

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 16 November 2017 commencing at 10.00 am and finishing at 3.45 pm

Present:

Voting Members:

Councillor Arash Fatemian – in the Chair

District Councillor Monica Lovatt (Deputy Chairman)

Councillor Kevin Bulmer

Councillor Mark Cherry

Councillor Dr Simon Clarke

Councillor Mike Fox-Davies

City Councillor Mark Ladbrooke (in place of City

Councillor Susanna Pressel)

Councillor Laura Price

Councillor Alison Rooke

District Councillor Nigel Champken-Woods

District Councillor Andrew McHugh

Co-opted Members:

Dr Alan Cohen and Dr Keith Ruddle

Officers:

Whole of meeting

Strategic Director for People; Julie Dean and Sam Shepherd (Resources)

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.

51/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

City Councillor Mark Ladbrooke attended in place of City Councillor Susanna Pressel.

Katie Read

The Chairman began the meeting by thanking Katie Read for all her good work as Policy Officer to this Committee and wished her well in her co-ordinating role for scrutiny in the County. He also welcomed her successor, Samantha Shepherd as Policy Officer to this Committee.

He also welcomed new member Dr Alan Cohen as co-optee and District Councillor Neil Owen representing West Oxfordshire District Council.

52/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

The following declarations of interest were received:

- Agenda Item 8 - Banbury Health Centre – Cllrs Arash Fatemian and Mark Cherry declared a personal interest on account of their being regular users of a GP practice in Banbury;
- Agenda Item 8 – District Cllr Andrew McHugh declared a personal interest on account of his appointment as a short-term locum at West Bar GP surgery, Banbury; together with his involvement in the running of social prescribing in Cherwell up to 2016;
- Agenda Item 9 – City Cllr Mark Ladbrooke declared a general interest on account of his wife’s employment in the library service at the Warneford Hospital.

53/17 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 14 September 2017 were approved and signed as a correct record subject to the inclusion within the Chairman’s Report (Minute 50/17) of the formal announcement of Dr Alan Cohen as a co-opted member of the Committee.

With regard to Minute 47/17 - Advice from the Independent Reconfiguration Panel (IRP) (final paragraph) – It was reported that the informal working group would begin its work in the near future despite the imminent change in chief executive of the OCCG.

54/17 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following members of the public addressing the Committee immediately prior to Committee discussion on the item itself:

- Agenda Item 9 – Sarah Lasenby, speaking as a member of the public
- Agenda Item 9 – Larry Sanders, speaking as a member of the public
- Agenda Item 10 – Written statement by Jane Southworth, on behalf of the Patient Participation Group (PPG), Deer Park Surgery, Witney

55/17 FORWARD PLAN

(Agenda No. 5)

The Committee considered a proposed Forward Plan (JHO5). During the ensuing discussion the Committee added the following:

- Update on Mental Health services with a particular look at the provision of mental health services to former servicemen; and
- Musculoskeletal Service – following discussion at the last meeting the Committee requested that a more detailed briefing, including a progress report, be taken to the next meeting in February. Members were asked to submit any further questions for Health to respond to.

56/17 HEALTH INEQUALITIES COMMISSION - UPDATE ON THE RESPONSE BY HEALTH & WELLBEING BOARD

(Agenda No. 6)

The Committee had before them a report which had been presented to the 9 November 2017 meeting of the Oxfordshire Health & Wellbeing Board (HWB) detailing progress made against the Health Inequality Commission (HIC) report's sixty recommendations (JHO6). The County's Strategic Director of People & Director of Public Health, Dr Jonathan McWilliam, together with Jackie Wilderspin (Public Health Consultant) and Ally Green, OCCG (representing Dr Joe McManners, Clinical Chair, OCCG) attended the meeting to respond to questions.

