Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 6 April 2017 at 10.00 am

Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman - Councillor Yvonne Constance OBE
Deputy Chairman - District Councillor Nigel Champken-Woods

Councillors:	Kevin Bulmer	Arash Fatemian	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Jane Doughty	Andrew McHugh	
	Monica Lovatt	Susanna Pressel	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *22 June 2017*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?
We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Yvonne Constance OBE Email: *yvonne.constance@oxfordshire.gov.uk*
Policy & Performance Officer	-	*Katie Read Tel: 07584 909530* *Email: Katie.read@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
Chief Executive

March 2017

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 2 February 2017 and the special meeting held on 7 March 2017 (**JHO3**) (***to follow)*** and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 19 - 20)

10:10

A draft Forward Plan is attached at **JHO5** for consideration.

6. Healthwatch Oxfordshire - Update (Pages 21 - 26)

10:15

Eddie Duller, OBE, Chairman of Healthwatch Oxfordshire (HWO) and Rosalind Pearce, Executive Director, will update the Committee on the activities of HWO since the last meeting and provide information on key messages from the public in relation to items on the Committee's Forward Plan. The update is attached at **JHO6.**

7. Quality of Care in Care Homes (Pages 27 - 34)

10:30

The Committee will scrutinise the quality and availability of care in care homes **(JHO7).** Representatives from the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council will attend to outline local arrangements for monitoring the quality of care provided and the work undertaken with care homes to ensure appropriate clinical and nursing support is available. A copy of the presentation slides is also attached at **JHO7**.

8. **Townlands Memorial Hospital** (Pages 35 - 40)

11:30

The Committee will scrutinise the development of a new rapid access care unit (RACU) at Townlands Memorial Hospital and review how this is working for patients and healthcare professionals in the area. The update is attached at **JHO8**. Representatives from the Oxford Health Foundation Trust and the Oxfordshire Clinical Commissioning Group will attend.

9. **Quality Accounts** (Pages 41 - 66)

12:00

Healthcare providers have a statutory duty to send their Quality Accounts to the local Health Scrutiny Committee for comment. Representatives from Oxford University Hospitals NHS Foundation Trust (OUH) and the Oxford Health Foundation Trust (OH) will present an overview of progress against their 2016/17 quality priorities and the emerging quality priorities for 2017/18. The reports are attached at **JHO9.**

A letter outlining the quality principles for South Central Ambulance Service in 2017/18 is also attached at **JHO9** for comment; however, no representatives will be present to answer questions.

In light of the timing of this Committee meeting, full quality account reports are not available at the time of the Agenda publication.

The full reports will be circulated separately to Committee members in the coming weeks and further feedback from the Committee will be collated and sent to providers as HOSC's formal comment on the Quality Accounts.

10. **Chairman's Report** (Pages 67 - 86)

12:45

The latest Chairman's report is attached at **JHO10.**

11. **ITEM FOR INFORMATION ONLY**

- The County Council's response to the Big Health & Care Transformation consultation - Phase 1 is attached at **JHO11 (*to follow*).**

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 2 February 2017 commencing at 10.00 am and finishing at 4.05 pm

Present:

Voting Members: Councillor Yvonne Constance OBE – in the Chair

Councillor Kevin Bulmer
Councillor Surinder Dhesi
Councillor Laura Price
Councillor Alison Rooke
Councillor Les Sibley
District Councillor Nigel Champken-Woods (Deputy Chairman)
District Councillor Jane Doughty
District Councillor Monica Lovatt
District Councillor Andrew McHugh
District Councillor Susanna Pressel
Councillor Arash Fatemian (In place of Councillor Tim Hallchurch MBE)

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: Director of Public Health and 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 tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

1/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Arash Fatemian attended in place of Councillor Tim Hallchurch.

2/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

3/17 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 17 November 2016 were approved and signed subject to the following:

- Min. 62/16, line 2 - Declarations of Interest - deletion of the word 'Banbury'
- Min. 68/16, page 11, penultimate paragraph – Oxfordshire Transformation Plan and Sustainability & Transformation Plan for Buckinghamshire, Oxfordshire & Berkshire West – Updates – deletion of the words 'would be' and addition of the word 'would' after 'engagement

4/17 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

The Chairman had agreed to the following speakers. All speakers to speak prior to discussion at the item itself:

Agenda Item 7 – 'Management of Pressures on Urgent Care'

- Ian Davies – Director of Operational Delivery, Cherwell District Council & South Northamptonshire Council
- Councillor Kieron Mallon – Banbury Town Council
- Eddie Reeves, Local Resident, Banbury

Agenda Item 8 – 'The Buckinghamshire, Oxfordshire & Berkshire West Sustainability & Transformation Plan

- Keith Strangwood – Chairman, 'Keep the Horton General'.
- Veronica Treacher – Member of 'Keep our NHS Public'

Agenda Item 9 - Oxfordshire Transformation Plan – Plans for 'Big Health & Care' Consultation

- Valerie Ingram – Horton Hospital Facebook Page and its supporters
- Clive Hill – Member of 'Chipping Norton Hospital Action Group'.

Agenda Item 11 – Closure of Deer Park Medical Centre, Witney

- Councillor James Mills – Leader, West Oxfordshire District Council
- Councillor Toby Morris – West Oxfordshire District Council
- Brenda Churchill – Chair, Patient Participation Group, Deer Park Surgery, Witney
- David Bailey – Patient at Deer Park Surgery, Witney

Order of Business

It was **AGREED** that Agenda Item 7 'Management of Pressures on Urgent Care' would follow Agenda Item 5 'Forward Plan'.

5/17 FORWARD PLAN
(Agenda No. 5)

The Committee **AGREED** the Forward Plan (JHO5).

6/17 MANAGEMENT OF PRESSURES ON URGENT CARE
(Agenda No. 7)

Ian Davies addressed the meeting in relation to Agenda Item 9 also. He urged the Committee to look at services under threat at the Horton Hospital as a whole, and not as a two stage consultation process, adding his warning that there was a real possibility that Accident & Emergency and Paediatrics service would also be closed. He added his concern that the two stage process lacked clarity and caused a prolonged uncertainty for the public. He pointed out that there were several small birthing units in the country with fully integrated obstetric services made up of a large number of doctors and which fully satisfied their training needs. He urged strong challenge from the Committee and for these services to be reviewed as a matter of urgency.

Cllr Kieron Mallon urged the Committee to consider the 'excessive' travel time from Banbury to Oxford in the event of a need for obstetric care as a result of complications. To add to this, as had been extensively reported on local BBC news, the Committee should consider the lack of public transport to Oxford from the suburbs of Banbury should travel by car be not an option; the 90 minute to 2 hour travel time; and the need to allow up to 1 hour for parking at the John Radcliffe. He highlighted his concern for vulnerable mothers from the ethnic minority population in the Banbury area who had been cited in studies as more likely to suffer complications in pregnancy. He reminded members that areas of Banbury had been included in the top 20% of the most deprived households in England, pointing out there had been no evidence to suggest that Health had considered demographic evidence in detail. He added that the Brighter Futures Programme had documented the importance of a feeling of safety as a contribution to a state of well-being for the most disadvantaged. Cllr Mallon also cited the 'misleading maternity information' given to pregnant mothers that most of the young were a low risk. In conclusion, he asked, on behalf of Banbury Town Council, that the proposals be reviewed as a matter of urgency.

Eddie Reeves addressed the meeting as a local resident of Banbury Calthorpe ward. He stated that he often found it a chastening experience when, in his occupation as a local solicitor he drafted wills bequeathing monies to Horton General Hospital. He urged the Committee to ensure that it remained a General Hospital. He made reference to the written submission made to Committee Members from Cherwell District Council and to the fact that the local MP was collating journey times to the John Radcliffe Hospital made by her residents. Mr Reeves stated his view that there was a great need for a fully functioning Horton General Hospital in Banbury, in view of its growing size and stature and in its role as a strategic centre in the north of the County. He re-iterated Cllr Mallon's belief that the two-stage consultation process was flawed and stated his concern that decisions had already been made ahead of the public consultation. Furthermore, these decisions were detrimental to both the residents of Banbury and those over the county border in South Northamptonshire who relied on the Horton's services.

David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group (OCCG) and Diane Hedges, Chief Operating Officer and Deputy Chief Executive, OCCG attended. Diane Hedges introduced the report highlighting that the management of pressures on Urgent Care was a continual challenge due to a number of factors detailed in the paper, but Oxfordshire was performing well compared to other areas nationally. However there was no complacency and there was a recognised need to look at process at the front end, in particular, flow through the hospital.

Members of the Committee asked questions exploring a number of issues, including:

- The recent alert status at the John Radcliffe Hospital, which resulted in some elective surgery being cancelled;
- A complaint that an outpatient appointment was cancelled after the patient had started their journey to hospital;
- The split between Adult Social Care and the Health Service in relation to the 122 Delayed Transfers of Care;
- The length of time ambulances were waiting outside Accident & Emergency in order to discharge their patients;
- Lack of promotion by OCCG of the GP Out of Hours service;
- The relationship between discharge delays and the recent closure of beds across hospital sites and the possibility of some beds being re-commissioned;
- Possible additional pressure on GP practices from the discharge of patients to their homes;
- The new model of ‘ambulatory by default’ exposing issues in the post-acute sector.

Health representatives responded with the following:

- There was a period 2 weeks ago when 7 elective operations were cancelled but, in the main all the doors were open. Members of the public were being reminded to use their local GP or local pharmacy where appropriate;
- The cancelled outpatient appointment was unfortunate and an apology was given. This was not normal action to take and indicative of the pressure the hospital was under;
- The reasons for delayed transfers could be due to a number reasons affecting health care and social care. Management initiatives, such as the reablement contract were often multi-disciplinary and couldn’t be singled out;
- There was not a major ambulance queuing issue currently compared to 2/3 years ago - Performance figures would be sent to the Policy Officer. Oxfordshire was performing better than many other Health authorities in the southern region;
- There were some staffing pressures for the Out of Hours service over this year’s winter period but it has seen 6,000+ patients which was 20% more than in previous years. There had also been 30% more home visits than in the previous year. Thus, to some extent, the service was being successful at keeping patients in their own home;

- Approximately 146 beds have been closed and 164 patients had become medically fit for discharge from the JR and the Horton hospitals. The major issue was about the support given to patients when they leave hospital, not the beds;
- The Liaison Hubs were the right place to assess patients leaving hospital if they had any needs upon discharge. All patients then had the opportunity of reablement services. The intention was not to put pressure on GPs and the OCCG was mindful of getting the balance right;
- The current initiative of carrying out ambulatory care by bringing the GP Out of Hours service into the JR, had not proved as successful as was hoped because the current premises were not suitable. The OCCG was constantly seeking other ways of 'breaking the cycle'.

At this point with regard to the management of pressures on urgent care in maternity at the Horton General Hospital, the Chairman then invited local member, Cllr Arash Fatemian to speak about the continued temporary closure of the Obstetrics Unit and the proposals contained within Phase 1 of the Oxfordshire Transformation Plan. He stated that the latest update on the position (dated 23 December 2016) on the recruitment of Obstetric doctors by Oxford University Hospitals NHS Foundation Trust (OUH) which had stated that:

'The OUH Trust Board made a decision on 31August 2016 that obstetric-led maternity services at the Horton could not safely be maintained. They (the Board) required the decision to be reviewed so that if enough doctors were recruited to run the service it could be reinstated.

The service was initially temporarily suspended with effect from 3 October 2016 with the hope that if enough doctors were able to be appointed in the meantime, then the service could reopen in January. This decision was reviewed at the end of October, and it was clear that there would only be three doctors in post in January out of the 9 needed. Therefore the suspension was extended again until March and it was decided to review the situation again in December after the next round of recruitment and advertising.

That situation was reviewed again this week and unfortunately, the current number of obstetric doctors remains at 3 and the maximum number of doctors likely to be in post by March is 5, which is not enough to reinstate the service at that point.'

Cllr Fatemian referred to this Committee's decision at the 30 September meeting, when it decided not to refer this matter to the Secretary of State, on the evidence that it was satisfied that OUH had adequate reasons for acting without consultation on the basis of urgency relating to the safety or welfare of patients or staff. The Committee agreed to monitor the temporary closure and the recruitment plan which was in place to increase staffing levels. The Trust's update on performance of maternity services at the Horton, dated 23 December 2016, stated that they would not have enough experienced and skilled medical staff in post to reopen the unit in March 2017 as planned.

At the request of the Committee, Nick Graham, Director of Law & Governance advised that the grounds for referral to the Secretary of State were limited to

circumstances where the Committee did not believe the reasons given for closure of the Obstetrics Unit to be adequate. In terms of procedure, if the Committee would have to demonstrate that it had taken steps to agree a local resolution with the Trust and there had been a lack of resolution.

David Smith confirmed that the OUH was still in a position that there were insufficient doctors to run the service. In response to concerns raised by the speakers that the two-phase OTP consultation was flawed, he stated that the OCCG was consulting in this manner as previously agreed with the Committee on 30 September.

On the conclusion of the discussion it was **AGREED**

(a) to thank the OCCG for the update on the management of pressures on urgent care;

(b) (on a motion by Cllr Fatemian, seconded by Cllr Bulmer and carried unanimously)**,** that, without prejudice, to refer the temporary closure of the consultant- led obstetrics unit at the Horton General Hospital to the Secretary of State for Health under Regulation 23(9)(b) of the 2013 Regulations, for consideration on the following grounds:
(1) that the Committee believed that the material grounds for not referring the matter had changed, ie. the Trust's recruitment plan had failed and the closure would now be longer than envisaged; and
(2) it considered that nothing could be gained by further discussion at a local level with the Trust.

7/17 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 6)

Eddie Duller OBE and Rosalind Pearce, Chair and Chief Executive, respectively, of Healthwatch Oxfordshire (HWO) presented their regular update to the Committee.

Eddie Duller wished to make it clear that HWO had no issue with the OCCG regarding the BOB STP engagement process, its issue was around the consultation process, and the fact that HWO had not seen the document prior to it being leaked.

In response to requests from three members of the Committee asking if the Witney Project could be extended to Wantage, Bicester and Thame in the future, Ros Pearce responded that HWO was trying to conduct geographically-based investigations and had not yet decided where to take them.

Eddie Duller was asked how HWO found the language and terminology in the OTP consultation document – which might either encourage or discourage the general public to truly reflect their views. He responded that he had found the language used 'difficult to the extreme', so much so that HWO had felt it necessary to run a translation service on their website.

In response to a question, Rosalind Pearce confirmed that HWO had not picked up any issues or concerns from other neighbouring counties about the consultations,

despite their close working with other counties. She undertook to look to HWO counterparts in those areas.

Eddie Duller and Rosalind Pearce were thanked for the report.

8/17 THE BUCKINGHAMSHIRE, OXFORDSHIRE & BERKSHIRE WEST SUSTAINABILITY & TRANSFORMATION PLAN (STP)

(Agenda No. 8)

Prior to consideration of this item, the Committee heard addresses from two members of the public:

Keith Strangwood thanked members of the Committee for its decision in relation to the closure of the Obstetrics service at the Horton General Hospital. He appealed to members to vote with their heart when its response to Phase 1 of the OTP consultation was considered on 7 March 2017.

Veronica Treacher stated that the capability of members of the public to influence many of the services featured in the STP was questionable, adding that despite the public engagement exercises carried out, it was driven by waiting times and audit. Plans had been presented as technical exercises and the language used constituted a language barrier. She added her view that the BOB STP largely remained secret and the public had not been given any information with respect to accountability and responsibility. Furthermore, that any changes had already been decided. She called for any re-configuration to be stress-tested to deliver effective services. She urged HOSC to make a stand and to call for further information about finance in light of public concern.

