OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Tuesday, 16 January 2024 commencing at 10.00 am and finishing at 14:00

Present:

Voting Members:

Councillor Jane Hanna OBE – in the Chair

District Councillor Elizabeth Poskitt (Deputy Chair)
Councillor Nigel Champken-Woods
Councillor Jenny Hannaby
Councillor Nick Leverton
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
Councillor Lesley McLean
Barbara Shaw

Officers:

Dan Leveson- BOB ICB Place Director, Oxfordshire
Lucy Fenton - Transformation Lead – Primary, Community & Dental Care Oxford Heath NHS Foundation Trust.
Susannah Butt - Transformation Director- Primary, Community and Dental Care.
Dr Ben Riley - Executive Managing Director- Primary, Community and Dental Care at Oxford Health NHS Foundation Trust.
Catherine Mountford- BOB ICB Director of Governance.
Kerry Rodgers- Director of Corporate Affairs at Oxford Health NHS Foundation Trust.
Karen Fuller- Corporate Director of Adult Social Care.
Ian Bottomley, Lead Commissioner – Age Well.
Pippa Corner- Deputy Director – Joint Commissioning; Health, Education and Social Care.

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/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

1/23 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

None were received.

2/23 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Cllr Hanna declared her interest as working for the health charity SUDEP Action.

Cllr Haywood declared his interest in working for the NHS.

3/23 MINUTES

(Agenda No. 3)

The minutes of the committee's meeting on 23 November 2023 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record.

4/23 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chair invited the registered speakers to address the Committee.

1. Statement by Cllr Stefan Gawrysiak

Cllr Gawrysiak urged the Committee to ensure that the topic of Short Stay Hub Beds in Henley was not lost, and that strong answers needed to be provided to these questions. Accountability was imperative given the lack of consultation regarding this matter.

Cllr Gawrysiak made the following points:

1. In 2016 the Henley Step Down beds were NHS beds to relieve pressure on the Royal Berks. These were provided by the Oxfordshire Clinical Commissioning Group (OCCG) and were designated as permanent beds replacing the Peppard Ward Beds. The reference for this would be David Smith OCCG and John Howell MP.

2. In 2021 they were still permanent NHS Beds because a consultation was had by Kate Teroni (OCCG Chief Executive) to remove the 4 RACU beds.

3. Why had these permanent NHS Chiltern Court Beds been removed without consultation with GP's, patient Groups, RBH, Henley Town Council, Townlands Steering Group, and himself as County Councillor?

4. If their status had changed from being NHS beds, then it needed to be clarified when this change occurred as well as what consultation took place; including Minutes and Agendas?

5. These beds had been reduced from 125 to 63 and shortly to 40. Why had this process occurred without consultation and without having a geographical element?

6. Why was it that South Oxfordshire, Thame, Henley, Wallingford, had no beds at all?

8. How could it be right to place a vulnerable elderly patient in Banbury some 45 Miles away? Was it expected for elderly family members to catch a bus to see their loved ones?

9. Cllr Gawrysiak asked for the evidence that the reduction of these beds had been through the proper due process.

Cllr Gawrysiak emphasised that how could it be right to have a policy that stated that SSHB provision could or should not be predicated on some form of Geography, such that it left South Oxfordshire with no beds. Cllr Gawrysiak questioned as to how it was right to provide beds in Banbury, Chipping Norton, Oxford and Abingdon and not Henley/Thame/Wallingford/South Oxfordshire.

2. Statement by Janet Waters:

Janet explained that she was chair of the Bell Surgery PPG, and that she also represented the PPGs from the HenleySonNet PCN representing Bell, Hart, Sonning Common and Nettlebed Surgeries. Janet outlined that she was well aware of the history of the provision of Short Stay Hub Beds (SSHBs), having been a member of the Townlands Stakeholder Reference Group which gathered data and information concerning the use of the original 11 beds allocated to the Chiltern Court Care Home.

Janet stated that as representatives of patients in this PCN area, they objected to the closure of the 7 SSHBs provided in Chiltern Court Henley. There had been no communication or consultation before the final decision was taken. They were presented with a final decision that would impact patients in South Oxfordshire adversely. There may had been no legal requirement to consult; however, the lack of engagement and communication led them to have a negative view of the ICB and its provision of services. The target to reduce SSHBs by 50% in Oxfordshire was inequitable, as it left South Oxfordshire with no provision at all.

Janet stated that she was aware of the national targets regarding patients being discharged from acute settings to return home. The 95 % national target was not focussed specifically on the frail and elderly and meeting their medical and care needs. Care at home was indeed best, but only when the facilities were in place and if patients could cope in this setting. Driving decisions around the SSHBs to meet a

national target was unacceptable to the local population that were benefiting from the supporting step between hospital and home or another setting.

It was understood that the target of 24-48 hours discharges from RBH or OUH was not being met. There was a problem with discharge and the provision of care at home. There had been a pilot, however, the evidence of success had not been made known and patients who were frail and elderly could not be at home for 3 days prior to assessment of their needs. However, Janet explained that from first hand experience, it took 3 weeks and 5 phone calls to get a coordinator to visit her 97-year-old mother at home after discharge from RBH after a hip operation last April. Janet was informed by the Home First team that they could not meet the targets due to staffing issues and there were too many demands on their services. The additional care hours that were provided was welcomed. However, there was no evidence that the removal of the SSHBs was safe and that it did not disadvantage patients.

The GPs supporting patients at Chiltern Court advised that there was a high occupancy in those beds and that there was a requirement for such a facility.