Dr McWilliam commented on the importance of keeping the topic alive amidst many other competing priorities. The Commission report had produced recommendations which were very specifically targeted at particular organisations and some which were outside of the normal statutory organisations. Furthermore, a key task of the HWB, in its capacity as an advisory partnership, had been to undertake an overview and co-ordinating role to the work of the Commission.

Jackie Wilderspin introduced the paper and responded to questions from members. The Committee welcomed the report recommendations and views, comments and questions from members were as follows:

- The usefulness of this work in breaking the silos apparent between organisations was very good. However, this type of work did not fit with planning timeframes and the measurement of performance. For example, BME women needed additional obstetric intervention in childbirth – was this taken into account with the proposals to close the obstetric services at the Horton General Hospital? Dr McWilliam responded that there was no need to wait for implementation of the proposals, organisations were welcome to act on them themselves;
- With regard to the need to carefully monitor food banks, in light of the Council's removal of funding to support homeless shelters, a member asked if the need for food banks was increasing and wasn't there a need to understand their use, rather than just mapping and monitoring? Jackie Wilderspin responded that

work was still ongoing in relation to their use and a report back on food bank activity had been requested;

- The decision to form an Innovation Fund was good but this might not meet the greatest need in some geographic areas. How robust was the strategy to conduct this? Dr McWilliam commented in response to this on the need to adopt three main approaches simultaneously. The greatest was the goal of adopting long term strategies for which funding was required both to spark and keep county-wide interest and to drive the Health Inequalities programme through. The short-term work was necessary to keep the programme rolling and action going via specialist interest and strategic drive. Health Inequalities were driven by population need, not where there were initiatives;
- The Joint Strategic Needs Assessment (JSNA) and all other policies were in danger of allocation to those who shouted the loudest? Jackie Wilderspin stated that the Commission had formed its report on representations from communities at meetings and objective data from the independent Director of Public Health's independent report and the JSNA. **Dr McWilliam encouraged a request from the Committee to see the assessment criteria to see which projects qualified for funding.** As an additional piece of scrutiny, and as a good companion to the Commission's report, he suggested that members read 'Oxfordshire Uncovered' by the Community Foundation which highlighted where inequalities lay across the county;
- In light of the recommendations contained in the report highlighting the future work needed to monitor the impact on school readiness in terms of previous family link work done with nurseries prior to the closure of children's centres, Dr McWilliam reminded the Committee that he had flagged up the need to take an overview of this trend in his independent report. He added that school readiness was monitored via Child Health. **The Committee requested an update on criteria determined and agreed upon;**
- A member asked about ongoing work on gaps in the provision of mental health services for older people in relation to access to the service on the basis of age, not need. NHS England had stipulated that it should be on need. Jackie Wilderspin responded that a review of mental health services was currently in progress and work was also ongoing on getting a mental health need assessment to support the review. The Health Inequalities Commission would be tapping into this review;
- In response to an enquiry about whether social prescribing was likely to arrive in north Oxfordshire, Jackie Wilderspin stated that explorations were ongoing into this issue as service use data was very poor. Patient records with regard to ethnicity were incomplete, the belief being that a proportion of patients chose not to have it recorded, thus making analysis impossible. However, whatever data was available could be used to encourage all organisations to make use of it equitably. She added that there were no detailed plans regarding social prescribing at present. A Team was currently working on it. **The Committee requested the timetable for rolling out details, when available, for social prescribing;**