David Smith attended for this item in his capacity as both Chief Executive of the OCCG and the lead for the STP footprint over Buckinghamshire, Oxfordshire and Berkshire West. Stuart Bell, Chief Executive of Oxford Health also attended. Mr Bell stated that although he was working through some projects at the broader BOB level, which tended to concern specialist services that required a larger footprint (such as cancer services), much of the planning, consultation and delivery would be via the three local systems. Referring to the last speaker's address, Mr Bell clarified that the STP did not exist as a statutory body.

Mr Bell advised that a new approach was to be taken based on local planning in contrast to the market situation which was the previous approach. This was reflected in the transformation process in Oxfordshire. Changes described in the STP were in line with those of the rest of the country. Furthermore, this federal approach meant that revised Terms of Reference were required for the Oxfordshire Transformation Board to ensure regular reports were provided on the STP and also to ensure an Oxfordshire view would be presented in the STP. An event had been held 2 weeks previously involving the wider local authorities, and a range of other organisations, to do a stock-take and to develop a process of engagement. There was recognition that this would involve significant numbers of the social care and home care workforce.

Members asked questions around the following areas:

- Whether there were other plans that had been through the Clinical Senate and NHS England;
- Why the BOB STP had not been consulted on and published as a holistic plan and not as part of the OTP consultation;
- How the work plan for the OCCG and the Senate worked out across Oxfordshire;
- Relation of the OTP/STP to common resource problems experienced by the Health service nationwide, such as over - use of agency staff, NHS equipment not being returned, charging foreign visitors for use of services etc;
- Sufficiency of staff numbers to undertake all that would be required;
- The source of the monies for investment;
- More managers meaning less money for the patients?
- A guarantee that there would not be commissioning with the private sector across BOB;
- How governance to tackle problems with a specialist service on the wider STP footprint would work– were there powers/sanctions to enforce by an oversight Board?
- The temporary or permanent nature of the STP. Will it become a new structure for the delivery of Health in this region and how would its governance work? Were STPs merely a re-invention of the Regional Health Authorities?

Mr Smith and Mr Bell gave the following responses:

- Oxfordshire was the first of the areas within the BOB STP to go out to consultation on its local plans;
- A plan is very different from a consultation. The STP was an attempt to pull together individual components relating to particular services, using the available resources in a more effective way. Each component would then need to be led by the appropriate statutory body - the components for Oxfordshire would be addressed by the OTP. Parts of the system were not delivering required quality of care, for example, waiting times and health inequalities that exist. It was necessary for the OCCG to do something about them, and this could not be done without making changes to the system;
- Regarding publicising the STP, the documents were on the OCCG's website, together with a short guide. There was a willingness to engage, and any comments on specific services included in the STP would be welcome. David Smith undertook to check whether the website was interactive;
- Phase 1 proposals had been through the Clinical Senate's assurance process which included a panel of clinical experts from outside the area. This report had been made public and Mr Smith undertook to provide a link to the report to members;
- There were projects looking at equipment and staffing issues at the moment. In particular, looking at ways of attracting people back to work from other sources, rather than via agency use. This had proved successful in relation to finding nursing staff, but was less so with clinical staff. The OCCG was looking at workforce issues across the BOB area, for example, looking at how

specialist services could be provided more locally within the BOB area. In addition, how the OCCG could make better use of electronic health records and also ways in which new digital technology could help provide healthcare and offset difficulties in recruitment;

- Staffing issues were more of a risk/constraint as training could be long-term. The OCCG was therefore taking a more systematic approach to the recruitment of people with different skills: for example, work with universities within the BOB network and the introduction of bursaries and graduate career progression in order to make the most of people's skills and supporting staff to operate at the top of their licence;
- The use of the STP as a basis for allocating investments of monies locally had already begun with bids submitted for Psychiatric and Diabetes services. As long as plans were already in place, responses could be speedy. Capital and national investment was very limited (for example, the OCCG had put in a bid amounting to £50m for investment in local GP practices, but only £2m was allocated). This made recycling a necessity, together with the need to seek opportunities for investment from other bodies. Mr Smith agreed that Health needed to tap into S.106 developer monies at every opportunity. The Committee would write to the Minister for Health about the underfunding of the NHS in Oxfordshire;
- There would be no new managers. In fact discussions were being held about how costs could be reduced via cuts in back office services;
- There was a Government Policy about Patient Choice and therefore the local NHS did commission services from the private sector. The OCCG was in the process of working up a delivery plan. Mr Bell commented that there was more provision of services in partnership with the voluntary sector;
- STPs were here to stay. However there was no intention to embark on wholesale change in the NHS. Individual CCGs would work locally and investment decisions would be made locally, thus giving greater accountability and more local control over the totality of the picture. Investment decisions for specialist services would be made centrally via NHS England across the STP footprint in accordance with gaps in care or inequalities. Some services might be commissioned on a bigger scale, for example, to include Swindon and Milton Keynes hospitals that were not in the BOB STP footprint. Conversely, this did not mean all commissioning of specialist services would be centralised through the STP: the OUH worked through a number of networks and alliances with other hospitals not in the STP according to the needs of patients and for better outcomes. One size did not fit all;
- Powers of compliance were decided between the CCGs – each might have different issues. The OCCG Board and each CCG still held statutory responsibility, but would work with other organisations for the good of the patients.

Mr Smith noted that whilst HOSC recognised that the OCCG did address some problems, such as the availability of sufficient domiciliary care to meet the changes made at Townlands Hospital, the STP was focussing on specific services. The Committee needed to see the local NHS working much more closely with local Councils with regard to planning consent and housing development.

Mr Smith agreed to come back to Committee with the delivery plans when they were available. This would provide the Committee with more information in relation to how the new system would operate.

Mr Smith and Mr Bell were thanked for the report and for their attendance.

9/17 OXFORDSHIRE TRANSFORMATION PLAN (OTP) - PLANS FOR 'BIG HEALTH AND CARE' CONSULTATION, PHASE 1

(Agenda No. 9)

Christine Ansell, speaking on behalf of Valerie Ingram, expressed concern, on behalf of the 22,000 supporters, that the Committee had voted to accept the split consultation. They considered it unwise, prejudicial and to the detriment of the people of Banbury and the surrounding area. It was their view that the services under review were interdependent. This would risk the potential removal of the obstetric led maternity unit, which would put into jeopardy the Special Care Baby Unit, Paediatrics and ultimately the Accident & Emergency department, effectively dispensing with all the acute services at the hospital. This would leave a rapidly expanding area with an inequality of health care, which in their view would go against council policies in core strategies drawn up by local authorities.

Christine Ansell queried whether maternity services were included within the discussion regarding the temporary closure of beds at the Horton.

She also put forward her view that the first consultation meeting on the plans, which had been held in Banbury, was not supported by any of the attendees. Furthermore it had been held in 'banquet style' rather than 'plenary style' which was limiting in terms of numbers able to attend, nor did it enable attendees to hear each other's views. She added that many of the meetings were held during the day which precluded the majority of the working population from attending. It was her view that this style of organisation called into question how meaningful the consultations were.

On behalf of Val Ingram, she urged the Committee to vote against the split consultation 'which delivered a second class health care service to Banbury', adding that the County's MP's were also of this view.

Clive Hill reported concern within the Chipping Norton community that there had been a 'complete lack of involvement of the people of Chipping Norton and district.' He informed the Committee that a request had been made by the Chipping Norton Action Group (CNAG) to the OCCG to hold a public meeting in Chipping Norton before options for Phase 1 of the consultation were determined. Mr Hill stated that despite a promise made by the Chief Executive, this event had not taken place despite repeated requests. Thus, the options had been decided with no public involvement in Chipping Norton. Following publication of Phase 1 of the consultation, the CNAG asked that the Chipping Norton consultation meeting be no earlier than mid to end February to allow time to publicise it. This was not taken into consideration. A meeting was arranged by the OCCG to take place on 2 February from 2pm – 4pm. This was not acceptable for a number of reasons, namely that it clashed with this meeting, was a weekday, most people were at work and young mothers interested in maternity services would be collecting their children from

school. An objection was made, but a change was not forthcoming. There were also concerns about the layout which was ‘cabaret’ style where numbers would be restricted. He expressed his concern regarding OCCG communication in general which had culminated in no advertisement to the community and confusion on the part of the public. The CNAG felt it was a ‘tick box’ process designed to minimise participation; and that the people of Chipping Norton and District had been ignored and side-lined.

David Smith , Dr Joe McManners, Chief Executive and Chair respectively, OCCG attended. They were accompanied by Julia Stackhouse, Communications & Engagement Manager, OCCG. Dr McManners and Mr Smith made a request that questions from members of the Committee be sent to the OCCG prior to the 7 March meeting itself, so that they could be certain that the correct people attended to respond to questions. David Smith encouraged the public to participate in the communication activities on the OCCG’s website, such as the survey and twitter feed, and not to limit activity to the public meetings.

Questions from the Committee covered the following areas:

- The difficulty associated with asking all the necessary questions if there was no co-ordination with the Sustainability & Transformation Plan (STP) or neighbouring areas. Would there be engagement with Phase 2 services on 7 March where there were links?
- Part of the rationale of care closer to home implied the use of Social Care/Neighbourhood Hubs and step down provision in community hospitals. How could the Committee make a decision on Phase 1 without knowing the proposals for that?
- The lack of reference to the Ambulance Service in the consultation documents;
- When there would be a further consultation date for the Thame area?
- The Rose Hill consultation venue was the only Oxford City one and thus travel for some people living in the City could be difficult;

Responses received to the above questions were as follows:

- A certain amount of flexibility was required on Phase 1 of the proposals, there being a need to ensure that the OCCG was engaging with colleagues across the board and HOSCs across the borders to give awareness of the impact on their residents. The OCCG had written to 80k households in the South Warwickshire, Gloucestershire and South Northamptonshire areas as part of the consultation. There had also been linkage with voluntary sectors across the borders and communications groups. HOSC had a clear expectation that there would be consultation on a number of proposals; this was part of the reason for splitting the consultation into two parts. The CCG was in the process of developing the proposals for Phase 2, for example, those for community hospitals. The intention was not to launch the Phase 2 consultation until the Autumn, but feedback in Phase 1 would be taken into the Phase 2 consultation;
- The OCCG would need to look at the system as a whole, including nursing care, community hospital beds, Social Care, GP provision etc

- The OCCG was engaging with the Ambulance Service in the same manner as with other organisations;
- The Thame consultation meeting was on Tuesday 14 March 2017;
- Rose Hill was an accessible venue and, as it was an area of deprivation, it allowed a different audience to engage with the consultation. The consultation as a whole was about a series of different events and a person could attend any of them. With reference to comments made by some of the speakers regarding layout, it was important for the OCCG to hear about what people said at the venues and a variety of layouts was employed in order to give the public the opportunity to raise their voice. Some were plenary, some round table etc. Any feedback from the public in relation to access problems at consultation meetings would be addressed.

The Committee urged the OCCG that, whatever was implemented as a result of Phase 1, it was sufficiently robust and rooted in reality so that a case could be made for easy integration into Phase 2 proposals. Mr Smith responded that specific services would be included as part of the investment in primary care services. Part of the proposal would be to move diagnosis into more local settings in order to provide services closer to home.

The Chairman thanked Mr Smith, Dr McManners and Julia Stackhouse for their attendance. She thanked them for the wide scope in terms of methods of communication and requested that the Oxford venues be looked into.

10/17 FRAMEWORK FOR PRIMARY CARE IN OXFORDSHIRE

(Agenda No. 10)

David Smith, Dr Joe McManners and Julie Dandridge, OCCG attended for this item.

The Committee had before them a paper produced by the OCCG setting out a draft framework for primary care in Oxfordshire (JHO10). The Chairman, in introducing the item, referred to the Committee’s discussion at the last meeting and the questions arising from it. A major issue raised was what could be done about the problems in the short term.

David Smith introduced the draft framework citing all the issues that primary care had experienced over the last 10 years, such as a rise in the numbers of older people with complex needs, double numbers of consultations for the over 80’s and the difficulties in recruiting and retaining GPs and other professionals in primary care. He explained that the OCCG was trying to identify a broad strategy to be used by groups of GP practices, localities and neighbourhood areas. This would entail looking at population groups, ways of expanding the workforce and at issues relating to premises. An action plan would be compiled looking forward and also looking at what was required in the short-term, such as how to attract more GPs and professionals and also to look at how to establish different roles within practice teams.

Questions asked by the Committee were in the following areas:

- The size of the GP units – was there a standard size?

- Whether practices were being encouraged or 'nudged' towards working together;
- The recruitment of more doctors;
- The appropriate circumstances to award a 15 minute appointment;
- Progression of 7 day a week working in GP surgeries;
- More funding for larger practices;
- Installation of IT to support the changes;
- Inclusion of patient transport in the framework – not just for older people, but for all ages needing it;
- The impact of the framework on residents in Bicester and Banbury;
- Whether practices were opting out of the Out of Hours service;
- It had long been noted that patient discharge would be made more rapid in the future. Did the Framework take account of this?
- When would there be consultation on the Framework?

Answers received were as follows:

- The Strategy was not about stipulating practice size, it was more about working across practices of approximately 30-50k residents in a neighbourhood with multi-skilled teams. There was a need to look at having a few practices working together, sharing the risks and even teams. This was the direction of travel the service had seen over the last few years;
- The OCCG was careful not to stipulate how practices should be organised because, for example, City practices were very different to those in Banbury and the strategy would have to work for the local area. This was a framework, not a plan. However, the OCCG would assist them in their move towards a better service, such as the establishment of clinical pharmacists in GP practices who would follow up on notes, blood results etc. Practices would also need to ensure that there is proper value for money for services;
- The recruitment of more doctors was a local and a national problem. The OCCG was looking at how to make Oxfordshire more attractive to doctors and other professionals. GPs were very reliant on the teams surrounding them. If the workload balance was right in the practice, then the OCCG could begin to attract people. It was often found that if a surgery was difficult to recruit to, then a downward spiral would result;
- Some practices gave 15 minute appointments already and also had a triage in place as it was important to identify the right patient to provide for. A clinical triage process was carried out by a GP or nurse. Patients were encouraged to see a nurse or pharmacist for minor illnesses. There were a number of models for this and the OCCG was not going to be prescriptive;
- Most surgeries were increasing access to additional appointments from 1 February, and in Oxford City from 1 March. Information regarding this could be found on individual practice websites. No contact for routine appointments could be made at weekends when the Out of Hours Service or Service 111 was available for urgent access. Not all practices would be operating 7 days per week all at the same time. The Government had to provide 30 minutes for every 1,000 patients. At the moment it was not looking to provide appointments all day Saturday and Sunday. There was a need to look at demand and the availability of appointments. GP or nurse appointments were

already being offered across the county for at least one and a half hours in the evening and at least 3 hours on Saturday and Sunday. The OCCG was trying to tie the hospital and GP appointments together in a pragmatic way. By working across practices there could be quicker access for patients;

- The OCCG needed to think about whether there were sufficient numbers of patients in a locality to require a particular service to be run. For example, a diabetic specialist nurse might be available in a locality, but not a bone cancer nurse. The challenge was to get as good a fit as possible with what funding, staffing, local access, etc. was available. If there was a group of practices specialising in care for older people, this could be pooled. This would also support the aim of giving more support to older people in their own home;
- Much of the IT and technological work had already been implemented. GPs could already see each other's records in a large part of the county. There was a need, however, to work across practices sharing good practice;
- Currently GP practices were paying for their own transport for patients. More work was required on this, together with thought given to options to provide it for all age groups. Investment had already been made in holistic services, for example, the OCCG was looking to trial more local drop-in services to be available at the end of the school day. Julie Dandridge undertook to report back to the Committee at a future date on this issue;
- The OCCG had discussed services in neighbourhoods in Bicester and Banbury. The manner in which the services would be designed would depend on where the patient was registered;
- GPs are independent and separate businesses – it is their choice whether to join a large hub which includes an Out of Hours service;
- With regard to patient discharge, there was a need to become more creative in Oxfordshire with, for example, joint posts with acute hospitals, or with combining research with clinical practice and seeing patients. Furthermore, a full day's work used to be a lot less than nowadays. This was one of the reasons why doctors were retiring. It was thought that better use could be made of the John Radcliffe as a teaching hospital. As more patients are discharged earlier from the OUH, there would need to be proper multi-skilled teams of hospital doctors and GPs to provide aspect. The Framework was about looking at people's health holistically from a biological and a social side;
- Consultation on the Framework would be part of Phase 2 of the OTP consultation but, in the meantime, the OCCG would wish to engage with GP practices about what it meant for them. The discussion would be based on where primary care fitted in with community hospitals/community care. Also, to inform the Phase 2 consultation, thought needed to be given to what network of services would be provided in the patient's own home. Discussion groups and forums had already taken place on this subject. These discussions would roll out more widely once the OCCG could be more specific about what was happening in the localities.

