialysis treatments. Following the consultation, OCCG would need to produce a Master Plan for Banbury. The plans would need to be realistic and funded. Timing would depend on obtaining the necessary planning approvals. It was felt that if the plans for the Horton were sufficiently ambitious, for example, they included key worker housing, the local planning authority should look favourably on the planning application.

Maternity services at the Horton

David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group commented that the temporary closure of the obstetric unit had been a result of judgements taken on clinical issues.

When asking about the implications for the maternity service changes the Committee was advised that the MLU was backed by community midwives. Of the 1284 maternity cases last year the great proportion had gone to the John Radcliffe. A significant amount of women went to the alongside MLU at the JR and some give birth at home or went outside the County. In response to a concern that epidurals were not available at the MLU, the Committee was advised that they were available at the alongside unit.

In response to questions about the MLU Chipping Norton Hospital, it was noted that this would be contained in Phase 2 of the consultation.

The Committee asked whether the 24/7 ambulance service stationed at the Horton for maternity transfers would be a permanent service following the consultation. Health representatives advised that it had been provided as part of the emergency closure. They would need to treat it as a pilot, and evaluate the data before making a final decision, which would be part of Phase 2. Committee members commented that it was difficult to support a proposal to permanently remove consultant-led service without knowing whether an ambulance would continue to be based at the Horton to transfer mothers to the JR.

In response to a suggestion that mothers had been denied the opportunity to choose to give birth at the Horton, Dr Berendt explained that he was happy to look at specific instances, but it may have been that it was not appropriate for them to go to the MLU.

Asked about the splitting of consultant-led maternity services and midwife-led services between the two phases of consultation, David Smith indicated that it had been based on the NHS's 4 tests for service reconfiguration. The OCCG's legal advice had been that the inclusion of MLUs in Phase 1 would not meet the public engagement test.

Responding to concerns that the impact of the proposals was not clear to lay people Tony Berendt explained that there were a number of fairly straightforward videos that explained what the changes meant. The Committee thought that more examples of the impact of proposals on individuals and communities could be used in the consultation.

The Committee questioned what modelling had been carried out on the impact of the maternity proposals at the Horton on maternity units in Warwick, Coventry, Northampton and others. Dr Berendt stated that this had been explained to mothers at the time. From Northampton and Warwick approx. 300 mothers were booking into the Horton, mostly because this had been an equivalent service closer to them than their own hospital.

Detailing how things had changed since 2008 Dr Berendt commented that there had been a loss of recognition for training in obstetrics at the Horton due the low volumes of births there. In 2011 there had been a lot of effort put in to ensure that it was possible to station people there on the basis of the training experience. A scheme was in place that had withered over time as the national workforce picture deteriorated. It was not true that the numbers of births there had been consciously down sized. In order to keep mothers safe, mothers with a higher risk pregnancy were recommended to give birth in Oxford.

Asked how secure they were in assessing a mother as low risk and therefore suitable to be seen at the MLU, the Committee was advised that risk was assessed throughout the pregnancy. It was not possible to ever say there was no risk. On average about half were low risk, a fifth high risk, with the remaining mothers a block in the middle where it was not known. Pregnancies were continually assessed. There would always be some in the low risk category that ended up being high risk. The key was how they were assessed when they went into labour. The thresholds for transfer to an obstetric unit were lower for those further away. In response to a question about transfers, the Committee was advised that there had been 73 deliveries to the end of February, of which 15 were transferred by ambulance and of those 4 had already given birth. Transfers were in line with national data. Transfers from Wallingford were also consistent with national data.

Responding to concerns about the lack of patient choice over maternity provision Tony Berendt stated that the service was configured against NICE guidance, but one solution did not fit all.

Asked what other Units around the country were doing, the Committee learned that there was a challenge nationwide. They heard that the maternity services at Redditch hospital had been closed for a year, and two others were discussing a merger.

Acute Stroke Services

Asked to clarify the relationship between the new rehabilitation wards and the Oxford Centre for Enablement, the Committee was advised that Reading did provide some acute stroke services, therefore there was a choice.

Care in the Community

In response to a question about care in the community provision Dr Holthof stated that they had been talking with other agencies to try and ensure there was capacity. There was visibility in the Discharge Liaison Hub about the numbers of beds and hours in the community for packages of care. There was HART and the ability to commission extra care home beds and extra resources for care in the community.

In response to questions about the balance of spending on care, Dr McManners explained that work was ongoing. Partners were working together to move funding from acute beds into support in the community. He added that there was still a gap and it needed all partners to be honest about what was needed and then to look at how that might be funded. David Smith highlighted the pooled budget and the need to engage around the health and social care interface. Responding to comments that

despite closing 146 beds the delayed transfer of care position was no better, Dr Berendt stated that without the action taken we would have seen a continuing and relentless rise in the numbers involved.

Responding to comments about Phase 2 David Smith suggested that there needed to be a joint piece of work with the County Council and engagement with the District Councils.

Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust and Chairman of the Transformation Board refuted concerns as expressed in the Cabinet report and comments that the impact of the proposals on Council services could not be modelled. He cited evidence of the impact from the temporary closure of acute beds in the 'Rebalancing the System' pilot. Jonathan McWilliam, Director of Public Health, commented that the report from County Council Cabinet considered the impact on their services serving the community. They were concerned about building a picture of the totality of services and without knowing the changes in Phase 2 it was hard to gauge the impact on those community based services. He agreed that all partners worked together to improve services. The response was about the strengths and weaknesses of this consultation.

District Councillor Ian Corkin commented that there was much to be positive about in the consultation and he appreciated the challenges being faced. However he believed that residents were being disadvantaged by the split consultation process, as it failed to address the interdependencies between health and social care. He suggested that the Committee should be asking OCCG to go away and come back with a proposal that rectifies that problem.

Councillor Constance referred to the areas of concern summarised by herself earlier in the meeting and added to during the afternoon session.

The Chairman then referred to the suggestion from Councillor Corkin and proposed that an appropriate response may be to adjourn at this stage for the issues discussed to be considered by the OCCG. Councillor Corkin reiterated his view that there were significant flaws in the process that disadvantaged residents in Cherwell and unless these issues were properly addressed the matter should be referred to the Secretary of State.

Nick Graham, Director of Law & Governance, advised that an adjournment would give an opportunity for the Committee to formally respond to the consultation, clarifying its concerns, and to give OCCG an opportunity to respond. If there was still dissatisfaction it would be open to the Committee to refer the matter at that point. There was some discussion about when the Committee could meet again and Nick Graham advised that it would be preferable to meet outside the purdah period. For clarity David Smith outlined the process following the end of consultation on 9 April.

The Chairman concluded that there was agreement for a special meeting of the Health Overview & Scrutiny Committee with OCCG once they had received the concerns of this meeting and the OCCG had an opportunity to respond.

JHO3