Other initiatives such as Hospital at Home were welcomed. However, these new services did not replace the need for patients to leave acute settings as soon as possible and be helped to take the next step in their recovery through a SSHB for a few weeks if required. This arrangement was still in place in other ICB areas and offered comfort, support and recovery to the patient and their family and friends. Why was Oxfordshire removing this important facility from so many in South Oxfordshire?

Another issue was the provision of SSHBs procured through 'market factors'. This seemed like cost cutting and the decision to take no account of area led to inequality of provision and unacceptable levels of travel. The travel times by car, train and bus for families, friends and carers to these locations were unacceptable to their PCN area. Why was location not taken into account in the decision? How could these travel times be ignored in the Impact assessments? A two-tier system existed, consisting of those that could afford to pay post-acute discharge into a care facility to get back on their feet and those that cannot pay. Patients were paying £10000 for two weeks care and enablement post hip replacement as there was no one to care for them at home. This is unfair if only those more affluent patients will be afforded this facility.

Janet concluded by asking for a reconsideration of the decision to close the beds and to review the location of future provision. There was a great strength of feeling of injustice in her PCN area as to how their patients would be supported post-acute hospital discharge. No evidence had been seen that the resources and provision will live up to the rhetoric.

3. Statement by Robert Aitken:

Robert Aitken introduced himself as a resident of South Oxfordshire living in Bix & Assendon, and as former Vice Chair of Bix & Assendon Parish Council. He explained that he had a long participation with the Townlands Steering Group, and was a trustee of the League of Friends of Townlands Hospital as well as an Ambulance Service Community Responder for nearly 10 years.

Robert objected to the proposed closure of the SSHBs in Henley and fully supported Councillor Gawrysiack's efforts to have this decision deferred to allow proper consultation. This decision was taken without any communication, let alone consultation, with local interest groups, the community, or even GP surgeries. The existing bed hub had been well used and was valued by local GPs. The argument put forward against consultation was that it was not needed as the beds' contract was with Oxfordshire County Council, so not NHS beds. The beds were a direct replacement for NHS beds in the old Townlands Hospital under an NHS contract; if that was subsequently switched, that too was without communication or consultation; and the beds continued to function as step down NHS beds.

The sole justification appeared to be to fulfil a national target, effectively that no more than 5% of hospital discharges be to bed hubs or equivalent. This was an arbitrary nationwide target, and may or may not had been right as such, but for it to be a prescriptive local requirement irrespective of clinical need was inappropriate.

Furthermore, the implication that a small minority would require a step-down bed was not being respected for this large area of South Oxfordshire, as it would have zero beds. There was no guarantee of space in alternatives which were getting squeezed too. In any event they were not close enough for family participation in the recovery.

Robert understood that the enhanced Care in the Home Service to support this was not fully in place, let alone trialled, when this decision was taken. Since then, Government decisions to increase the minimum wage, resulting in further unfunded pressure on local authorities, and new limits on legal immigration of care workers' families, were likely to put further pressure on the labour-intensive home care system.

Robert asked the Committee to imagine the situation of an elderly person, possibly themself a carer, being discharged from hospital with a spouse unable to care for a rehabilitating partner, or with no-one at home. The idea of servicing this rehabilitating minority only via an uncertain drop-in care service did not bear thinking about.
Failure to get this right would be hugely detrimental to those patients affected and to the functioning of the main hospitals left with further bed blocking pressure.

Robert concluded with the following questions:

- Why had there been no prior consultation, and why the subsequent refusal by NHS representatives to engage except at the most minimal level?
- What evidence was there that this decision, supporting data, and its implications had been fully exposed to and approved by HOSC?

4. Statement by Victoria Wright:

Victoria introduced herself as having worked in the public sector for over 15 years, having also been involved in spending review submissions and strategic planning. Therefore, she was fully aware of the austerity measures for the last 12 years, and the impacts this has had on buying power in terms of number of staff due to salary

increases, and the rising costs of consumables and capital equipment. The NHS had not been immune to this, and the comments she was making were her personal opinions being grounded in the experience working in the public sector. Victoria became a member of the Wantage Town Council Health Committee in May 2023, and had been involved in the co-production exercise around the future of Wantage Community Hospital ever since. Victoria was impressed by the willingness of the Health partners to creatively develop a future for the local healthcare provision. This could not have been easy given the existing constraints, that they had come with ideas in relation to how they could work within the aforementioned constraints.

Throughout the Public Engagement Exercise, a number of stakeholder meetings were held, through which it became clear that there were 4 distinct needs for health services within Wantage:

1. Maternity Provision.
2. Access to local palliative care beds.
3. Access to Urgent Care through a Minor Injuries or First Aid Unit.
4. Access to local outpatient appointment following the success of the Pilot Schemes.

The above options were examined in detail by the NHS as well as by the Sub-Committee, and the NHS outlined that there were constraints around current workforce in specific areas as well as in funding for some options at this particular point in time. For instance, not only were the capital costs for a walk-in X-Ray facility unavailable at this time, but there was also a shortage of radiographers.

It was clear through discussions that both the size of the estate and the capital running cost would prevent all 4 of the aforementioned options happening within the Hospital. Victoria believed that the co-produced report provided a pragmatic and realistic set of recommendations on what could be provided at this point in time to provide the hospital with a sustainable future within the current funding constraints. The NHS had made an effort to ensure that the local community had been engaged in the co-production process thus far, including members of the co-production team standing in the market square to speak to residents; and that they had offered to continue engagements in the coming year. The engagements with Verve Consultants was also a useful addition to this process. At the local public meeting that was held the week prior to the HOSC meeting, residents raised concerns that some options were not being provided for given the growing population in Wantage. This was covered in the motion passed unanimously by the Town Council.