All were thanked for their attendance.

11/17 CLOSURE OF DEER PARK MEDICAL CENTRE, WITNEY
(Agenda No. 11)

Prior to consideration of this item the Committee heard addresses from the following members of the public:

Cllr James Mills urged the Committee to support the closure of Deer Park Medical Centre as a substantial change of service. He expressed his concern that the informal meeting comprising some members of the Committee and representatives from the OCCG had not invited local representatives to attend, particularly when local issues around workforce and the local planning authority were to be aired. He pointed out that thousands of houses were to be planned which would cause major problems if there was insufficient provision of primary care.

Cllr Toby Morris stated that currently Witney was experiencing a 25% vacancy rate for GPs which caused concern particularly as 2,000 houses were due to be built in the Witney area. For this reason it was the Town Council's view that the closure of Deer Park Surgery constituted a substantial change in service as it was an important satellite for patients living in the West Witney, Cogges and central Witney which amounted to half the size of Witney. He pointed out that Witney Town Council had not been consulted on the proposed change by the OCCG and expressed concern that the OCCG had sent letters to the dispersing patients that morning, which was immediately prior to discussion by this Committee.

Brenda Churchill referred to the Court decision, from the previous day, not to continue with the application for judicial review on the grounds that the application had not been made early enough. It was the view of the Patient Participation Group that the OCCG should have discussed the procurement issues with them earlier. Furthermore, they believed that the OCCG should have conducted a broader and more meaningful exchange on the impact of the closure with the local public. She also expressed her concern that there had been too many meetings in private. She urged the Committee to take the view that it was a substantial variation in service, as requested by the district council, the local MP and others. She asserted that very few patients had left the surgery to go to other surgeries because they wanted to remain at the practice.

The Chairman assured Mrs Churchill that no conversation had taken place behind closed doors with the CEO of the OCCG at any time.

David Bailey stated that the decision to close Deer Park Medical Centre made even less sense after listening to the previous item relating to future changes in primary care in Oxfordshire. He told the meeting that in 1993 he had suffered a heart attack and, since that time, the Deer Park Surgery, which had been rated as a 'good' surgery, had taken great care of him. He expressed his concern that the Ambulance Service and the OUH might struggle to respond to emergencies leading to patients not receiving the same level of care. He asserted that GPs were leaving other surgeries, yet the OCCG were planning to remove three GPs from Deer Park who would not be transferring to another surgery. He concluded by urging the Committee to refer the closure to the Secretary of State.

The Chairman then asked the County Council's Director of Law & Governance & Monitoring Officer, to give an update on events since he wrote the paper (attached at JHO11) in relation to the Deer Park Surgery. He reported that events had overtaken the content of the report since the Court hearing had occurred the previous day. His view was that it was not helpful to speculate on what the Judge had said at the hearing. A primary aspect on which the judgement had been made was the delay from the claimants (the Patient Participation Group) to make the submission and that there was no reason why the application could not have been brought earlier. He emphasised that there had been no delay on the part of the Committee, or criticism in the way that it had approached the matter. Committee members had given consideration as to whether the closure would be considered a substantial variation of service by the Committee on 12 December 2016 in an informal, further fact finding meeting to which OCCG representatives had been invited. The meeting today was the first meeting for it to be considered formally and in public by the Committee, subsequent to 12 December. He pointed out that the law did not assist in that there was no legal definition of what constituted 'substantial'. It was the OCCG's view that it was not a substantial change. He advised that if members of the Committee were in agreement with the OCCG, then it would constitute the end of the discussion, but if there was disagreement, then consideration would need to be given about how to go forward ie. consultation on the closure, or referral to the Secretary of State. He confirmed that it was the OCCG's decision about what action they wished to take in the future.

David Smith pointed out that a two hour discussion had taken place with HOSC members on 12 December; that a procurement process had been carried out and the current operator had been the sole bidder. The bid was too high and in the absence of an alternative suitable provider, the OCCG had to take a decision to close the practice at the end of March 2017. He added that the OCCG had previously extended the provider's contract by 1 year. He stated that the OCCG had to inform the patients as soon as the judicial review process had been completed, as it was getting very close to the closure date and patients had to be dispersed to other practices. Mr Smith stated that the OCCG were happy to accept that public consultation would take place, but asked the Committee when this should happen given the timescale.

Questions asked by members of the Committee were in the following areas:

- At the 12 December meeting, members of the Committee had asked for information on financial savings for analysis;
- The Committee ought to have been informed earlier so that different solutions could have been considered;
- On 11 August 2016 Virgin Care, the provider, had confirmed that they were prepared to continue providing services at Deer Park and this had been shared with the local MP;
- The OCCG's consultation process on the closure and their willingness to make it feasible;
- If there was any community-led initiative for the surgery to continue;
- Why letters to patients regarding their dispersal had been sent out that morning, despite an informal steer from Committee members on 12 December that they considered the closure to be a substantial change.

- Would there be patients who were ‘orphans’ who would not be able to find a surgery in Witney to register with?
- What about patients who were, prior to closure, part of a screening programme and, after closure to which their notes could be transferred? Relying on the Cardhill Formula that only 20% of patients were active on a GP list at any one time, could put patients at risk. The outcome of this would be to skew a receiving surgery’s workload, without the funding that followed it.

Answers received from the questions posed by members were:

- The OCCG would make no savings from the closure of the Surgery;
- Virgin Care had confirmed that their original tender bid still stood as it was. Therefore Virgin Care’s bid was not affordable within the contract. A consequence of paying more money to Virgin Care would be that more money would have to be paid to other practices and funding was not available for this;
- A ‘toolkit’ had been considered with HOSC on whether it was a substantial change. As of now, the practice was closing and patients had been written to. Practices were already taking on further staff to accommodate the rise in numbers of patients and some patients had already registered with other practices. It was reiterated that the OCCG had wanted to begin to inform patients much earlier and advise them on registering with other practices. The judicial review process had put a halt to the letters being sent out earlier. They then went out at the earliest opportunity on notice of the result of the hearing;
- It would be very difficult at this late stage to accommodate a community-led initiative to keep the surgery open. The contract had already been extended;
- The patients would have a choice of who to register with;
- The process of transfer of patients was worked out in conjunction with Virgin Care. Text messages were to be sent to patients reminding them to re-register and Virgin Care would be telephoning some. This would be the subject of ongoing reviews.

On the conclusion of the discussion, Cllr Bulmer put forward a motion, seconded by Cllr Dhesi, and carried by 12 votes to 0, that this was a substantial change in service.

In light of the above agreement that it was a substantial change in service, the Committee then considered what action it wished to take. David Smith stated that there was no time for the OCCG to undertake a consultation. Julie Dandridge reiterated that the OCCG could not leave the despatch of letters to patients any longer and confirmed that other practices were able to take the patients being dispersed. Moreover, it was unsafe for the patients not to have a service. Normally there needed to be three and a half months for the dispersal of patients.

Nick Graham advised that as the Committee was in disagreement with the OCCG about whether it was a substantial change in service, if any further action proposed by the Committee was not acceptable to the OCCG, then the only course of action left to the Committee was to refer the matter to the Secretary of State.

Cllr Bulmer then put forward a motion, seconded by Cllr Dhesi, to refer the change in service to the Secretary of State on the basis that consultation with the public and patients at Deer Park Medical Centre was inadequate and the closure of the surgery

would not be in the interests of residents and patients in the Witney area. This was carried by 12 votes to 0.

12/17 CHAIRMAN'S REPORT

(Agenda No. 12)

The Committee considered the latest Chairman's report (JHO12).

It was **AGREED** to note the report.

.... in the Chair

Date of signing ....

HOSC Forward Plan – April 2017

Meeting Date	Item Title	Details and Purpose	Organisation

22 June 2017	Transformation implementation	• Report on the outcome of the phase 1 consultation and decision of the CCG Board on future model for
		  ○ critical care facilities;
		  ○ acute stroke care;
		  ○ planned care
		  ○ changes to acute bed in order to move to an outpatient (ambulatory) model of care
		  ○ maternity services at the Horton
			Whole System – (Stuart Bell, Transformation Board Chairman)

22 June 2017	Health visiting services	• Impact of changes to children's centres on provision of health visiting service • Performance of newly commissioned service	OCC & OH
22 June 2017	Dementia services	• How OCC/OCCG are working together to support people with dementia in light of changes to Daytime support • OCCG's dementia strategy and jointly commissioned Dementia Support Service (changes in May)	OCC & OCCG
14 September 2017	Health Inequalities Commission Report	• Health and Wellbeing Board's response to the report of the Health Inequalities Commission • Including info on local activities focused on obesity prevention work	Whole system & HWBB
14 September 2017	Air Quality	• How OCC and partners are addressing the issue of air quality.	OCC & Districts
Future Items			
Summer 2017	Health and Care Transformation Consultation Plans for Phase 2	• Committee scrutinises the health and care consultation plans for Phase 2	Whole System
Summer 2017	Health and social care	• Impact of workforce shortages in reablement &	OCC

Updated: 28 March 2017

	workforce	domiciliary care on acute services • Impact of ASC precept	
Summer 2017	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
Summer 2017	FOR INFO – GP appointments	• Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored	OCCG
Autumn 2017	Health and Care Transformation Consultation Phase 2	• Committee formally receives and scrutinises the health and care consultation proposals • A deadline for the formal response from the Committee is advised by the CCG	Whole System
	Health and Wellbeing Board	• How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration? • Is there effective governance in place to deliver this? • How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for greater integration?	Whole System

healthwatch Oxfordshire

Experiences of a patient over 100 days

John Radcliffe Hospital West Wing, beginning of October 2016

The plus points: Excellent diagnosis, spine operation and nursing.

The minus points: The food. The daily menu choices at the JR seemed very enticing but in reality, although nutritious, the meals were never very appealing. Food plays a large part in the psychology of recovery.

It was planned to move me to the Oxford Community Hospital, but this was changed to Bicester Community Hospital at short notice. There was a long delay on the day of the move and I arrived at my new location late in the evening, having waited all day for transport.

Bicester Community Hospital

I had a good, comfortable en-suite room, but after two days the floor beneath the shower needed mending, which was not done while I was there.

I got little physiotherapy. I had two sessions in the gym to work out where I would need a grab rail and at what height I would need a bed at home so that I could get off it. Over 21 days, I got no more than 4 hours of supervised physiotherapy. To me, this seems like having the cost of keeping me but not having the opportunity to make me more independent. I could walk a short way with my walker. But I could not rise from the bed or wheelchair onto my walker.

The Occupational Therapist was extremely helpful in seeing what I needed in order to cope at home. She accompanied me to my home one day. As a result, she arranged for me to have a hospital bed which would enable me to get my boots on and stand onto my walker.

But after 21 days, I was moved at very short notice – I was told the ambulance was waiting – to take me to the nursing home.

Nursing Home, Banbury

The plus points: A safe location for a period.

The minus points: Unsuitable accommodation and poor communication.

I arrived late morning, not met by anyone, and was left in their lounge. Later in the day, two carers came and took me to a small room on the first floor which had no toilet or shower, just a hand basin. The only accessible toilet for me was on the floor below. I asked to speak to someone about moving to another room. I was told they would look for one. This didn't happen. A commode was placed in the room.

It seemed to be a home for people with dementia, rather than a stepping stone for patients recovering following an operation.

I saw the physiotherapist for about five minutes a day, four days a week, when I had one little walk. I believe she was in contact with the OT (*Occupational Therapist*) in Bicester. But I needed more practice to enable me to (a) get my boots on and strapped so that I could stand to get out of bed, (b) stand from a chair and wheelchair, and (c) transfer into a bathroom. The staff did not seem to have the time to allow me to do this myself. Their ability to communicate clearly in English to someone hard of hearing did not help.

Near the end of my stay at Banbury, I saw someone (who turned out to be the ?manager) welcome a new patient. I asked her why she had not spoken to me when I first arrived, and why I had been put in a room with an accessible toilet. Her reply was that I should have complained earlier.

I tried to find out who was planning for my discharge home. I couldn't, so I asked a friend to find carers for me. She phoned the Home to find out if it would be safe for me to go home with carers. They told her I would need 2 carers four times a day. But nobody told me this. In fact, I left with 1 carer, twice a day which was adequate.

Over all

The plus points: I was very grateful to the NHS for helping me in my hour of need. The excellent emergency care and treatment.

The minus points: There was not enough physiotherapy given in either Bicester or Banbury.

Note from author: I am not complaining, a friend of mine said I should write to Healthwatch to hear my experience.

1 In their own words

A snap shot of patient experiences gleaned so far from our Witney project

JR – Trauma Department

All staff I met were helpful. Any requests I made were dealt with in timely fashion, and I felt respected. All staff were focussed on their jobs and made the experience as good as possible for me. (improvement) Shorter waiting times for follow up appointments – if possible.

JR Hospital

On one occasion my son's appointment was changed but I did not receive the information notifying me of the change and due to the consequently missed the appointment I then had to seek to get him re-referred.

Another incident is to do with my son's referral to community paediatrics for autism assessment which took a long time due to a lost referral form.

The people / professionals I have dealt with are amazing and a real credit to the service.

The individuals who are amazing need much more recognition.

Systems need to be rethought to be more effective.

Witney Hospital

The service was very good and the lady was very professional though I did feel very isolated as the physio would come for around 30 mins then go leaving me with instructions of how to get my son walking. I then wouldn't see her for another 2-3 weeks being left on my own to do the physio was very overwhelming and scary experience feeling it was all down to me physically to get him walking or that's how it felt.

The advice although not rocket science was worth its weight in gold.

More regular visits with physio to help the carer feel more supported.

Churchill

Once you're in the system – care is excellent in all parts of it, staff…but to get into system 1st!!!

Churchill Outpatients

Dreadful – nightmare to park, long waits. Didn't feel I was given the time – not treated holistically – (they) saw the diagnosis other than the person.

(need) better organisation of outpatient system, communication – re appointment received letter inviting me to appointment after I I'd already seen the consultant and had my appointment.

Car parking makes you feel v stressed before you get to appointment

Staff looked exhausted so are doing the best they can.

Warneford Hospital

Sister has mental health – took overdose made a patient at the Warneford for 4 weeks. Excellent staff. (improvement) - More beds available – she could have done with more time but they needed the beds.

John Radcliffe Eye Hospital

Laser treatment – prompt and caring. Thorough examination and helpful information about condition.

Witney Community Hospital

Visited Dr … seen straight away, blood test and ECG done. Now 3hrs later x-ray complete. Excellent service. Efficient and quick. Everybody very helpful and polite.

MIU

Wanted to know if broken toe. Was worried about waiting. Seen in 10mins – got x-ray in another 10mins, saw doc straight after that. Strapped broken toe….nurses are brilliant

111

Amazing – although once called an ambulance when they didn't need to – turned up at A&E & they said …111 had been too cautious.

They saved my mum's life – she felt ill & she thought it was heartburn & they told her it was a heart attack & called the ambulance.

Cardiac Unit at JR

Can't fault them, got me back on my feet and their ongoing support has kept me mobile. I could hardly walk before I went into hospital – now I go to the gym!

(good) The ongoing rehab & support via the gym at Windrush. Cardiac nurse who I can call at any time if I am worried about my heart.

Paramedics & A&E @ J Radcliffe

My 94-year-old mother had a fall at her care home…Paramedics were called – a quick response lady came, then she called an ambulance as she felt mum needed her neck/back checking out…The paramedics took both mum and myself up to the JR. Here she was assessed promptly, painkillers given and a complete body scan. Thankfully the only real damage was a bad cut to her head which needed stitches.

Excellent caring from both paramedics and hospital staff. Mum dealt with very thoroughly & competently. Also assessed next day to ensure she was well enough & had good mobility to be returned to her care home.

(improvements) – more information given to waiting relatives? I only found things out by going to find staff and question them. Without me doing that I'd have had a 5 hour wait not knowing anything until the doctor actually called me through.

2 Healthwatch Oxfordshire Update

2.1 Witney project update

Our month focusing on Witney is under way and we will report in June on what we have heard.

2.2 Buckinghamshire, Oxfordshire & Berkshire West (BOB) Sustainable Transformation Plan (STP) Freedom of information request (FOI)

We are waiting a response from the Commissioner.

Healthwatch attends the BOB STP Communications and Engagement Group and is contributing to the development of a dedicated website.

2.3 Oxfordshire Health Transformation

The Big Consultation Phase 1 consultations began on January 17 and we have attended every meeting bar one. Our report to HOSC meeting of March 7 summarised the key issues we have heard from the meetings and from individual contacts including:

What is the 'real' future of Horton General Hospital?

How can we properly comment on the closure of hospital beds when we are not told how the 'closer to home' care will be delivered and how this might impact on Phase 2 of the 'Big Consultation'?

What is going to happen in the second phase to community hospitals?

People are asking questions that are not addressed in the current consultation documents including about the impact on parking if the more outpatient appointments are delivered from the Horton; and the capacity in community hospitals and the care sector to support the 'closer to home' health care strategy.

An obvious gap in the information supplied in the Big Consultation documents has been any reference to the impact on social care, third sector partners and carers by the drive to 'closer to home' delivery of care. The decision by Oxfordshire County Council (OCC) Cabinet on February 21 'not to support the proposals based

Healthwatch is concerned that were the second phase of consultation will be developed without active input by Oxfordshire County Council and third sector partners that a similar response will be forthcoming from OCC.

2.3.1 Summary

Healthwatch Oxfordshire would have preferred a single health and social care transformation consultation.

Healthwatch Oxfordshire wants to see a Phase 2 consultation that is presented as a joint health and social care transformation document. The current draft OCCG timetable for the launch of Phase 2 of the transformation consultations is due to begin in November 2017. Surely this is sufficient time for the commissioners and providers to work together to achieve a health and social care transformation plan that will present the people of Oxfordshire with a system wide vision for the future on which to be consulted?

2.4 Deer Park Surgery

Healthwatch Oxfordshire has been very concerned that as of writing (23/3/2017) more than 2,000 patients have yet to register with a new surgery. We have taken a pro-active role in encouraging patients to register at another surgery – by the time you read this Deer Park will be closed. This has resulted in news-paper headlines including:

'Final warning to patients: find yourself a new doctor' (Oxfordshire Guardian 23/3/17),

'Deer Park patients are urged to move 'before it's too late' (Oxford Mail 16/3/17) and

Deer Park is set to close..(Witney Gazette 22/3/17)

We have regular contact with the Deer Park Patient Participation Group and Oxfordshire Clinical Commissioning Group and are feeding back to the OCCG issues that are being heard in the community regarding challenges facing patients looking to register at new surgery, concerns over appointment waiting times.

In April, Healthwatch will pull together the key stakeholders in order to learn from this experience of a surgery closing in Witney.

Quality of care in Care Homes

Oxfordshire Health Overview and Scrutiny Committee

6 April 2017

Benedict Leigh, Interim Deputy Director, Adult Social Care

Sula Wiltshire, Director of Quality & Innovation and OCCG Lead Nurse

NHS
Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

Background

- There are just over **4,895 care home places** for older people across 111 care homes in Oxfordshire.
- More than half of the places are purchased by people who fund their own care.
- Around 35% are purchased by Oxfordshire County Council and 9% are purchased by Oxfordshire Clinical Commissioning Group
- Oxfordshire County Council has a statutory responsibility for market development and sustainability.
- Oxfordshire County Council and Oxfordshire Clinical Commissioning Group are responsible for the quality of the care we commission

NHS
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Clinical Commissioning Group

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COUNTY COUNCIL

CQC Quality Ratings

- Care homes are regulated nationally by the Care Quality Commission (CQC) who conduct periodic inspections and award an overall rating.
- The CQC has a quality and a market responsibility

- As at 1st March 2017, 116 care homes had received overall ratings:
  - 3 care homes are rated as 'outstanding' (3%) compared to 1% nationally
  - 92 care homes are rated 'good' (79%)
  - 19 care homes are rated as 'require improvement' (16%).
  - 2 care homes are rated as 'inadequate' (2%)

- 82% of Oxfordshire's care homes are rated 'outstanding' or 'good' compared with 76% nationally

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Outstanding services

- Three care homes in Oxfordshire have achieved an overall Outstanding rating:

Vale House, Littlemore

CQC inspection area ratings
(Latest report published on 25 May 2016)

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Outstanding
Well-led	Good

The Grange Stanford in the Vale

CQC inspection area ratings
(Latest report published on 9 June 2016)

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Outstanding

Cleeve Lodge Goring

CQC inspection area ratings
(Latest report published on 26 October 2016)

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Outstanding

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

Local oversight of quality

- Alongside the national CQC process there is local management of quality and the market.
- A multi-agency Care Governance Group meets regularly to review serious concerns, safeguarding alerts, complaints, etc.
- We also collaborate in regional and national market intelligence groups.
- The CCG Quality Committee meets bi-monthly to ensure quality and clinical standards of healthcare are adhered to.

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Support

- Care homes receive a range of support from the Oxfordshire health and social care system
- This includes:
  - Business advice and quality support from Oxfordshire County Council
  - Nursing and therapy support from Oxford Health NHS Foundation Trust
  - Nursing, therapy, and medical support from Oxford University Hospitals NHS Foundation Trust
  - Medical cover from primary care
  - Infection control support from public health

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What does good look like

- At their best care homes provide the opportunity for people to live good fulfilling lives, with appropriate support.
- The best way to understand a good service is to ask a local outstanding home to describe how they work with their residents.

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Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: Thursday 6 April 2017

Title of Paper: Update on NHS Services delivered at the new Townlands Memorial Hospital

Purpose: To provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on the NHS services provided at the new Townlands Memorial Hospital in Henley on Thames, which serves the local community of south Oxfordshire.

Senior Responsible Officer: David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group

1. Introduction

The following paper provides an update on the redevelopment of the Townlands Memorial Hospital in Henley on Thames and associated NHS services.

2. Background

In 2012, Oxfordshire Primary Care Trust (PCT) approved the business case for the new Townlands Hospital. In 2013, the planning and responsibility for commissioning services was transferred to the Oxfordshire Clinical Commissioning Group (OCCG) as part of the NHS reforms.

The model of services in the 2012 business case was based on the type of service provision that fitted with the way health care was organised and delivered at that time.

Since then many things have changed; the NHS together with social care in Oxfordshire are changing services to deliver more care in local communities which helps to avoid admission to acute hospitals, except when necessary and for those patients who are admitted, keeping the time in hospital as short as possible.

Following a public consultation that concluded in June 2015 it was agreed to proceed with a new model of care at Townlands Memorial Hospital including the implementation of a Rapid Access Care Unit (RACU) and to purchase a number of beds from the new Chilterns Court Care Centre to support patients.

3. Service Developments

3.1. Oxford Health NHS Foundation Trust

Many services provided by Oxford Health NHS Foundation Trust (OHFT) were transferred from the old hospital into the new Townlands Memorial Hospital in March 2016. This included the minor injuries unit and the out of hours primary care services.

From April 2016 to March 2017 the minor injuries unit has managed 5,498 patients suffering minor injuries of which 98% were seen and treated within the 4 hour target. Below outlines the activity on a month by month basis:

2016/17	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb
Patient No’s	464	507	572	565	472	582	529	486	435	452	436

All of the above service activity is comparable to the activity for 2015.

From April 2016 to March 2017 the out of hours service supported 8,314 people within the Henley location. Below outlines the activity on a month by month basis:

2016/17	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb
Patient No’s	810	765	681	801	711	834	801	716	803	759	643

Other services provided by OHFT at the Townlands Memorial Hospital include podiatry, musculoskeletal services (relating to joints, bones and spine), speech and language therapy, nutrition and dietetics. The district nursing and health visiting services also use the facility as a base to support the provision of care directly into patient homes within the locality.

The new RACU opened its doors to the public on the 23 January 2017. This was a significant delay to the original timeline. There had been a number of issues to overcome, in the past year, namely the recruitment of a consultant to lead the multi-disciplinary team delivering the service.

The RACU provides assessment and treatment of patients with a crisis or deterioration in their health or long term. The service offers a clinic so that patients can be assessed by a consultant and, if needed receive diagnostic tests or treatments such as intravenous antibiotics on the same day to help avoid a stay in an acute hospital.

A patient who has attended the RACU may be discharged and continue to be treated in their own home or admitted to a RACU bed at the Chilterns Court Care Centre next to the unit.

Eleven beds for NHS patients are also located in the Chilterns Court Care Centre. Four beds are allocated for suitable RACU patients with medical support from this service, while the other seven are for patients who need a further period of recovery or rehabilitation (intermediate care beds) before going home or to a permanent care home when they no longer need hospital care. Medical cover is provided by the Bell and Hart Surgeries in Henley and the GP out of hours service.

The new RACU service has supported:

- 43 new patients (by the end of 21/3/17)
- 130 follow up treatments (by end of 21/3/17)
- 8 inpatients – with a length of stay between one and 24 days, with an average length of stay of nine days.

3.2. Royal Berkshire Hospital NHS Foundation Trust

The Royal Berkshire Hospitals NHS Foundation Trust (RBFT) provides outpatient services at the Townlands Memorial Hospital.

There are eight clinic rooms available in the new hospital and much work has been undertaken to increase the number of clinics held there. Within the old hospital, four clinic rooms were available with an average of 700 attendances per month. Since moving to the new hospital this has increased to over 1,200 attendances per month.

The increase in activity is a combination of both increasing existing services and new clinics starting. Those new services include:

- Trauma & Orthopaedics: spinal clinic and paediatrics
- Endocrinology: bariatric
- Plastic surgery
- Respiratory
- A new diabetes clinic will start once specialist nurse support is in place.

A minor procedures room is available which has enabled a ‘see and treat’ dermatology service to be commenced, whereby patients requiring a minor operation can have this carried out on the same day as their outpatient appointment.

Feedback from both patients and clinical teams continues to be extremely positive.

RBFT held an open evening for GPs on 27 September 2016 to discuss the outpatient services, future plans and gain first hand referrer feedback. This was a very positive evening for all. A further GP evening is planned later in 2017.

3.3. Orders of St Johns Care Trust (OSJCT) & Chilterns Court Care Centre

The Chilterns Court Care Centre opened its doors to residents on 30 November 2016. The new 64-bed care centre includes three floors dedicated to providing specialist dementia care and incorporates a number of features to promote recollection with residents. Each of the home's bedrooms has an en-suite shower and toilet facilities, along with access to digital television, telephone and Wi-Fi, as well as a 24-hour nurse call facility.

Each wing is arranged into small household units, each with its own communal dining and lounge areas, along with specialist bathing facilities, to give a domestic feel.

The home also includes several 'destination zones', including a high street themed first floor, complete with a shop, cafe and hair salon. The rest of the building is fully furnished throughout and decorated to a high standard, incorporating breakthrough dementia technologies to assist residents. Additionally, the property's outdoor area provides a safe and secure garden for residents to access and includes a fully landscaped sensory garden with raised planters, vegetable patches and water feature.

As mentioned above, OCCG commissions 11 beds from OSJCT in the Chilterns Court Care Centre. Seven are intermediate care beds (ICB) and there are four to support the RACU. The seven ICB beds have been fully occupied since the opening of the care home. There has been utilisation of the four RACU beds but activity is increasing due to this being a new service.

The average length of stay for the ICB beds is 18 days. For the beds to support the RACU the average length of stay is nine days.

OCCG will continually review the beds to see if the resource in the most effective manner. OCCG has the ability to buy further beds by using Oxfordshire's well-established spot purchase system. This system allows OCCG to access beds from those providers who have beds available at the time they are needed, without having to pre-commit funds. Our priority will be to purchase a bed within the OSJCT care home wherever possible. However, if a suitable bed was not available OCCG would purchase a bed from the next nearest provider to the patient's home.

Over the past year the Care Quality Commission (CQC) have inspected a wide range of services within Oxfordshire including acute and community providers, independent hospitals, care homes hospices and ambulance services.

On 25 January 2017 the CQC made an unannounced visit to the Chilterns Court Care Home. The CQC report was published on 13 March 2017 with the care home being rated as requires improvement. For the full report please see here: http://www.cqc.org.uk/sites/default/files/new_reports/INS2-3228938858.pdf

OSJCT and OCCG are disappointed with the outcome of the recent inspection. Following the transfer of patients and staff at the end of last year, as residents and colleagues have settled into their new home, OSJCT became aware of various issues that needed to be addressed. An action plan was already in place to resolve many of these before the CQC

visit. OSJCT has discussed this plan in detail with the CQC and are working hard to ensure all steps are taken to implement the necessary improvements.

OSJCT is also providing opportunities for the local community to come into the home, for example to attend its Dementia Café, which started recently. They very much look forward to developing closer ties with people in Henley.

3.4. Second floor of the Townlands Memorial Hospital

NHS Property Services are continuing to work with interested parties from the health sector with the aim of finding a tenant for the second floor.

4. Official Opening

The new Townlands Memorial Hospital was officially opened in a short ceremony on 28 March 2017, by Tim Stevenson OBE, Her Majesty's Lord-Lieutenant of Oxfordshire. Over 40 guests attended the event, including the Mayor of Henley, which recognised the success of the facility during its first year of operation.

5. On-going public involvement

As part of continuing patient and public engagement, OCCG formed a Townlands Stakeholder Reference Group (TSRG) in December 2015. The group is made up of representatives of local community groups, patients and carers as well as clinical and social care colleagues.

The purpose of the Townlands Stakeholder Reference Group (TSRG) is to bring together patients, carers and the public from the local community with NHS organisations and Oxfordshire County Council to ensure public views and experiences are taken into account in the implementation of the Townlands hospital redevelopment.

In the past year the group has met on a monthly basis with every second meeting held in public. Members of the public have the opportunity to submit questions at the beginning of the meeting with a slot at the end of the agenda to raise further questions or make observations.

Items covered at the meeting have included how social care works with the NHS, performance updates on services provided, communications and engagement with the local community and the on-going development of the RACU.

More information on the TSRG including associated papers and minutes of meetings are available here: http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/townlands-hospital-consultation/stakeholder-reference-group/

6. Conclusion

The opening of the Townlands Memorial Hospital, on 14 March 2016, and the associated development of the Rapid is an important step; it is at the forefront of OCCG's emerging transformation plans which will lead to services being delivered in new ways, with increased emphasis on preventing hospital admissions and providing more care in the community.