Victoria urged the Committee to consider this motion, and in particular, to consider the part of the report that mentions there would be ongoing considerations to Urgent Care and to a local offer of palliative care. Overall, the co-production exercise was a positive process with good engagement from the NHS. Victoria welcomed firm commitments from the NHS to explore all the recommendations, and expressed that it was not advisable to refer this matter to the Secretary Of State for Health and Social Care at this time, as doing so would add significant delays and lead to a likely loss of CIL (Community Infrastructure Levy) funding, which was the only source of

capital funding at this time. A referral would prevent modernisation and keep the hospital in a temporary and insecure future.

5/23 CHAIR'S UPDATE

(Agenda No. 5)

The Committee Chair outlined the following points to update the Committee on developments since the previous meeting:

1. A report containing recommendations from HOSC had been submitted to Oxfordshire CAMHS.

2. A document containing feedback collated from HOSC on the most recent Health and Wellbeing Strategy Document for Oxfordshire had been shared with Public Health Officers. It was crucial that HOSC had ongoing engagement with any future delivery plans for the Health and Wellbeing Strategy once these were produced.

3. The Chair and Health Scrutiny Officer had met with the SCAS Chief Governance Officer to commission a paper for the February HOSC meeting, on an update on the Ambulance Service's Care Quality Commission (CQC) improvement Journey.

4. The Chair and Health Scrutiny Officer had met with Karen Fuller (Adult Social Care Director) to discuss the reasoning behind the closure of Short Stay Hub Beds in Henley, as well as to understand how this sat in the broader context of providing support to people who left hospital within their own homes.

5. An updated matter that was advised to the Committee in June last year regarding medicines and epilepsy had since been communicated as a central safety alert CAS-ViewAlert (mhra.gov.uk). A letter had been sent by two leading epilepsy charities, Epilepsy Action and SUDEP Action (Oxfordshire based); to the Neurological Alliance who had made this available to national policy makers. Epilepsy Action, SUDEP Action, and Neurological Alliance had requested that this letter be tabled urgently at Oxfordshire JHOSC because of the deadline for ICB action plans in this matter by 31st January; and the likely impacts on Oxfordshire patients, clinicians, and NHS management. A letter was also tabled from Professor Marian Knight (University of Oxford) in support and the Chair stated that she had received serious concerns from Oxfordshire clinicians. A question was raised about concerns of medicine shortages for anti-seizure medications and it was also raised that the medicine is used for mental health as well as for epilepsy.

The Committee **AGREED** to **DELEGATE** this matter to the scrutiny officer and Chair to:

1. Liaise with the ICB with a view to an update regarding the ICB response to the alert and required local action plan to date, and consideration of the suggestion by patient charities that a delay is sought to implementation of this

measure because of the severe pressures in the NHS and until adequate resources could be made available to local systems. This was based on an understanding of the likely impacts and how best to support clinicians, patients, and managers.

2. Write a letter to the Chair of the Parliamentary Health Scrutiny Committee requesting consideration of scrutiny of the latest safety alert given; the proposed timescales for implementation, the lack of a national impact assessment, or the lack of resources to support the new requirements.

6/23 WANTAGE COMMUNITY HOSPITAL UPDATE

(Agenda No. 6)

Daniel Leveson (BOB ICB Place Director, Oxfordshire); Lucy Fenton (Transformation Lead – Primary, Community & Dental Care, Oxford Health NHS Foundation Trust); Susannah Butt (Transformation Director-Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); Dr Ben Riley (Executive Managing Director-Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); had been invited to present the final co-produced report providing details on both the outcomes of the Public Engagement Exercise around Wantage Community Hospital, as well as on the final offer as to which specific services would be provided at the Hospital following the closure of the in-patient beds in 2016.

It was highlighted that the Committee had received a written report from the Health Scrutiny Officer, which provided some context as well as clarity over the process around the decision that the Committee were required to make during this item.

The Committee Chair explained that the members of the Substantial Change Working Group (Cllr Hanna, Cllr Barrow, Cllr Champken-Woods, and Cllr Hayward) had considerations as well as provisional recommendations which were to be shared verbally with the Committee by herself.

The Chair reminded the Committee that 31 January 2024 was the date that formal powers of referral to the Secretary of State by HOSCs were to be removed by the government, and that this had influenced the necessary timing of this extra meeting and the intensity of work; including the public meetings that had been held in the lead up to the HOSC meeting.

The Oxford Health (OH) Executive Director of Primary Care and Community Services explained that the Public Engagement Exercise had represented an intense piece of work over the last 6 months, and it presented a fantastic opportunity to engage with local representatives and members of the stakeholder group to determine a secure future for Wantage Community Hospital. It was explained to the committee that the coproduction with the local stakeholder reference group had shared various different sources of information and types of data available on the health needs of the population (including the Joint Strategic Needs Assessment as well as service data) that supported the findings in the report.

The Committee were informed of the importance of the local community's engagement in the exercise and its stakeholder engagement events, and how the NHS had taken the views of the local community seriously and that these had influenced the recommendations.

The OH Executive Director of Primary Care and community Services also reiterated the three scenarios as to how the hospital's future ground floor services that were presented to the community during the engagement exercise, and explained that there were some key principles that would be used to guide the decision as to the future services. Such principles included a consideration that the community wanted clarity about a secure future for the community Hospital and that it was imperative for there to be sustainability around the future services that would be agreed and delivered.

It was explained to the Committee that the recommendation that was ultimately proposed in the co-produced report was that the closure of the inpatient beds would become permanent, and for the redevelopment of the ground floor of the hospital into a clinic-based facility.