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Oxford Health
NHS Foundation Trust

Report to the Oxfordshire Joint Health Overview and Scrutiny Committee
6th April 2017

Quality Account
For information

Executive Summary
The following report provides a summary of progress against the 2016/17 quality objectives identified in the trusts Quality Account. A detailed update on progress after six months against all the objectives was presented and shared at the trust's Quality Committee, Board of Directors (in public), Council of Governors Forum (in public) and also external stakeholders including our main Commissioners, Health Overview and Scrutiny Committees and Healthwatch organisations.

The report also outlines the timeline for developing the annual Quality Account and the proposed overarching quality priorities for 2017/18 (the detailed quality objectives are still in development).

Progress against current quality objectives (2016/17)
In total there are 35 quality objectives and some progress has been made against all.

The quality objectives are aligned against the below four overarching quality priorities;
- Enable our workforce
- Improve patient, families and carers experiences
- Increase harm-free care
- Improve quality through service pathway remodelling and innovation

Those quality objectives where we have made significant progress include;

- Established system and support for nurses to complete revalidation. Revalidation is a new process for nurses from April 2016 to demonstrate their practice is safe and effective.
- A large range of work has been led by the staff health and wellbeing group
- Falls resulting in harm in community hospitals and older people mental health wards is reducing
- The trust, Buckinghamshire MIND, Buckinghamshire Adult Learning and the University of Bedfordshire are working together and launched the new Buckinghamshire recovery college in January 2017. This follows the success introduction of a recovery college in Oxfordshire in 2015.
- PEACE[1] trained champions have been identified across all mental health wards and bespoke escalation training trialled on two community hospital wards to reduce and provide more alternatives to restrictive practice. As a result we have seen a reduction in the total number of restraints as well as the number of prone (face down) restraints.

[1] PEACE stands for Positive Engagement and Calm Environments.

- Making families count training has been delivered to a range of staff as part of improving how we engage and work with families. In addition the trust's external accreditation with the Carers Trust was renewed in December 2016 which has driven work in the last 12 months on delivering carer awareness training to staff and developing a statement of expectations (also may be known as a carers charter) with carers that will go across organisations in Oxfordshire.
- Improvements in GPs being informed of ongoing psychotropic monitoring requirements by adult mental health teams, although more work is needed.
- Good progress on developing a new eating disorder pathways for adolescents across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset
- Waiting times for step 4 psychology services has reduced for Oxfordshire adults of working age
- A new ambulatory care model, the Rapid Access Care Unit, opened in January 2017 within the Townlands Memorial Hospital in Henley-on-Thames
- Improving physical health care to patients being treated by mental health services
- Continuing to roll out a cognitive behavioural therapy service in Oxfordshire salaried dental service to reduce the need to use sedation
- An internal quality peer review programme is established across clinical services, with over 50 reviews completed.

The following objectives have had delays; however we still plan for all to be started or completed by the end of March 2017;

- Implementation of the Nursing Strategy objectives for year one
- Introduction of a new trust wide electronic appraisal system (being piloted at the moment)
- Roll out new staff leadership development pathways (pathways are developed but will not start until 2017/18)
- Introduction of the four day PEACE foundation team training to all mental health wards
- Developing diabetes care on the community hospital wards
- Increasing the number of apprenticeship schemes

The areas we are experiencing challenges in are;

- Recruitment and high agency use for nurses across all directorates and doctors for some specialisms
- Technical issues with our electronic health record system affecting ease of use and completeness of information
- A large amount of improvement work has been completed to reduce pressure damage across the community hospitals and district nursing teams, however we are currently unable to demonstrate the impact of these actions
- Waiting times for step 4 psychology services for Buckinghamshire adults of working age, and older people across both Oxfordshire and Buckinghamshire

<u>Quality priorities and objectives for next year (2017/18)</u>

The quality objectives for 2017/18 have not yet been fully consulted and approved, however we will continue to focus on four overarching priority areas with a proposed slight amendment to two of the priority areas as below;

- Improve staff engagement
- Improve patient, families and carers experiences
- Increase harm free care
- Promoting health and wellbeing for patients, service users, clients, and staff

Timeline for developing the Quality Account

The trust is currently preparing the annual Quality Account which will include a detailed review on our quality achievements and successes over the past year (2016/17), as well as to identify areas for further improvement, including our quality priorities and objectives for the year ahead (2017/18).

The Council of Governors have selected one of the 2016/17 quality objectives from the Quality Account for testing by the external auditors. In addition the trust has selected two national indicators for testing. This testing is a mandatory requirement for NHS organisations based on assessing data quality and accuracy of reporting for that indicator by looking at the key processes and controls.

The final draft annual Quality Account will be sent out for consultation with external stakeholders from 19th April 2017 and will be due back on 12th May 2017. The trust will then finalise the document at the board of directors meeting on 24th May 2017 ready to be submitted to NHS Improvement as part of the Annual Report by 31st May 2017 and published as a stand-alone document on NHS Choices by 30th June 2017.

Author and Title: Jane Kershaw, Head of Quality Governance
Lead Executive Director: Ros Alstead, Director of Nursing and Clinical Standards

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South Central Ambulance Service NHS
NHS Foundation Trust

Clinical Directorate
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Tel: 01869 365159

21st February 2017

To: Overview and Scrutiny Committees/Healthwatch

Debbie Simmons
Director of Nursing
Thames Valley/ Wokingham CCG

Simon Hawkins
Contract Manager Thames Valley

Julia Barton
Director of Nursing
Fareham and Gosport CCG

Julie Gumbrell
Head of Quality
Fareham and Gosport CCG

Dear Colleague,

I am writing to ask for your feedback and engagement in agreeing our quality improvement priorities for the 2016/17 Quality Accounts.

SCAS have engaged widely internally to develop the proposed priorities and used a variety of sources of intelligence such as feedback/complaints/incidents/audits and compliance actions to inform our planning.

The Quality Accounts and report provides a framework to assess the quality of the service on what matters to patients and informs the public, our commissioners and staff about the quality of care provided to patients and families.

It also provides assurance about our commitments to improve the quality of the service through the setting of key priorities and actions.

Preparation has begun to produce the 2016 -17 Quality Accounts. The Quality Account report will provide the following (although this list is not exhaustive):

- A statement from the Chairman and Chief Executive
- Set out our statutory requirements as a Trust
- Describe our journey to the “good” rating from the CQC
- Identify key priority improvement areas
- Provide assurance statements from our commissioners
- Demonstrate engagement with other partners such as Overview and Scrutiny Committees, our Council of Governors and other stakeholders
- Describe our progress against the current priorities
- Describe our progress with the Workforce Race Equality Standard and Staff Survey for equal opportunities
- Outline our approach to Duty of Candour
- Describe our commitment to the Sign up to Safety Campaign
- Give data on a variety of mandated indicators as described by NHS England

It is important to note that the data set cannot be completed until April 2017 as that will be the end of year reporting timeframe.

We will take into account, the feedback received when setting the priorities for next year and in our review of this year. Along with your comments we will, of course, provide you with the full report once it is complete.

Mandated indicators to be included in the Quality Accounts for Ambulance Services (NHS England)

- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period
- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of Category A telephone calls resulting in an ambulance response by the Trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.
- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period.
- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period.
- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.
- The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Proposed priority improvements for Quality Accounts (SCAS)

- The priorities outlined have been highlighted as areas/issues emerging throughout the course of the year and have been selected as areas SCAS feels the need to improve on.

The following are the proposed local areas and priorities for next year:

Priority 1 Patient Safety

1a	To improve the recognition of sepsis in adults in CCC (Clinical Coordination Centre) and Emergency and Urgent care (999)
1b	To complete a clinical governance review of the Emergency and Urgent Care (E&UC) 999 service and implement the recommendations
1c	To provide a consistent approach to medicines management which is compliant with the regulatory standards

1d	To continue to implement the workstreams in the national Sign up to Safety campaign to improve patient safety across all services

Priority 2 Clinical Effectiveness

2a	To report on the percentage of patients with Stroke and Heart Attacks who receive an appropriate care bundle (mandated indicators) (as described above)
2b	To report on the percentage of patients receiving an emergency Ambulance response within 8 minutes and 19 minutes (mandated indicators) (as described above)
2c	To review and improve call abandonment for NEPTS (Non-Emergency Patient Transport Service), 999 and 111 (2 year priority)
2d	To increase clinical assessments in CCC (call centres) ensuring consistent methods and application across the services (3 year priority)

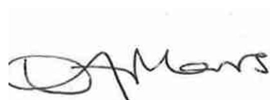
Priority 3 Patient Experience

3a	The data made available to the National Health Service Trust or NHS Foundation Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.
3b	To improve and learn from HCP (Healthcare Professional) feedback in all services
3c	To ensure a service that is consistently responsive, listens and engages with feedback from al variety of sources in NHS 111 and PTS

I would be very grateful for any feedback and if you would review the priorities and provide comments to me on the suitability / relevance of the chosen priorities for next year by 8th March 2017 at debbie.marrs@scas.nhs.uk

A full report can be obtained from 31st May 2017 onwards when it will be published.

Yours Faithfully



Debbie Marrs
Assistant Director of Quality

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Oxford University Hospitals NHS
NHS Foundation Trust

Title	**Oxford University NHS Foundation trust 2016/17 Quality Account 2016-17 and Proposed Quality Priorities 2017-1 for the Joint Health Overview and Scrutiny Committee April 2017**

Status	For information
History	

Board Lead(s)	Dr Tony Berendt, Medical Director

Executive Summary

1.	This paper sets out the programme of work that was undertaken by Oxford University Hospitals NHS Foundation Trust in 2016/17 in order to deliver the identified Quality Priorities. The method and provisional choices for the 2017/18 Quality Priorities are contained within the body of the report.
2.	**Recommendation** HOSC members are invited to discuss and provide feedback on this overview of progress against 2016-17 quality priorities, and to note the emerging quality priorities for 2017-18.

1. Introduction

1.1. The essence of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. OUHFT's mission is to provide excellent and sustainable services to the people of Oxfordshire and to patients who come to the Trust in order to access specialist regional, national and international care which may be unique to our Trust. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence which is the essence of our clinical strategy and our research and training programs. Contained within this presentation are commitments to quality priorities within the domains of patient safety, clinical effectiveness and patient experience.

1.2. Throughout 2016/17 we have reported to our board, our staff and our commissioners on progress against our quality priorities.

1.3. A well-received patient public and staff engagement event was held at the Trust on 16th January 2017. This event included short films outlining the 2015/16 quality priorities and why they might continue as well as round table discussions in which participants could highlight their most important areas of work from the current priorities, other quality improvement work going on in the Trust and suggestions for new areas of focus. The outputs from this event were reviewed by the Trust's Quality Committee.

1.4. A number of our 2016/17 priorities will continue as the work programmed was expected to extend over more than one year.

1.5. Staff have been involved in setting quality priorities via our business planning process and discussions in Clinical Governance Committees across the Trust.

2. Did we achieve the 2016/17 Quality Priorities?

We chose the following as our work programmes for 2016/17

2.1 (Priorities 1a -1e in table 1) Preventing harm and deterioration including programs for:

- Medication safety (in response to audits in 2014/15 and including antibiotic stewardship- a national Commissioning for Quality Improvement and Innovation (CQUIN)
- Acute kidney injury, AKI, (an alert affecting 30 patients per day)
- Recognition and treatment of sepsis (National CQUIN)
- Care 24/7 (NHS national priority)
- Nationally recognised iPad based track and trigger SEND project

2.2 (Priority 2 in table1). Following an expert external review of our investigations of Never Events that occurred in the Trust in 2014/15 we are committed to:

- Further Human factors training to enhance the lessons learned from adverse events.
- Improving our systems for sharing learning within and between teams across the Trust

- Improving our systems for ensuring knowledge of and compliance with essential policies

2.3 (Priorities 3a -3c in table1). More effective care with better patient experience including programs for

- End of life care (proposed local CQUIN)
- Dementia care
- Our Compassionate Care program to improve patient experience throughout the Trust

2.4 (Priority 4 in table 1). Stake holder engagement and partnership working including:

- Improving our interface with primary care and other key partners
- Our Delayed Transfers of Care Program

Table 1
Priority 1A: Medication safety

Goal	Target	Evaluation
To improve compliance with the safe and secure medicine standards	100% compliance and if required an action plan to address any non-compliance	We did not achieve this. Compliance with the safe and secure storage of medicines standards has improved but not to 100% -action plans are being monitored and progress challenged in the Clinical Governance Committee.
To increase the number of medication incidents reported (indicative of an open and learning culture)	15% increase	We did not achieve this. Work has continued to encourage the reporting of medication incidents wherever possible. The successful introduction of electronic prescribing (ePMA) may be a factor.
To reduce the proportion of medication incident reported and graded as moderate or above in severity.	10% reduction overall, 20% reduction with insulin, anticoagulation, antimicrobial and omitted or delayed administration of essential medicines.	We partially achieved this. The 10% overall harm reduction has been achieved and 20% reduction in 3 of the 4 target areas. The target areas that have achieved a reduction are insulin, antimicrobials and delayed and omitted prescribed medicines.

Priority 1B: Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

Goal	Target	Evaluation
Development of Trust wide education on AKI	Non-medical health professionals	We achieved this. A trust wide education programme is now in place. The education provision will be ongoing long term to address the issue of staff turnover.
Improve communication with primary care for patients who have suffered AKI	To include AKI 2/3 flags in discharge summaries	We achieved this. All AKI flags are now included in discharge summaries.
Pharmacy review of medication in patients with AKI	Increase early review of medication in AKI	We partially achieved this. The medication review tool has been rolled out across the Trust and staff are being educated to implement this. It will become live by 31st March 2017 and then we will have fully achieved the aims.
Work with primary care colleagues to improve management of AKI in primary care	Admission avoidance	We achieved this. Primary Care alerts have been live since November 2016 with associated bespoke AKI care bundles in Primary Care. The OUH NHS FT model is being used in Buckinghamshire.

Priority 1C: Identification and early treatment of Sepsis

Goal	Target	Evaluation
Prompt recognition of sepsis	Standardised screening for sepsis across the Trust	We achieved this. We have developed and implemented an electronic Sepsis Screening Tool ('Sepsis Agent') for adult emergency admissions and inpatients which puts alerts on our computer screens for patients who may be septic. Since then more than 90% of patients meeting the criteria for screening have been screened for sepsis in the areas where this has been implemented.
Prompt antibiotic treatment of sepsis	Antibiotics to be administered within 1 hour of presentation with severe sepsis	We partially achieved this. The proportion of patients with sepsis that receive antibiotics within 1 hour has increased among both emergency admissions and inpatients (55% and 45%, respectively to the end of December 2016.

Priority 1D: Care 24/7

Goal	Target	Evaluation
All critically ill patients will be seen and reviewed by a consultant twice daily including all acutely ill patients directly transferred, or others who deteriorate	By Q4 100% of patients in intensive and areas defined as high dependency will be reviewed by consultants twice daily.	We achieved this. Our audit results demonstrate that 100% of our critically ill patients in intensive and high dependency areas have been reviewed twice per day by consultant level doctors and then daily as required within 'drop down units'.
Complete our program of work to implement the four critical standards by March 2017.	By March 2017 the bi-annual audits will be complete with data and actions reported to NHS England	We achieved this. We have carried out six monthly audits of more than 250 emergency admissions against these four priority standards. OUH NHS FT has performed extremely well in these audits, and the most recent published results reflect high standards of care delivered across the Trust.

Priority 1E: SEND System for recording and viewing patients' vital signs

Goal	Target	Evaluation
Complete planned roll out across the OUHFT NHS Foundation Trust	Roll out to JR Cardiac Centre and West Wing, Horton ED, NOC Centre for Enablement and Outpatient areas	We achieved this SEND has been fully rolled out according to plan and is in use.
The wards and clinicians from any location can access real-time vital sign observation charts and Track and Trigger scores	Clinical staff will use the system to capture patient observations in real-time	We achieved this SEND is now accessible from every computer in the trust. Clinical staff are using the system to capture patient observations in real-time.
Nursing time saved recording vital signs and calculating Track and Trigger scores	Nurses can provide better patient care due to saving time when using SEND to record patients' vital signs	We achieved this A research study of 577 observations of nursing practice found a 17% (35 second) median saving in the time to undertake observations when comparing SEND with the preceding paper system.

Priority 2: Human factors training

Goal	Target	Evaluation
To deliver human factors training incorporating simulation to healthcare professionals from all Divisions	18 one day courses	We achieved this. 18 one-day courses for multi-disciplinary teams across OUH NHS FT have taken place.
To develop a Human Factors and Quality Improvement Advisory Group and an associated strategy for quality and safety led by the Deputy Medical Director	To deliver a human factors and QI strategy for the OUHFT with the explicit aim of building capability across the Trust and delivering a sustainable programme of quality improvement	We achieved this. The Human Factors (HF) and Quality Improvement (QI) advisory group meets monthly to monitor and guide progress in Human Factors and Quality Improvement domains.
To deliver train the trainer courses to build capability and sustainability in human factors training across the OUHFT	Four one day ambassador courses to train an additional 50 trainers	We achieved this. Train the Trainer course for OUH NHS FT HF Ambassadors has been completed and we have trained 50 champions.
To deliver training in quality improvement for healthcare professionals and managers from all Divisions	One day Human Factors (HF)/ Quality Improvement (QI) training	We achieved this. Training provided by the Patient Safety Academy has delivered one day HF/ QI training for over 70 staff.

Priority 3A: End of life: improving people's care in the last few days and hours of life

Goal	Target	Evaluation
Additional palliative care provided in Emergency Department (ED) and Emergency Assessment Units (EAUs)	Palliative care staffed to provide daily rounds in ED and EAU	We achieved this 100% of patients recognised to be near to the end of life at ED and EAU had a palliative care review within 24 hours to the end of December 2016 and this is projected to continue in the future. (Data refresh awaited).
Improved feedback from families	95% of families offered a feedback form	We did not achieve this A bereavement survey has been piloted across a cohort of wards and has been received very positively. The Bereavement Team will offer the feedback form from the end of March 2017.
Swan scheme in place	Symbol Known to and understood by all staff	We partially achieved this Swan Scheme roll out: Renal, 7A, 7B and Oncology wards have been identified as working towards achieving accreditation by the end of March 2017. The symbol has been chosen: sunflower. Information will be disseminated to all staff via the staff update in April 2017.
Improved staff confidence, skills and knowledge	75% of staff have undertaken e-learning training	We did not achieve this Cascade training is now in place: more than 100 senior nursing and medical staff have been now been trained in EOLC. E-learning modules have been agreed and will be rolled out in 2017/18
Anticipatory medication	95% of patients have these medicines on discharge	We did not achieve this. Work has progressed within the Trust on this and partnership work continues with Oxford Health NHS FT to advance this priority.
Joint work on discharge	Understanding blocks to discharges	We did not achieve this. Work on this will roll on to 2017/18

Priority 3B: Dementia Care

Goal	Target	Evaluation
Dementia data reviews	90% of patients aged 75 years and over screened for dementia	We did not achieve this The current dementia screening rates have improved to 60%. Significant work is being carried out to improve compliance.
To promote a positive experience for patients living with dementia and their carers during any engagement with hospital services.	Improvement in qualitative feedback	We partly achieved this The Trust continues to work closely with Carers Oxfordshire on the Carers Project. The Outreach Worker from the charity regularly attends the Trust's Dementia Information Café and holds drop-in 'surgeries' on the Acute General Medicine wards at the John Radcliffe, as well as taking referrals from Staff. Qualitative data has shown a positive response to these sessions.
To promote dementia awareness via training to relevant staff within the hospital	75%	We achieved this. Figures for the relevant staff trained for tier 1 dementia training were 73% (up to 8th March 2017) with a projection that the year-end target of 75% will be achieved.
To enhance the current knowledge and understanding of dementia through appropriate training to all relevant staff.	Training of 50% of frontline staff	We achieved this 65% of relevant frontline staff have received training in 2016/17.

Priority 3C: The compassionate care program

Goal	Target	Evaluation
To provide classroom training sessions for 1500 frontline staff on Delivering Compassionate Care	1500 staff attend classroom sessions in 2016/2017 financial year.	We achieved this. Up to 8th March 2017 1,400 employees had attended the training on Delivering Compassionate Care. 6 dates for delivery are planned before 6 April 2017 providing places for 110 delegates bringing the projected total to over 1500.
To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff.	50% of attendees complete evaluation 3-6 months post-training in 2016/2017 financial year.	We achieved this. Quarterly surveys to attendees measuring training outcomes continue to be circulated and have achieved a 100% return rate. An interim evaluation has been completed and demonstrates a 95% ‘highly satisfied’ response.
To provide E-Learning training accessible to all staff on concepts underpinning Delivering Compassionate Care	1500 staff access and complete E-Learning Package sessions in 2016/2017.	We did not achieve this A review is in progress to establish plans to increase the penetration of this course across the frontline staff group.

Priority 4: Stake holder engagement and partnership working

Goal	Target	Evaluation
To involve stakeholders in future strategy	Work collaboratively as a healthcare system across Oxfordshire	We achieved this The Trust continues to participate in the Sustainability and Transformation Plan (STP)
To improve communication of patient information to primary care colleagues	To deliver 98% all e-discharge summaries to primary care colleagues within 24 hours of discharge	We did not achieve this 80% of discharge summaries currently are e-messaged to primary care colleagues within 24 hours of discharge
To improve assurance that all test results have been acted upon	To endorse 95% of test results on EPR within seven working days	We did not achieve this. Following revision of the trajectory in conjunction with OCCG, the February 17 target was achieved with 80% of test results endorsed on EPR within seven working days against a target of 78%
Progress system wide improvement in quality of care	Deliver aims of the delayed transfers of care (DToC) program	We achieved this. It is the Trust's priority to get patients back to their home environment as quickly and as safely as possible by supporting them for up to 6 weeks in their own home with re-ablement support. It is also the Trust's aim to prevent hospital admission by supporting patients already in the community to whom we have been alerted by our primary care colleagues. The Trust has 140 re-ablement workers supporting on average 180 patients and clients per day in the community. The Trust is providing over 350 hours of care per week for those patients who have been identified as requiring a long term care package and who are awaiting our social and health care colleagues to identify local domiciliary care providers to take over these care packages. The Trust is working closely with Oxfordshire County Council on this priority.
To ensure patients and families have an improved experience of the discharge process from inpatient care	Establish a working group by 30th November 2016. Launch a revised patient discharge booklet by 31st March 2017.	We achieved this. The working group has been established. The revised patient discharge booklet has been launched. Four discharge workshops have run at the John Radcliffe, the Churchill, the Nuffield Orthopaedic Centre and the Horton to reduce the number of delayed transfers of care by earlier and comprehensive discharge planning.

3.0 How we are choosing our priorities for 2017/18

3.1 Here we describe a suite of quality priorities for the coming year. These are part of a wider work plan to deliver high quality care to all of our patients. All quality improvement work is monitored closely by our Clinical Governance and Quality Committees and we regularly report our performance to our commissioners and regulators.

3.2 A well-received patient public and staff engagement event was held at the Trust on 16th January 2017. This event included short films outlining the 2015/16 quality priorities and why they might continue as well as round table discussions in which participants could highlight their most important areas of work from the current priorities, other quality improvement work going on in the Trust and suggestions for new areas of focus. The outputs from this event were reviewed by the Trust's Quality Committee.

3.3 The most support for continuing priorities was for Partnership working and End of Life Care

3.4 Our Governors have expressed interest in adopting End of Life care as their chosen priority for 2016/17.

3.5 A number of our 2016/17 priorities will continue as the work programmed was expected to extend over more than one year.

3.6 Over the year ahead, we aim to prioritise the delivery of quality improvements across a range of projects and services. There are nine Trust wide quality priorities. There have been several different drivers in the development of these projects:

- Priorities set for the NHS nationally;
- Priorities arising through feedback that the Trust has received from service users and our local Healthwatch organisation;
- CQUIN (Commissioning for Quality and Innovation) projects developed with our commissioners from NHS England and Oxfordshire Clinical commissioning group
- Priorities set from a review of incidents and internal audit reports and
- Priorities articulated in our Annual Business Plan.

4.0 Draft Priorities for 2017/18:

Using the methodology outlined above our current draft priorities are as follows:

Patient safety

- Partnership working
- Safe discharge
- Preventing patients from deteriorating – time critical care (Heart attack, stroke, blood clots in the lungs, sepsis including the use of the SEND system)

Clinical effectiveness

- Best care for patients with mental ill health including preventing need to come to the Emergency Department and their care during physical illness
- Cancer pathways

- Go digital

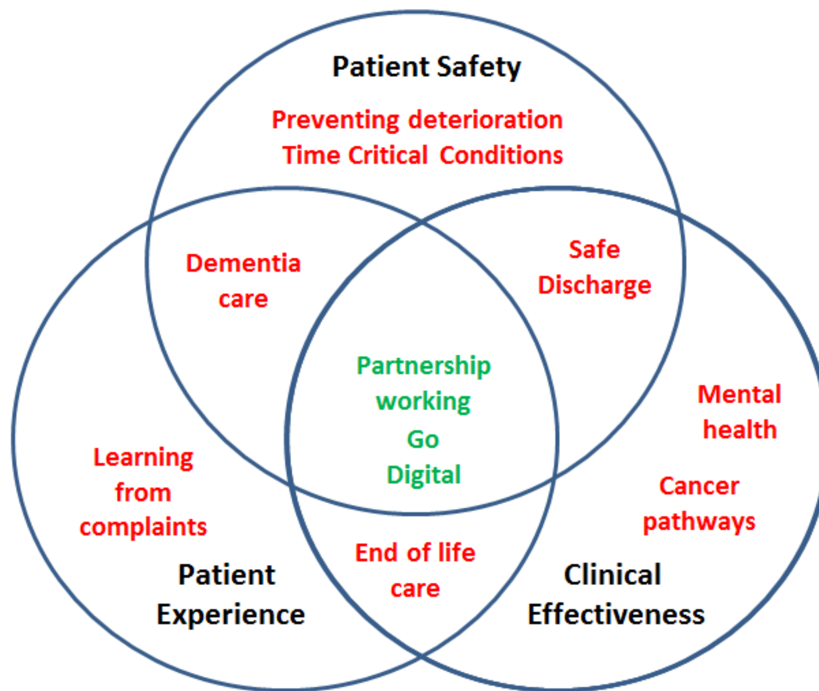
Patient experience

- End of life care
- Dementia Care
- Learning from complaints

5.0 Draft Quality Priorities 2017/18

The table below follows the format we have developed in previous years and links the proposed priorities to the three quality domains of patient safety, clinical effectiveness and patient experience.

Table 2



7.0 Why we chose these Draft Priorities for 2017/18:

7.1 Patient safety

7.12 Partnership working – This was the top choice from our patient and public consultation event in January. It is also a major strategic aim for the Trust to work with system partners across Oxfordshire in areas such as the STP. Our CQUIN (Commissioning for Quality and innovation) programme this year includes partnership networks with other hospitals to deliver best quality care together for spinal surgery, specific blood disorders and chemotherapy etc.

7.13 Safe discharge – This is an area which spans one of our areas of work from last year but also builds on feedback from patients and GPs that we could improve in this area. It was also the favourite new priority from our patient and public event.

7.14 Preventing patients from deteriorating – time critical care (Heart attack, stroke, blood clots in the lungs, sepsis including the use of the SEND system) – This was the third most popular priority to continue at our patient and public consultation event and is a theme from our incidents or near misses.

7.2 Clinical effectiveness

7.21 Mental Health – We know that the Emergency Department (ED) is not the best place to care for patients with mental ill health and we will be working with Oxford Health to find ways to prevent the need to come to ED for patients and we will work on improving care for those with mental health conditions during physical illness requiring admission to our hospitals. This was the second most popular suggested new priority at our patient and public event.

7.22 Cancer pathways – Delivering timely and co-ordinated care for patients with Cancer is a major priority for us and our regulators NHS Improvement.

7.33 Go digital – We have been named a 'global digital exemplar' which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. As a digital exemplar, we have ambitious plans to accelerate the opportunities that digital technology offers, in line with the ambition of the NHS to be 'paper-free' and for patient records to be held electronically and accessible across different systems. We are committed to ensuring these processes improve our safety, effectiveness and patient experience.

7.3 Patient experience

7.31 End of life care- This was the second most popular priority to continue when we asked our patients and public at our event in January 2017. We agree that while we achieved a lot last year we can still do more to develop our end of life care in 2017/18.

7.32 Dementia Care – Dementia is an increasingly common condition and we want to continue to build on last year's progress in this area.

7.33 Learning from complaints – It is fundamental that we improve how we listen to our patients and learn from their experiences therefore we want to make this a priority this year.

8.0 Conclusion

8.1 HOSC members are invited to discuss and provide feedback on this overview of progress against 2016-17 quality priorities, and to note the emerging quality priorities for 2017-18.

Dr Anthony Berendt, Medical Director Oxford University NHS Foundation Trust
Dr Clare Dollery, Deputy Medical Director Oxford University NHS Foundation Trust
23rd March 2017

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Health Overview and Scrutiny Committee – 20 April 2017

Chairman's Report

Liaison meetings

The Chairman attended the following briefings with representatives from health and social care organisations between February 2017 and April 2017:

8 February – Oxford University Hospitals Trust
A visit with other members of the Committee to the Discharge Liaison Hub at the John Radcliffe Hospital.

13 March – 'BOB' Scrutiny Chairmen and Oxfordshire Clinical Commissioning Group
An informal meeting with the scrutiny chairmen from Buckinghamshire, Reading, West Berkshire and Wokingham to exchange views, concerns and questions about the 'BOB' Sustainability and Transformation Plan.

Oxfordshire County Council

21 March – Council debate on the County Council's response to Phase 1 of the Big Health and Care Consultation
The Chairman spoke to make clear that the 2 Phase consultation was the result of HOSC requiring consultation by January 2017 on the temporary closure of the obstetric service at the Horton General Hospital and the acute bed closures across hospital sites. The resulting 2-phased consultation was agreed by HOSC at its meeting in November 2016. The Chairman also stated that the remit of HOSC as a county-wide scrutiny committee is to examine proposals on the strength of the evidence and their merits. In the debate councillors focused primarily on the phasing of the consultation. The Council voted to object to Phase 1 of the consultation. A summary of the Council's response will be attached as an addendum.

Visit to the Discharge Liaison Hub

On 8 February the Chairman and five Committee members visited the Discharge Liaison Hub at the John Radcliffe Hospital to see first-hand how the discharge of patients, many of whom are frail with complex needs, is coordinated and managed by a multi-disciplinary team.

Lily O'Connor, Divisional Head of Nursing and Governance - Medicine, Rehabilitation and Cardiac Nurse Division and Dr James Price, Divisional Director – Geratology, Oxford University Hospitals Trust (OUHT) provided an overview of the functions of the Liaison Hub and the key barriers to discharge.