The OH Executive Director of Primary Care and Community Services stated that the Trust would progress an application for Community Infrastructure Levy (CIL) funding to support the refurbishment of the hospital's ground floor, but that the application would only proceed depending on the decisions of HOSC on the report.

The Committee were informed that letters of support had also been obtained from key stakeholders, who were supportive of the recommendations outlined in the co-produced report. These included letters of support from Oxford University Hospitals NHS Foundation Trust as well as Oxfordshire County Council.

The BOB Integrated Care Board (ICB) Place Director for Oxfordshire also expressed thanks to Wantage Town Council and the stakeholders who participated in the Public Engagement Exercise; and explained that upon assuming his post as ICB Director of Place he had heard two things. Firstly, that the community wished to reengage with the NHS; and secondly, that they wished to resolve a secure future for Wantage Community Hospital. The Place Director thanked the Town Council and Stakeholder reference group for engaging in the process which had planned outcomes.

Cllr Hannaby, Chair of the Wantage Town Council Health Committee, was invited by the Chair to read out the motion that was passed unanimously:

"The Council notes that the co-production exercise had determined that:

1. *On average 1361 OX12 residents per year currently access the Minor Injuries Units elsewhere in the County – predominantly in Abingdon. It's estimated that this will grow to 1745 visits per year with the forecast population growth.*
2. *Approximately 60 OX12 residents through the year are placed in In-patient Community Hospital beds elsewhere in the County (5 per month with a 34 day average stay). This number is not expected to grow due to the changes in alternative health and care pathways.*

3. *Currently, 1445 OX12 residents per year have used the ophthalmology outpatient appointments pilot at Wantage Community Hospital. The ICB have indicated that approximately 21,168 OX12 residents per year would benefit from expanded outpatient services if additional clinic space was made available (30,240 visits in total).*
4. *Within the hospital building there is insufficient space to provide more than one of the options of inpatient beds or expanded outpatient clinic offering.*
5. *The capital cost of providing a MIU in Wantage would be in excess of £3 million given the need for it to include comprehensive X Ray facilities to be fully viable.*

Given the above the Council is minded to support the recommendations of the co-produced report. Namely the permanent retention of existing outpatient pilot clinics and additional outpatient services which would be facilitated by accessing approximately £600,000 of CIL funding to carry out necessary refurbishments and other capital expenditure.

In agreeing to the above the Council also:

1. *Welcomes the commitment by the ICB to bring forward plans to source palliative care beds in the local community but also will continue, through discussions with Health partners including OCC Social Services, to seek ways by which early discharge and inpatient rehabilitation can be provided locally – for example within local nursing home settings.*
2. *Appreciates the engagement with health partners so far and wishes to continue this to identify means by which services provided by a Minor Injuries Unit or First Aid Unit could be sourced locally. For example, we note that GP led Urgent Treatment Centres are provided in some communities and would, inter alia, wish to explore if this is a facility that could be provided at Mably Way."*

Cllr Hannaby added her own observation that she hoped that in the future there could be local availability of national capital funds for much needed local health resource. However, Cllr Hannaby emphasised that Wantage Community Hospital needed to have a permanent future as local councillors had been active in pressing for this as far back as 2006 when plans for the closure were made public. The plan, funded by CIL capital and existing revenue, would give the hospital this security and additional much needed hospital services. Working on the plan would mean continued trust in the NHS and a leap of faith, but she welcomed co-production and thanked the BOB ICB Director of Place for his offer to meet with the public again in June to share progress.

The NHS were asked for their response to the Wantage Town Council motion, and the BOB ICB Director of Place welcomed the motion and thanked the Town Council and the stakeholder reference group. The Place Director explained that the NHS would clarify that the 3 million costing for a walk-in Xray is for capital and revenue costs and that the palliative care commitment was to continue to work with stakeholders so that Wantage would be included as a local area for additional services.

The HOSC Substantial Change Working Group welcomed the good understanding that had been achieved and that once delivered, the plan would give Wantage Community Hospital a sustainable future and would provide a growing population with a foundation of increased hospital services for the community for the next few years, and that this could be built on as and when the context of financial, estate, and workforce constraints improved.

The Chair highlighted that the Substantial Change Working Group had considered the co-produced report, and through scrutiny of the NHS engagement with the community and in agreeing to the recommendation NOT to refer this matter to the Secretary of State for Health and Social Care, had taken the following key points into consideration:

1. There was evidence of an intensive and good engagement process over six months: The Working Group considered that this had been a much improved experience for the stakeholder reference group and Wantage Town Council Health Committee. The HOSC Working Group and officer worked intensively since the February HOSC meeting through to now with direct scrutiny and weekly engagement. The Working Group expressed thanks to the NHS partners, the Wantage Town Council Health Committee, and the stakeholder reference group which included the previously worked with community on the OX12 who had been involved throughout. The wider Committee also thanked the public who participated in public meetings as well as the survey.

2. The Working Group noted that the report presented included a time-tabled plan to modernise the hospital, confirm temporary specialist clinics, and to open new hospital services. This differed from the experience of the community and HOSC of the OX12 project which, after a lengthy process, resulted in a report in January 2020 that recommended the hospital inpatient beds, subject to further work to confirm, should permanently close without any proposed plan for improved hospital services or a timetable.

3. The NHS had also agreed to both the size of the population currently at 33,179 rising to 41,000 by 2030, as well as the history of the community hospital with the stakeholder reference group with the assistance of HOSC research. The NHS offer contained in the report, once delivered, would provide expanded community-based specialist clinic provision at a time of growing need and integration across the NHS to better join up as well as increase provision.