Liaison Hub beds
Patients in Hub beds, based in care homes across Oxfordshire, are usually a) waiting for therapy in a community hospital, b) being assessed for continuing healthcare, or c) people with large care packages / complex needs who are in a Hub

bed for their safety to be assessed. Not every patient who is discharged goes into a Hub bed. In particular people who have severe cognitive impairment and challenging behaviour, or patients who would be likely to decline are not supported in Hub beds.

There were a reported 102 beds in use at the time of the visit, which represented an increase since December 2016. It was explained that this is linked to seasonal variability.

Barriers to discharge
OUHT cited the key barriers to discharging patients as the ongoing intensive care and support needs of a small number of patients, and workforce challenges within domiciliary care. In particular, the availability of home care in South Oxfordshire compared with the needs of patients there was viewed as an issue, particularly as a large care provider in South Oxfordshire left the market in September. Committee members acknowledged that there was a strong correlation between higher funding and the availability and flexibility of home care. The complexity of the regulatory framework and expected standards within home care also add pressure to this market.

Members asked about approaches to tackling workforce challenges in health and social care. Whilst opportunities for professional progression are available within OUHT, Health colleagues felt that more defined career pathways could be developed. In particular, programmes that help young people access the healthcare system, e.g. volunteer schemes and apprenticeships. It was agreed that more work needs to be done in this area. Members were reminded that there is a work stream focused on workforce in the Transformation programme.

Before ending the visit members were given a tour of the Acute Ambulatory Unit where people whose needs escalate are seen as outpatients, and the Clinical Coordination Centre where GPs can receive immediate advice from a consultant physician about assessing a patient. These are both initiatives used to prevent unnecessary hospital admission.

OUHT colleagues where thanked for facilitating the visit, which provided greater insight into and understanding of the Liaison Hub and informed the Committee's forward plan.

Feedback on 'BOB' scrutiny chairmen's meeting

On 13 March the Chairman met with the chairmen of the health scrutiny committees from Buckinghamshire, West Berkshire, Reading and Woking to share views, concerns and questions about the Sustainability and Transformation Plan (STP) across the 'BOB' footprint. Ann Donkin, STP programme manager and David Smith, footprint lead and Chief Executive of Oxfordshire Clinical Commissioning Group attended to answer questions.

The scrutiny chairmen from other areas shared similar concerns to Oxfordshire's HOSC, i.e. concern about the level of stakeholder and patient engagement on the STP, financial risk management across the footprint, and governance arrangements for the STP that clearly demonstrate where accountabilities lie.

It was emphasised that the 'BOB' STP is an amalgam of local delivery plans (e.g. the Oxfordshire Transformation Plan), therefore councils should engage with the process through their CCGs and Healthcare Trusts at a local level. There are however, a small number of footprint-wide initiatives where services can be managed more effectively at scale.

It was revealed that if there was a funding gap in the STP, each local health system would have to meet this. David Smith gave assurances that he is working in partnership with leaders of the local health systems and if he did not agree with local proposals, he would work collaboratively with them to find a joint way forward.

It was reported that Rachael Shimmin, Chief Executive of Buckinghamshire County Council has recently joined the STP Executive Board to facilitate better communication with local authorities across the footprint. The STP commissioning executive is still in its formative stages and aims to provide a formal structure for CCGs across 'BOB' to meet – the exact governance arrangements need to be agreed.

The group agreed that the meeting had been useful and it would be worth meeting again in 6 months' time to inform the scrutiny of delivery plans at a local level, as well as having an overarching view of progress at a footprint-wide level.

Letters sent on behalf of the Committee

1. HOSC's response to the Phase 1 Big Health and Care Consultation

A letter was sent to the CCG stating the specific concerns raised by HOSC on 7 March in response to the consultation and the Committee's subsequent recommendations in accordance with the 2013 health scrutiny regulations. The Committee's letter and the reply from the CCG are below:

Date: 13 March 2017

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Contact: Katie Read, Policy Officer
Tel: **01865 792422**
Direct Line: 07584 909530
Email: katie.read@oxfordshire.gov.uk

David Smith, Chief Executive &
Dr Joe McManners, Clinical Chair
Oxfordshire Clinical Commissioning Group

[sent by email]

Dear David and Joe,

Re: OJHOSC's recommendations on the Phase 1 Big Health and Care Transformation proposals

At its meeting on 7 March the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) formally scrutinised the content of proposals in the Phase 1 Big Health and Care Consultation and considered their impact on patients and the public. In accordance with Regulation 23(4) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 this letter outlines the specific concerns raised by OJHOSC on 7 March and the Committee's subsequent recommendations.

Whilst acknowledging that Oxfordshire's health system needs to change significantly as part of the national transformation programme, the Committee was concerned by the lack of support for the proposals from key stakeholders at this stage. In particular, the Committee would like the OCCG to address the following areas of concern:

a) **The credibility of a two phase consultation.** The Committee noted concern that splitting the Big Health and Care Consultation into two phases, with community services and general practice in Phase 2, does not enable the public and key stakeholders to understand OCCG's overall vision for Oxfordshire's health services or assess the impact on them. Moreover, the lack of any options in the consultation has led to a perception that the OCCG has already decided on a way forward and members of the public are not able to influence the outcome.

b) **The confusing nature of the consultation*.*** Committee members noted concerns that the technical language used in consultation documents is confusing for the public and there is a lack of knowledge about what services are currently available and how these will change. Members noted that the consultation lacks sufficient explanation about how the proposals will impact individual patients and communities.

   The Committee recommends that the OCCG considers amending the consultation to:

   - Ensure that all future public consultation events and online information is amended to remove technical language to express explanations in layman's terms;
   - Include case studies and patient stories to demonstrate what impact the proposals could have on patients individually and on their communities; and
   - Include an overview of current services (particularly at the Horton General Hospital ('the Horton'), and how these would change if the proposals were implemented.

c) **The unknown effect of the proposals on partner services.** The Committee is concerned that key partners are unable to assess the impact of the proposals in Phase 1 without knowing proposals in Phase 2. In particular, OJHOSC is concerned that Oxfordshire County Council has not been able to model the impact of the proposal to permanently close 194 acute beds on

Adult Social Care. The OCCG has not demonstrated to the Committee that sufficient alternative community provision is available alongside or ahead of the proposal to close beds, or that there is the workforce to deliver this. As proposals for community hospitals are expected in the Phase 2 consultation, the Committee questions whether the temporary closure of 146 of these beds has contributed to recent increases in delayed transfers of care, and added to any pressures experienced in Emergency Departments during this winter period.

The Committee expects to see the results of further work with Oxfordshire County Council to establish what effect the proposal to permanently close 194 beds will have on adult social care resources.

d) **An ambiguous picture for the future of maternity services, particularly in the north of the county.** The Committee has concerns that the overall picture for maternity services in the north of the county is not understood whilst the proposal to permanently downgrade obstetric services at the Horton in Phase 1 is separated from proposals for midwifery-led units (MLUs) across the county in Phase 2. In particular, the inclusion of example options for Chipping Norton MLU in the Phase 1 consultation document has led to confusion and uncertainty about the future of this service and caused unnecessary public anxiety.

OJHOSC has noted the weight of opposition from elected representatives to the proposed permanent removal of consultant-led provision at the Horton and the continued challenge over transport times and ambulance support affecting public safety, access and choice.

The effect of the Committee's decision to refer the temporary downgrade of obstetric services at the Horton to the Secretary of State in February is not yet known.

The Committee recommends that the OCCG:

- Takes immediate action to clarify the proposals for maternity services in the north of the county as a whole in the Phase 1 consultation, or develops an alternative approach to consulting on these proposals;
- Presents a comprehensive appraisal of options for maintaining obstetric services at the Horton, including the potential for an obstetrics rota between the JR and the Horton;
- Provides specific answers to:
  - the numbers of mothers transferred from the Horton to the JR during the temporary closure,
  - travel times from the Horton to the JR for these mothers, and
  - the future of ambulance support at the Horton for mothers needing to be transferred.

e) **The interdependencies between Phase 1 and Phase 2.** The Committee is concerned that decisions on Phase 1 proposals will pre-determine the outcome of a Phase 2 consultation because of inherent interdependencies. The removal of consultant-led maternity services at the Horton affects the

sustainability of other services, including the Special Care Baby Unit, paediatrics, gynaecology and anaesthetics.

The Committee expects to see proposals to remove or reduce the risk of pre-determination. (In Phase 2 it will be necessary for the OCCG and Oxford Health to clarify the role of community hospitals in relation to the proposal to further develop the Early Supported Discharge Service.)

f) **Plans for investment at the Horton General Hospital.** The Committee is concerned that there is no commitment to invest in redevelopment of services at the Horton. OJHOSC understands why residents do not trust the proposals for a major diagnostic/ day treatment centre at the Horton to transfer more than 60,000 appointments from the John Radcliffe.

   The Committee asks that the OCCG and Oxford University Hospitals Trust demonstrate how they intend to make the planned investments at the Horton should the proposals in Phase 1 be approved.

g) **Chronic parking and access issues at Oxford University Hospitals Trust hospital sites.** The Committee is concerned about the lack of detail in the business case on planned investments in parking and access across hospital sites to manage the volume of additional patients expected at the John Radcliffe and the Horton as a result of the proposals. The evidence given on 7 March suggested that success required planning permission and construction of a number of multi-storey car parks on hospital land in Oxford and Banbury. If, as in the past, this permission is not forthcoming, this would to render the proposals void.

   The Committee asks that more information is shared on the masterplans for the Horton, John Radcliffe, Churchill and Nuffield Orthopaedic Centre including:

   - the impact modelling of Phase 1 proposals on parking and access across hospital sites,
   - how investment for these plans is being secured, and
   - any feasibility study completed,
   - the timeframe and process for obtaining the required sites and planning permissions.

h) **A lack of focus on health inequalities.** The Committee is concerned that there is a lack of evidence about how the Phase 1 proposals will impact health inequalities and how any adverse effects on vulnerable groups will be mitigated. There is particular concern that the proposal to downgrade maternity services at the Horton will disadvantage residents in Banbury, parts of which are among the 20% most deprived nationally.

   The Committee requests evidence of how Phase 1 proposals tackle health inequalities and what measures will be taken to mitigate any adverse effects on the health of residents in the most deprived areas of north Oxfordshire.

i) **Limited engagement with neighbouring areas.** The Committee is concerned that there has been insufficient engagement with, or understanding of the impact on, bordering health systems, particularly in Warwickshire and Northamptonshire in relation to the proposals at the Horton.

   The Committee recommends that OCCG consults further with residents and health scrutiny committees in Warwickshire, Northamptonshire and other neighbouring areas affected by the proposals in Berkshire, Buckinghamshire and Swindon.

The Committee invites you and representatives from Oxfordshire's Healthcare Trusts, to a further, formal meeting with OJHOSC (on a date to be arranged) to respond to these concerns and present proposals for how they might be addressed.

In the event that it is not possible to hold a meeting prior to the end of the consultation period, the Committee would seek a commitment from the OCCG that any recommendations or comments made by OJHOSC (in addition to those above) would be considered in the OCCG Board's deliberations about a way forward.

Furthermore, it would be helpful if you could clarify, in accordance with Regulation 23(1)(b)(i) of the 2013 Regulations, the proposed date by which you intend to make a decision to proceed with the proposals.

I look forward to your response.

Yours Sincerely

Cllr Yvonne Constance OBE
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

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Cllr Yvonne Constance OBE
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23 January 2017

By email:
yvonne.constance@oxfordshire.gov.uk

23 March 2017

Dear Yvonne

Re: Phase 1 - Big Health and Care Consultation

Thank you for your letter of 13 March 2017 and we look forward to discussing these matters further with the Joint Health Overview and Scrutiny Committee (JHOSC) in due course. Naturally, we think it imperative that health and social care bodies work together to deliver the integrated services which our communities need, although we are mindful of the care we need to take not to prejudice other processes you have started. Specifically, your decision to refer Oxford University Hospitals NHS Foundation Trust's (OUHFT) decision to temporarily close consultant led maternity services at the Horton, see more below.

In specifically responding to each point raised using your lettering system and on which we will expand at the next meeting, our comments are:

a) We set out the reasons for moving to a two phase approach in our note prepared for the JHOSC meeting on 17 November 2017 and discussed this during the actual meeting. Specifically you will recall that we thought it important to move forward with '*those areas where there are the most pressing concerns about workforce, patient safety and healthcare*'. However, we were '*clear that our proposals for community based care would benefit from continued development with a wide range of stakeholders prior to us launching a public consultation on any service change*'.

   In response to this paper recorded in the minutes of the JHOSC meeting on 17 November 2017 *'Members of the Committee then, in discussion with Diane Hedges and Andrew Stevens AGREED to approve the consultation Plan as presented and to AGREE that the OCCG should proceed with Phase 1 of the consultation in January and requested that:*

   - *With regard to options relating to obstetric/midwife-led units in the north of the county – if any proposal impacts on any surrounding services, then information on this should be included in the consultation;*
   - *Options around the closure of any other service at the Horton Hospital be included and considered together, for example emergency abdominal, viability of paediatric care, Accident & Emergency – and if they are not included in the first phase, then nothing in the first phase would prejudice the second phase;*
   - *Proposed delivery of planned care at the Horton would be included in the consultation paper and the impact of changes in GP delivery would be made clear;*

- *That the geographical detail be easily identifiable so that the public can be clear about proposed changes to be made to services in their locality; and*
- *Clarity on the meaning of 'ambulatory care'.*

Given the information provided, which includes the paper provided to the JHOSC for the 17 November 2016 meeting and other documents provided for public consideration during the Phase 1 Consultation, which includes the PCBC, then we do think we have set out the overall vision for the provision of health services in Oxfordshire. However, we do think more needs to be done to explain the integrated health and social care provision on community based care for Phase 2.
In the Phase 1 Consultation document we clearly seek views on proposed changes with regard to:
- How we use hospital beds
- Planned care at the Horton General Hospital
- Acute stroke services
- Critical care at the Horton General Hospital
- Maternity services at the Horton General Hospital

In consulting the public we are mindful of the need to put forward realistic options which we believe, on the basis of the process undertaken to date, are viable to implement. Further, we will consider alternative solutions and options which are put forward during the process we are undertaking, which includes the public consultation.

b) We have provided a 'Glossary of Definitions' with the Consultation document and will look at that again, but think technical language has been avoided as far as possible.

As to case studies, you will note that the consultation document concentrates on giving the public the information we believe they need to understand what we are proposing. Where possible during events and conversations with consultees we have used case studies of patients and how the proposals will affect them. However listening to the feedback from consultees we will, for Phase 2 provide case studies to illustrate the proposals / options.

Not all current services at the Horton Hospital are impacted on by these proposals. Therefore the consultation document concentrates on those on which we want the public's view.

c) As you are aware we are working with the County Council through the STP process. Further, NHS England has recently announced an assurance process to address prior to closing beds. This will be worked into our implementation programme and no beds will close until we are assured it is safe to do so.

In addition OCCG is considering establishing an independent advisory assurance panel to support implementation of all the decisions we make following this consultation which we hope will provide both the JHOSC and the

public with additional confidence. We would welcome your views on this and will be happy to expand on the role of that Panel when we meet.

d) Given the decision of the JHOSC to refer temporary maternity decisions taken by OUHFT to the Secretary of State then we think we need to be careful not to prejudice that on-going process. Naturally, we will carefully consider the views of the Secretary of State and IRP in due course. Further, we are very aware of the views expressed by MPs and fully appreciate the emotive nature of changes to maternity services. However, you will appreciate that the safety and welfare of patients and staff are of paramount importance to the CCG in commissioning services. To support our understanding on these issues we also have an independent view from the Clinical Senate, and the view of local clinicians to develop the options on which we are consulting.