4. The likely loss of the benefit to Wantage Community Hospital and the area's residents of CIL (Community Infrastructure Levy held for NHS health improvements in the Vale of White Horse) funding for the refurbishment of the hospital, and the likely loss of benefit of securing the future of the hospital for hospital specialist services was also taken into account. The Committee had heard from clinicians who had led the existing temporary hospital clinics that they wanted their clinic to be

confirmed rather than being temporary in nature. The Working Group (and wider Committee) also heard from the public, who did not wish to lose the ophthalmology and other temporary clinics at the hospital.

5. The stakeholder group had agreed that the plan proposed had to be sustainable to avoid the loss of services. Working up a plan had to take account of the enablers and constraints, as this would be crucial for sustainability of the plan as well as hospital-like services more broadly. The key enablers and constraints were shared with a Stakeholder reference group workshop and meetings, and were also subsequently shared with the public. These included:

    (i) Constraints of the estate available for hospital services in the community. Additional space had been a matter of liaison by the NHS with regard to whether estate was available at Mably Way Primary Care Network, although there was no available space at this time.

    (ii) The national context regarding capital available for local infrastructure improvements meant that the only funding available were CIL funds held for health at the Vale of the White Horse. This was the funding available if made a priority by the NHS. This would happen if the HOSC supported the proposed recommendations in the co-produced report, with ongoing local scrutiny. A referral to the Secretary of State would have resulted in a delay to this funding.

    (iii) There were also constraints related to workforce. Dr Ben Riley had explained to the public that there were serious shortages of workforce in some areas such as radiography for X-ray services. However, other areas of the workforce were well provided for such as community nursing.

6. The Working Group were pleased to see the letters of support and assurances that were provided with the co-produced report. It was reassuring to see the expressions of support for the proposed recommendations in the co-produced report from both Oxford University Hospitals NHS Foundation Trust as well as Oxfordshire County Council.

7. The Working Group were pleased to see that there was a commitment to ongoing co-production with the community as part of the project delivery plan for reconfiguring the services to be provided on the ground floor of the hospital and wider integration. It was also positive to see that the offer was being made to meet with the public to report progress against the project in June.

The Committee were informed that 2022 marked the reopening of live births following OUH and HOSC liaison and the Wantage Stakeholder reference group; and the NHS had decided it would not be of interest to reopen this discussion as this service was confirmed. Options for the use of the ground floor were tested in respect of an inpatient hospital unit or repurposing the clinical space for a mix of specialist outpatient clinics with a mixture of preventative and urgent care. A data pack as well as the outcome of public engagement had been shared with the stakeholder reference group at a workshop on the 4 December 2023. Oxford Health would prioritise confirming the temporary clinics with Oxford University Hospitals and would close the beds permanently so that the exact mix of additional specialist clinics could be worked up.

In terms of alternatives to in-patient beds, it was welcomed that the report recognised that the contributions from lived experience of being sent home from hospital were mixed and that improvements to the service had been introduced in December, and there was a commitment to learn from the contributions of the Wantage public through the Wantage public engagement exercise.

In terms of how and when CIL funding would be secured, the BOB ICB Director of Place reported that there had been communication with the CEO of the Vale District Council already. It was also the Substantial Change Working Group's understanding that provisional holdings of CIL funding with an estimate of the finance required could be made easily pending any formal application for funds. It was clarified that it would be Oxford Health NHS Foundation Trust that would make formal decisions concerning the hospital and make the application with system support for the funding. The committee was strongly of the view that a provisional holding of £600,000 be made by the NHS as soon as possible after the meeting.

In response to a query from the Committee regarding the assurances that Oxford University Hospitals could provide, the Trust's Director of Strategy and Partnerships gave assurance that she had attended the Wantage Community Hospital workshops. The Trust had a proven track-record of bringing out specialist clinics to Wantage Community Hospital. Hospital specialists liked coming to Wantage Community Hospital and the provision of additional clinics in community settings was very much part of the OUH strategy. The Director confirmed the commitment of existing clinical leads for their existing clinics as well as for working with partners to match the needs of the community with what additional hospital services OUH could deliver.

Moreover, the Committee also sought reassurances as to the liaison with Wantage Primary Care Network (PCN) for the proposed recommendations in the co-produced report. Oxford Health reported that liaison with the Primary Care Network with Dr Brammell had been effective. Dr Brammell had attended workshops also. There was a timings issue regarding receiving a communication from the PCN as the lead for the project was on maternity leave. Oxford Health had liaised with Dr Elaine Barber, the new clinical lead to ensure that the clinical lead received the report. Oxford Health were confident the PCN would be supportive of the plans, and that Dr Barber specified that she would have expected that if there were any concerns at all, that these would have been communicated.

It was emphasised by the Committee that ongoing scrutiny was essential going forward on both the process as well as the outcomes around the key stages outlined in the proposed project delivery plan. The assurance of coproduction was important

as the exact outcomes would depend on each additional service and could include research as well as performance outcomes for the population.

The Committee **AGREED** to the following recommendation made by the HOSC Substantial Change Working Group:

1. That the matter of the closure of inpatient beds at Wantage Community Hospital is NOT referred to the Secretary of State for Health and Social Care.

The Committee also **AGREED** to issue the following recommendations to the NHS:

1. That there is no undue delay in securing the CIL funding available in full for the purposes of providing the additional proposed clinical services on the ground floor of Wantage Community Hospital given the removal of the in-patient beds since 2016. It is recommended that there is a maximisation of the ground floor of the hospital for the purposes of expanding these specialist services.

2. That the Project Delivery Plan for the future of the hospital's ground floor services is delivered on schedule as much as possible, and that there is ongoing scrutiny over the process of delivering the plan and its outcomes for the local population.

3. For a meeting to be convened as early as possible between identified leads within BOB ICB, Wantage PCN, Oxford University Hospitals, Oxford Health, Oxfordshire County Council, Wantage Town Council, and HOSC; with a view to plan for continued momentum on co-production and agreed scrutiny moving forward.

7/23 SUPPORT FOR PEOPLE LEAVING HOSPITAL; AN UPDATE ON THE OXFORDSHIRE WAY

(Agenda No. 7)

Karen Fuller (Director, Adult Social Care) and Ian Bottomley (Lead Commissioner, Age Well); have been invited to present a report on the Oxfordshire Way and the support provided to people leaving hospital.

The Chair highlighted that the purpose of this item was to receive an update on the support for people leaving Hospital and the Oxfordshire Way. It was emphasised that upon commissioning the paper for this item, the Committee sought an outline as to the kind of support that residents could receive upon being discharged from hospital, and to look at this in the context of the Discharge to Assess (D2A) Process and the Oxfordshire Way.

The Chair also specified that key attention should be placed on the rationale behind prioritising care at home, and any National Directives and Nationally set Targets around this; and that it was also important for the Committee to understand how effectively the D2A process was working, and how it met people's healthcare needs.

The Lead Commissioner for Age-Well informed the Committee that Oxfordshire was on a journey to improve how the system helped people leaving hospital. Oxfordshire

needed to ensure that 95% of people leaving hospital returned to their usual place of residence. Oxfordshire was focused on getting people home and had rolled out a Home First D2A to achieve this. It was more possible to move to this approach due to operational and commissioning improvements that had been made, and the Home First D2A was better for Oxfordshire's residents.

The Committee were informed that Oxfordshire also utilised short-term bed options each winter to increase flow out of hospital and to keep A&E moving, leading to the short stay hub model. Short-term beds created a further step in the onward journey, and they needed social work, therapy and medical cover to each bed. Most of the people in those beds eventually went home (over 70% of people in short stay hub beds). Oxfordshire was required to get 95% of people directly home from hospital; however the current achievement was 91-92%. There had been an improvement to the flow home through reablement, where 78% of people were now discharged without requiring any further care. In order to get to the 95% target, there was a need to support 15-20 people from bed-based to home-based pathways. The learning from the discharge to assess pilots indicates that only 33% of people waiting in beds for long-term care actually required that care. Getting people home first was therefore in line with national policy; the right thing to do for residents in line with the Oxfordshire Way; and was now possible because of changes that had been made in the Oxfordshire system.

The Committee were also informed about the Transfer of Care Hub in the hospital; which allocated patients to the appropriate discharge pathway, anticipated and pre-empted any barriers to discharge, and promoted a discharge to assess approach.
In regards to the Home First D2A model, there had been extended reablement through national Additional Discharge Funding to extend the reablement model to include:

1. Short-term live-in reablement care and/or
2. Short-term waking nights to support reablement
3. Discharge to assess pick-ups

It was also explained to the Committee that there had been increases in capacity to enable people to be supported at home including:

1. Short-term additional support from local providers to deliver the Home First D2A model funded from Additional Discharge Funding.

2. Increases in care hours delivered at home under the Live Well at Home framework from 27,888 to 31,095 per week from December 2022 to December 2023, an increase of 7.65%.

Additionally, the Director of Adult Social Care outlined a resident's story which demonstrated the impact of Home First D2A. The experiences of the resident (Beth) with the D2A process had been indicative of the effectiveness of this model. It was explained that through adequate support, Beth was able to make a recovery in just 19 days and had fully regained her independent lifestyle. The Director of Adult Social Care also reiterated that it was important that the support for people leaving hospital is looked at as a system. Historically, Oxfordshire had not performed well with

regards to Delayed Transfer of Care, and therefore, something had to be done differently. Oxfordshire was, in comparison to other areas, ahead of the curve in terms of the Transfer of Care Hub. The Adult Social Care Director emphasised that the Transfer of Care Hub was genuinely a multidisciplinary team, with input from Adult Social Care also.

The BOB ICB Place Director added that Oxfordshire was working well as a system, and that the NHS and the local authority should be congratulated for this. There was a commitment to continue to work toward building the Partnership between the NHS and the County Council, as well as to support people to live well independently in their homes.

In response to a query from the Committee regarding the level of public or stakeholder engagement around prioritising support for people in their homes and the decisions made in this context, the BOB ICB Place Director explained that the engagement could have been better, and that lessons will be learned from the public engagements undertaken in Wantage as part of determining the future of Wantage Community Hospital. The Director of Place outlined that the system needed to find ways of communicating with the public and stakeholders regarding some of the ensuing changes as well as some of the positive developments and activities undertaken by the system; including around the Transfer of Care team, the D2A, the Urgent Community Response, the Virtual Wards, and the Hospital at Home. All of the improvements in these aforementioned areas were enabling the system to provide better support for people in their own homes and giving people the independence that they want.

The Committee asked the following three questions in relation to the withdrawal of Short Stay Hub Beds (SSHBs) in Henley:

1. Who was responsible for commissioning these beds?
2. What engagement had there been around the withdrawal of these beds, and when specifically did any engagements occur?
3. What would the potential consequences be of delaying the closure of these beds?