- The current proposals on maternity are clearly set out in the Big Consultation document, see pages 33 to 41, and will be further expanded on across Oxfordshire during Phase 2. However, as you will appreciate, we must keep an open mind as to realistic options which could be viable and consider the views of the Secretary of State and IRP in due course.
- As requested:
    - At the end of January 2017, which is the current point we have validated data for, 25 mothers transferred from the Horton General Hospital to John Radcliffe
    - The travel time, as set out in the validation session with the Community Partnership Network on the 28 November was defined as being thirty nine minutes (Off Peak) between the Horton General Hospital and the John Radcliffe
    - Future ambulance provision is currently a static ambulance stationed outside of the maternity unit, but cannot be finally modelled till a decision is taken.

e) We are clear on the need to maintain an open mind and not predetermine decisions, given the two phases of consultation we are undertaking. This, in our opinion, is evident from our approach. This approach will be overseen by your Committee and our regulator, NHS England.

f) As to plans on investment, I hope you will appreciate that we must make a clear decision first and then a Full Business Case will be prepared by the provider.

g) It is OUHFT's intention to develop multi-story car parks across all its sites. This will reduce the overall footprint of the car parks across the sites, and improve traffic flow within the site and allow new technologies to be implemented. Further discussions will be required with the local planning departments in scoping these proposals.

h) We do fully appreciate our statutory obligations, which clearly require us to assess equalities and inequalities, as is set out in:
    - s.149 Equality Act 2010 – which relates to the public sector equality duty

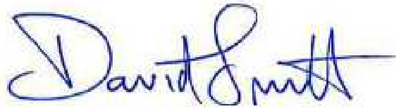
- s.14T NHS Act – the duty to reduce inequalities of access and outcomes.

These are on-going duties and we have undertaken analysis throughout this process to inform our views. Following analysis of the responses to the consultation then we will further consider how these views inform the decisions which we have to take. Naturally the CCG Board will be provided with detailed information on the equality and inequality issues and will also consider what further actions need to be taken as we move to implementation of decisions made.

i) We have appropriately engaged with our neighbouring areas.

The CCG intends to make a decision on the options set out in Phase 1 early summer 2017.

Yours sincerely



David Smith
Chief Executive

Dr Joe McManners
Clinical Chair

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2. Referral to the Secretary of State for Health - Deer Park Medical Centre

On 2 February HOSC unanimously agreed to refer the CCG's decision not to re-procure services at Deer Park Medical Centre, Witney to the Secretary of State for Health. The Committee's referral letter and the response from the Secretary of State are below:

OXFORDSHIRE
COUNTY COUNCIL

Date: 8 February 2017
Our Ref: OJHOSC/SoS/DPMC

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Contact: Katie Read, Policy Officer
Tel: **01865 792422**
Direct Line: 07584 909530
Email: katie.read@oxfordshire.gov.uk

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
LONDON SW1A 2NS

Dear Secretary of State,

Re: Referral of Oxfordshire Clinical Commissioning Group's decision not to re-procure services at Deer Park Medical Centre, Witney

On 2 February 2017 the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) decision not to re-procure services at Deer Park Medical Centre (DPMC), Witney to the Secretary of State for Health. This referral is made pursuant to Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The primary care services provided by Virgin Care at DPMC are due to end on 31 March, after which the surgery will close, unless you act in your capacity as the Secretary of State to prevent this.

The Committee and the OCCG have been unable to reach agreement on whether the OCCG's actions regarding DPMC constitute a substantial change in service and no satisfactory local resolution has been found. that This referral is therefore made, pursuant to Regulation 23(9)(a) and (c) of the 2013 Regulations, on the basis that consultation with the public and patients at DPMC was inadequate and the closure of the surgery would not be in the interests of residents and patients in the Witney area.

Background

The sustainability of primary care services and OCCG's actions to support vulnerable GP practices has been an ongoing area of scrutiny for the OJHOSC.

Earlier in 2016 the Chairman of OJHOSC was briefed on the re-procurement of services at DPMC and the OCCG was asked to complete a 'substantial change assessment'. This assessment provides an overview of the proposed change, the people it will affect and the impact it is likely to have, as well as any planned or past engagement and consultation activity. It is the start of a process used by the Committee and local NHS organisations to identify whether a proposal constitutes a substantial change in service. This is known locally as the 'toolkit'.

In response to patient concerns and those of Committee members, the OJHOSC had a strategic discussion about the OCCG's approach to managing the current pressures on general practice in November 2016. An overview of the changes at DPMC was presented as part of this and the Committee agreed to hold an informal 'toolkit meeting' to examine the completed substantial change assessment.

An informal toolkit meeting was held on 12 December 2016. At this meeting the OCCG maintained that its action in respect of DPMC was *not* a substantial change in service, but the majority of OJHOSC members present concluded that it *was.* The Committee requested more information on a number of areas, which has only

been provided in part. The OCCG's completed assessment and outcome of the toolkit meeting are enclosed for your information.

The matter was then formally considered by OJHOSC on 2 February 2017. Agreement could not be reached with the OCCG on whether its decision not to re-procure services at DPMC constituted a substantial change. Furthermore, no satisfactory local resolution to the issue was presented.

The Committee was also made aware that a patient at DPMC had submitted an application for judicial review proceedings on whether the OCCG had met its statutory duties to involve and consult the public under s.242 NHS Act 2006. Although OJHOSC was initially advised to delay its consideration of the issue until the litigation had concluded, the permission hearing was held on 1 February and the Committee was informed that permission had not been granted at its formal meeting the next day. As such, the question of substantial change was dealt with at this meeting.

Reasons for referral

The OJHOSC resolved to refer the matter to the Secretary of State on the grounds that inadequate consultation had taken place with the public and patients at DPMC before a decision not to re-procure services was made, and this decision was not in the interests of residents and patients in the Witney area.

The Committee's key areas of concern were that:

- Deer Park patients would experience some reduction in service, such as longer waiting times for routine appointments at other surgeries and the loss of a twice weekly walk in clinic.
- The closure would present travel and access issues for patients, for which the OCCG did not provide adequate mitigations.
- The proposed mitigations would introduce elements of a new operating model for general practice that should be the subject of public consultation.
- The views of local stakeholders, including West Oxfordshire District Council, Witney Town Council and the Deer Park Patient Participation Group, were that patients at the surgery would be detrimentally affected by the closure.

Members were also concerned to learn that the OCCG had sent letters to patients about registering with other practices before formal consultation with the Scrutiny Committee on the question of substantial change had taken place on 2 February. It is understood that the OCCG had done this following the conclusion of the litigation the previous day.

In light of services ending at DPMC on 31 March and the OCCG's actions, the Committee requests that you expedite your review of this matter and consider instructing the OCCG to halt the dispersal of patients at DPMC until the outcome of your review is known.

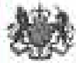
Yours Sincerely

Cllr Yvonne Constance OBE
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Enc:

1. DPMC substantial change assessment, as completed by the OCCG, 12 December 2016
2. Record of the informal Committee meeting to discuss the OCCG's assessment, 12 December 2016
3. OCCG Presentation for HOSC toolkit meeting on DPMC, 12 December 2016
4. Email from the OCCG – Availability of appointments at DPMC, 13 December 2016
5. OCCG Impact Assessment - DPMC closure, 18 October 2016
6. Questions put to the OCCG Board on DPMC, 29 November 2016
7. OCCG report – 'Primary Care in Oxfordshire', presented to OJHOSC on 17 November 2016
8. OJHOSC minutes, 17 November 2016
9. West Oxfordshire District Council DPMC Working Party minutes, 9 November 2016 & 26 October 2016
10. West Oxfordshire District Council Economic and Social Overview and Scrutiny Committee minutes, 19 January 2017, 24 November 2016 & 6 October 2016

DPMC Patient Participation Group report for West Oxfordshire District Council Economic and Social Overview and Scrutiny Committee, 25 October 2016 (appendices available on request)



Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

POC_1073014

Councillor Yvonne Constance
Oxfordshire Joint Health Overview and Scrutiny Committee,
County Hall,
New Road,
Oxford,
OX1 1ND

14 MAR 2017

Dear Cllr Constance,

RECONFIGURATION -: Oxfordshire Clinical Commissioning Group's decision not to reprocure services at Deer Park Medical Centre, Witney. Formal referral under Regulation 23(9) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Thank you for your letter of 8th February 2017 referring to me the proposal not to re-procure services at Deer Park Medical Centre, Witney. I am today writing to the Independent Reconfiguration Panel (IRP) asking them to undertake an initial assessment of your referral.

The option to look again at what services should be provided at or in the immediate vicinity of Deer Park Medical Centre is one to be considered by the IRP. I am, however, satisfied that, based on the evidence presented to me, the option to continue the existing service expired some months ago, and that it is not now a safe or practical option. I have decided not to make any directions at this time, having regard in particular to the potential risk to patient safety, to unpick the current arrangements for handling the inevitable consequences of the ending of the existing contract.

I have also asked the CCG to consider (bearing in mind also the requirements of safety and efficiency) taking no further actions, pending the outcome of the IRP review, that would preclude a future resumption (or re-commissioning) of services at/on/near the existing site.

I wish to take this opportunity to reiterate that patient safety is my first and foremost priority and the priority of the NHS. It is therefore vital that all Deer Park Medical Centre patients should register with another surgery nearby, in line with the arrangements made by the CCG, to ensure that, whatever the outcome of the IRP review, they have continued access to the services they need.

Should the IRP advise me that a full review is necessary, you will have the chance to present your case to them in full.

I have asked the Panel to report to me no later than Tuesday 11th April 2017.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to Oxfordshire CCG.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

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3. Referral to the Secretary of State for Health – temporary closure of consultant-led maternity services at the Horton General Hospital

On 2 February HOSC unanimously agreed to refer Oxford University Hospitals Trust's (OUHT) temporary closure of consultant-led maternity services at the Horton General Hospital to the Secretary of State for Health. The Committee's referral letter is below. To-date there has been no response from the Secretary of State regarding this referral.

OXFORDSHIRE COUNTY COUNCIL

Date: 14 February 2017
Our Ref: OJHOSC/SoS/HortonMat

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Contact: Katie Read, Policy Officer
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Email: katie.read@oxfordshire.gov.uk

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
LONDON SW1A 2NS

Dear Secretary of State,

Re: Referral of the temporary closure of consultant-led maternity services at the Horton General Hospital

On 2nd February 2017 the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) unanimously agreed to refer Oxford University Hospitals Trust's (OUHT) temporary closure of consultant-led maternity services at the Horton General Hospital ('the Horton') to the Secretary of State for Health. This

referral is made pursuant to Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Background

In 2006 the then Oxford Radcliffe Hospitals NHS Trust (ORH) proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the Special Care Baby Unit from the Horton in Banbury to the John Radcliffe Hospital (JR) in Oxford. The Committee believed that the changes were not in the interests of people in the north of the county and referred the matter to the Secretary of State, who supported this view.

The Independent Reconfiguration Panel advised that the Trust and the Oxfordshire Primary Care Trust were to invest in, retain and develop services at the Horton, as it considered the Hospital to have an important future role in providing local care to people in north Oxfordshire and the surrounding areas.

ORH maintained consultant-led maternity services at the Horton supported by a training programme for junior doctors working in obstetrics. However, in 2012 post graduate obstetric training accreditation at the Horton was withdrawn. This was predominantly due to the low numbers of births at the Hospital, which meant limited exposure to complex cases, and the difficulties experienced in recruiting sufficient numbers of middle grade doctors.

The Trust then developed a Clinical Research Fellow programme to support consultant-led provision, but they reported that national recruitment shortages in obstetric posts led to a reduction in applications which made it unviable. The programme closed in December 2015 and a rotational middle grade rota was created to staff the obstetrics unit.

In September 2016 the Committee was informed that OUHT were intending to temporarily close consultant-led maternity services at the Horton from 3rd October 2016, as they were unable to adequately staff the unit in a safe and sustainable manner.

OJHOSC held a further meeting in September to scrutinise OUHT's contingency plan for continuing Maternity and Neonatal services at the Horton. This included evidence of the Trust's efforts to maintain consultant-led maternity services and a discussion about the impact of temporarily closing the obstetrics unit and the associated risks.

At the meeting the Committee agreed that the Trust had provided satisfactory reasons for invoking an urgent temporary closure of consultant-led maternity services at the Horton General Hospital without consultation. It was agreed that the matter should not be referred to the Secretary of State at this stage on the following basis:

- A reduction in consultants at the unit was imminent,
- The Trust's recruitment drive had so far failed, although the Trust had not ceased its recruitment efforts and appointees were being offered contract extensions as an incentive,

- Alternative options for staffing the unit had been considered, e.g. the rotation of doctors with the John Radcliffe (JR) in Oxford,
- The question of travel times from the Horton to the JR had been thoroughly explored and a dedicated ambulance would be available 24 hours a day at the Horton to transfer complex cases to the JR,
- A decline in the numbers of births at the Horton was explained as the result of an increase in risk factors during delivery and more people being advised to go to the JR,
- High risk patients would be advised to go to the JR before they entered labour, so there was less need to transfer complex cases during labour, reducing risk.
- The majority of outcomes from other free-standing midwife-led units in Oxfordshire were reported to be safer because of a reduced risk of medical intervention.
- Provision of extra facilities and staff at the JR would be available to cope with the additional births from the north of the county and the equipment moved there could be moved back to the Horton.
- **Assurances were given by the Trust that they planned to reopen the unit by March 2017 on the strength of an action plan to recruit more consultants.**

To monitor the situation carefully the Committee requested regular updates on the status of consultant-led maternity services at the Horton, the number of women transferred to the JR in labour, and the recruitment of obstetricians.

The Committee was also keen to establish that a decision to temporarily close consultant-led maternity services at the Horton General Hospital would not pre-determine the outcome of the Oxfordshire Health and Care Transformation (OTP) Phase 1 consultation.

Phase 1 of the OTP consultation, which launched on 16 January 2017, includes a proposal to move obstetric services, the Special Care Baby Unit and emergency gynaecology inpatient services permanently to the JR, whilst maintaining midwife-led maternity services at the Horton.

Since the summer of 2016 the Committee has heard many passionate appeals from campaign groups, residents and MPs in the north of the county for consultant-led maternity services at the Horton to continue, as this would otherwise mean a downgrading of the Hospital.

OJHOSC plans to scrutinise proposals for permanent changes to maternity services in Phase 1 of the OTP at a special meeting on 7 March 2017 and provide its formal response to the consultation thereafter.

Reason for referral

The Committee chose not to refer this matter to the Secretary of State in September having agreed a local resolution with the Trust, namely that the closure would be temporary and a recruitment plan was in place to increase staffing levels by March at the latest, if not before.

The Trust's update on performance of maternity services at the Horton, dated 23 December 2016, stated that they would not have enough experienced and skilled medical staff in post to reopen the unit in March 2017 as planned.

OJHOSC believes that the material grounds for not referring the matter have therefore changed, i.e. the Trust's recruitment plan has failed and the closure will now be longer than envisaged.

The Committee considers nothing further can be gained by discussions at a local level. OJHOSC has provided effective challenge to the temporary changes in provision of maternity care, but it will not agree that ongoing material service changes should take place without consultation.

Therefore, at its meeting on 2 February, the Committee resolved to refer the matter to the Secretary of State under Regulation 23(9)(b) of the 2013 Regulations and to ask that you refer the issue of provision of maternity services at the Horton General Hospital to the Independent Reconfiguration Panel.

I look forward to your response.

Yours Sincerely

Cllr Yvonne Constance OBE
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Enc:

1. OUHT report to OJHOSC 'Contingency Plan for Maternity and Neonatal Services', September 2016
2. OUHT updates on maternity at the Horton General Hospital, 10 November, 5 December and 23 December 2016
3. OJHOSC meeting minutes, 15 September and 30 September 2016
4. Oxfordshire Health and Care Transformation Phase 1 consultation document

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