The Director of Adult Social Care responded that the County Council had commissioned these beds on behalf of the system. SSHBs were initially put in place in Oxfordshire at a time when the system did not have the capacity to enable flow. It was emphasised to the Committee that these were not statutorily required beds, and were established at a point in time to help with system flow. These beds had previously been flexed, particularly during the winter months when demand for these beds may had been higher. Another important consideration was how the Oxfordshire Pound was maximised to ensure that people received the best benefits. Therefore, the system would flex beds up and down as required. The Director of Adult Social Care also explained that 17 SSHBs were already closed in the North of the County, and that the flexing of SSHBs was an indication of business as usual. The Committee were informed that initially, the hub beds were commissioned by Oxford University Hospitals NHS Foundation Trust, and that this had destabilised the market. It was decided that the County Council was the best place for these beds to be commissioned as it had the best relationship with the market.

It was also reiterated to the Committee that considerations of how to best maximise the use of the Oxfordshire pound was a factor in determining the closure of the SSHBs in Henley, which had cost £11000 a week in totality to remain in place. However, the Adult Social Care Director emphasised that the withdrawal of the beds was not driven purely by financial considerations, but was also a crucial element of supporting people at home and helping them to regain independence.

The Director of Adult Social Care also explained that it is difficult to determine what people need when they were in a hospital bed. Therefore, if people were enabled to go home with the necessary wraparound care, including with Occupational Therapy, Social Workers, as well as Urgent Care at home, this would also make decisions regarding people's long-term care needs much more effective.

The Committee urged for there to be more effective communication with the public and key stakeholders around the broader context in which the withdrawal of SSHBs were taking place. This would allow for both a greater understanding as to why such withdrawals were occurring as well as a reassurance to residents as to the alternative services that would be provided to them in the absence of these beds.

The Committee enquired as to whether there was adequate support for people being discharged from hospital whilst they were at home within the 72 hours? It was queried as to who the assessor would be upon arriving home from hospital, and as to how soon after arriving home would the assessment take place. The Deputy Director of Adult Social Care responded that the Transfer of Care Hub, which operated in the hospital, would review all the referrals that came in when a patient was ready for discharge. As part of this process, a multidisciplinary team in the Hub would determine whether there were concerns with a patient's home environment. If any concerns were identified, such as equipment needing to be provided or furniture needing to be moved, efforts would be made to put things in place in preparation for the patient's return home. However, in circumstances when concerns had been identified subsequent to a patient already being discharged and arriving home, social care teams (including Occupational Therapy, social workers, and coordinators), were able to respond very rapidly to resolve the concerns or to ensure same day equipment was provided. In cases where patients already had a relative at home who was able to help support them upon arrival, a mutual agreement may be made that the patient is discharged initially but that the domiciliary provider would arrive as soon as possible to set up the care and understand what was required.

The Committee referred to how the report referred to the importance of getting people discharged and assessed at home wherever possible, and enquired as to the extent to which the suitability of a patients home was taken into account prior to discharge. The Director of Adult Social Care explained that there may also be requirements for shower or bathroom adaptations, but that was not a significant risk in the short term, as support could be provided for discharged people to wash alternatively pending the completion of the adaptation work for instance.

The Committee emphasised that some patients who were discharged may require ongoing support in taking their medications appropriately, and queried as to whether this was being taken into account, and the measures that would be taken to provide

support in this regard. It was responded that support for patients and their medications is undertaken as part of the original setup with the domiciliary provider, who are certainly experienced in being able to support people with their medication needs. The Home First team was also looking at a range of technologies that could support with medication reminders and in helping people to be able to take charge of their own recovery journey and their ongoing needs when it was appropriate to do so. However, for individuals who had a broader package of care, support with medication was incorporated into their ongoing care plan.

The Committee referred to the live well at home providers, and enquired as to how many organisations were being worked with that provided this care, how flexible they were, and whether there was an appropriate level of workforce in this area. The Lead Commissioner for Age Well responded that there was a need for flexibility in their teams, and that things were improving in that regard. A lot of work was undertaken with the providers, and that providers had been expected to be much more sophisticated in their ability to recycle the right staff. Providers had also been encouraged to think about how they organise the right people to the right space so that they could work 7 days a week. There had also been an advantage from the additional discharge funding, which had been used to fund some short-term arrangements with other providers.

The Committee enquired as to whether a hierarchy existed for the purposes of monitoring providers, particularly if something were to go wrong in the services that were supposed to be provided. It was also queried as to whether there was a clear and accessible complaints process for discharged patients to be able to access if they were not satisfied with the services they were receiving. The Deputy Director of Adult Social Care explained that it was crucial to take into account that all the relevant teams were working across the board providing many care hours every week. All providers worked to a quality assurance framework that ensured that mechanisms were in place to escalate with health professionals if there were any concerns. Having multiple teams working collaboratively provided the advantage of identifying any issues or challenges with a discharged patient early on. Work was also undertaken with providers to look at incidents and to determine whether the right escalations were made at the right time and whether the right health professional was contacted. It was also highlighted to the Committee that the Adult Social Care team were not medical professionals, although they were competent in being able to recognise the changes in an individual's circumstances and in being able to send up the signal to relevant providers who will help them to resolve such issues. There were adult social care link workers working alongside domiciliary providers, and therefore there were a number of individuals who had eyes on a discharged person, and they could make escalations as appropriate.

The Committee queried as to whether patients who were being discharged were provided with written information or a leaflet with details on the services they would receive, and whether this included information on who to contact if they had any concerns. It was explained to the Committee that a Home First leaflet was being updated, and that there was a leaflet in development which covered all the discharge pathways and was going to be ready imminently.

The Committee enquired that given the system's commitment to ongoing learning and evaluation, would there be considerations to take into account the outcomes and feedback of the recent Public Engagement Exercise held in Wantage around the

future of the Wantage Community Hospital. The ICB Director of Place responded that the Wantage engagement exercise was discussed at the ICB's executive management committee, and the case of Wantage was being utilised across the BOB footprint as an example.

The Committee enquired as to how effective the communication and coordination was between the NHS and Care Providers. It was explained to the Committee that system meetings were held daily, where points of escalation or concern are raised. Therefore, there were daily escalations within the system that were being heard and addressed.

The Committee queried that despite the positive factor of most people having a preference for being at home as opposed to in a bed, were there any potentially negative consequences if Oxfordshire was not meeting nationally set discharge targets, such as reductions in funding, and whether this might have been a vital context for the closure of beds. It was responded that the system had to demonstrate how effectively the money had been invested to make a difference to the residents of Oxfordshire. The case for having additional discharge funding was dependent on meeting discharge targets, and it would be difficult for Oxfordshire to argue the need for further funding if such targets were not being met. In response to a query by the Chair as to how this would influence the public or stakeholder engagements that took place, the BOB ICB Director of Place explained that at times decisions had to be made in an agile a manner as possible and that some of the system's capacity had to be flexed in some occasions. The Director of Place also specified that the system needed to find ways to have conversations with communities in regards to some of the changes that the system would need to make. But this would require bandwidth, capacity, and immense time and effort on the part of senior officers to be able to reach out and talk to all communities.

The Committee queried whether there were any indications to suggest that the use of D2A had actually resulted in an improvement of hospital flow within Oxfordshire. It was outlined to the Committee that the D2A process was slowing the growth in the demand for hospital services, and was also reducing delays to discharging.

The Committee enquired as to whether there was a consistent criteria that was utilised to determine which patients would be more suited to the D2A process. The Deputy Director of Adult Social Care responded that the Transfer of Care team were charged with looking at the initial referrals and making a pathway decision. The system was working hard collectively to make such discussions around a patient's discharging arrangements as robust as possible. People working in the Transfer of Care team had access to a whole range of health and social care systems to help understand what was most appropriate for each patient.

Related to the above point, the Committee also enquired as to what would occur in the event of a patient refusing to leave hospital due to concerns regarding the care they will receive upon being discharged. The Director of Adult Social Care explained that there were processes around how to deal with such circumstances in the rare occasions when they do arise, and that there were also choice protocols across all hospitals in Oxfordshire. In such circumstances, patients would also be advised on what the consequences of them remaining in hospital may be on other patients who may urgently require hospital admission.

The Committee queried as to how long the system had tracked outcomes for people discharged home, and how long subsequent trips to hospital were observed. It was responded that the system worked collectively to track individuals who have had made frequent subsequent trips to hospital. Data was also looked at by the system to monitor if a particular individual has had regular trips to hospital subsequent to being discharged, and decisions could be made as to how to provide an alternative service to such individuals that may be more suited to their needs.

The Committee emphasised that there were existing pressures within primary care, and queried how well-resourced neighbourhood teams were in the context of such pressures, and whether there was further funding for these teams or if it was a case of joining up existing provision. The BOB ICB Director of Place specified that there was some funding that was secured for integrated neighbourhood teams. However, part of this would also include utilising resources that had already existed in the system, as well as attempts to secure further avenues of funding.

The Committee **AGREED** to issue the following recommendations:

1. That a process of learning and evaluation is reviewed and developed. It is recommended that input from Healthwatch Oxfordshire and service users is also enabled inasmuch as possible so as to improve the process of learning and evaluation.

2. For the establishment of clear KPIs for the purposes of measuring the performance of services delivered under Discharge to Assess and the Oxfordshire Way. It is recommended that there is clear transparency around this, alongside the inclusion of lived experience (including the learnings from the data in the Wantage area co-production work) and the evaluation of long-term outcomes.

3. For communications and regular public engagement to be adopted so as to provide reassurances to the public as to the quality of the services they could expect to receive upon being discharged from hospital; and for any additional feedback from the public or stakeholders to be heard.

4. For patients to be clearly communicated with in relation to the services they will receive upon being discharged from hospital. It is also recommended that leaflets for patients include an outline of the complaints processes in place.

5. To ensure that staff who provide support for discharged patients at home receive adequate and ongoing training.

6. To ensure that integrated neighbourhood teams are sufficiently resourced and geographically spread in as appropriate a way possible so as to meet demand across both rural and urban areas. It is recommended that any available resources are maximised to meet demand for support at home.

It was also **AGREED** that site visits would be arranged to provide the Committee with insights into how the Discharge-to-Assess process functioned in practice.

8/23 RESPONSE TO HOSC RECOMMENDATIONS
(Agenda No. 8)

The Chair outlined that the Committee had received acceptances and responses to each of the 4 Recommendations made by the Committee during its item on Winter Planning in its meeting on 21 September 2023.

The Committee **NOTED** the responses.

9/23 FORWARD WORK PLAN
(Agenda No. 9)

The Chair and Health Scrutiny Officer provided a brief outline of the items to be held in the remainder of the Committee's meetings in the 2023-2024 civic year.

The Health Scrutiny Officer informed the Committee that the ICB's Primary Care Strategy would be scrutinised by BOB HOSC, whilst this Committee would examine GP and Dentistry Provision at Place-level within Oxfordshire.

The Committee **AGREED** the proposed work programme for the upcoming meetings throughout the remainder of the 2023/24 civic year.

10/23 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 10)

The Committee **NOTED** the progress made against agreed actions and recommendations.

..... in the Chair

Date of signing .....

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