- A member asked if there was more that could be done by the HWB to encourage take-up on services to assist with poverty, ie the living wage and affordable housing. In addition, was there anything Public Health could do to increase the provision of affordable housing within the county. Dr McWilliam stated that it was a joint effort by both the county and district councils, both being public health organisations. It was the key business of the Health Improvement Board, a partnership group reporting to the HWB who engaged with all the wider determinants of Health affecting all key organisations;
- In response to a question about whether the recommendations of the Commission were reflected in the STP plans for major development in Health to respond to need, Dr McWilliam stated that this Committee in its role as scrutineer, had an important role to play in prompting each organisation to think about health inequalities, adding that it would be very helpful if HOSC was to keep it on its future Agendas in order to keep the subject alive. **Ally Green agreed to request Dr McManners, Chair of the Commission, to give a response to the Committee's questions and these to be circulated to all members of the Committee;**
- A member asked about issues relating to housing need for older people in social housing. **Jackie Wilderspin responded that this had not been addressed as yet, but once it had she would circulate a response to the Committee;**
- A member expressed concern in relation to the abundance of references to the support of older people digitally and about the complex nature of the forms, such as that for the Attendance Allowance applications. Dr McWilliam agreed with this observation.

On the conclusion of the question and answer session, the Committee thanked Dr McWilliam and Jackie Wilderspin for their attendance and AGREED that the Health Inequalities Commission recommendations be re-visited every 6 months for the foreseeable future.

57/17 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 7)

The Committee welcomed Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) to present the regular update of issues/activities since the last meeting (JHO5). She offered her Chairman, Professor Smith's apologies as he had been delayed. Rosalind Pearce highlighted the following:

- There would be a stall on Stroke Awareness at Thame Market on 28 November. She reported that despite the usual practice of working with HWO Buckinghamshire, unfortunately they would be unable to join in on this occasion. Cllr Champken - Woods thanked her for arranging this as it was at the request of the Committee. She added that a stall was also planned in a town in the Vale of White Horse area in April next year;

- A key recommendation coming out of the recent Forum meeting was that the Oxfordshire Health & Wellbeing Board (HWB) needed to have better ways of engaging with the voluntary sector. Dr McWilliam responded that this had been taken on board and a review of HWB Board governance was taking place. This matter would be on the HWB Agenda for the next Board meeting on 22 March 2018;
- HWO would be facilitating a meeting to establish a project fund in January 2018 to enable research on Health Inequalities.

Questions and responses received from the Committee were as follows:

- In response to a question about whether issues had been raised with HWO about the restricting of day services, Rosalind Pearce stated that people had contacted HWO post change. Many were unhappy that they were unable to access services that they would have to travel further to. Age UK had been doing a significant amount of work in the community with the people affected, as had HWO following their concern about social isolation amongst older people. She added that HWO was planning to try to understand the longer-term impact of this and then to embark on a piece of work starting in September 2018, for report in February 2019;
- Rosalind Pearce was asked if there had been any work done by HWO on waiting times for GP practices, as this tended to increase numbers attending Accident & Emergency departments. She stated that HWO had found that people were not happy if people had to wait for longer than one week and there was significant dissatisfaction after two weeks. It was the view of HWO that there was a need to re-educate the public in order to change the way they booked appointments. For example, to encourage them to book a further appointment on their way out from an appointment, if appropriate, or to encourage them to see an alternative doctor sooner rather than later with their preferred one. Nowadays patients could see the practice nurse or the local pharmacist depending on the problem. She added also that now there was a GP service operating in the acute hospital;
- In response to a question about what HWO planned to tackle next, she stated that HWO had a rolling annual plan in place. She added that HWO tried to state what they had heard from patients and the public and action taken by HWO as a result, together with any action implemented by an organisation as a consequence. This assisted in HWO gaining a better feel of its impact and the difference made;
- Rosalind Pearce confirmed that HWO would accept anonymous accounts from the public, often of their experiences of the administration of services, not generally on the delivery of care. Ideally, this would come from the patients themselves, as the patients' story was the most powerful voice. She added that often people did not understand that HWO was an independent body and felt there needed to be a way of disseminating an understanding that what they had to say would not affect their care in any other way but a positive one;

- Rosalind Pearce was asked how could HWO engage in the reduction of poverty and in raising wages? She responded that whilst HWO was pleased that Oxfordshire was looking at and tackling health inequality issues, it had not been engaged in a campaign to reduce poverty as it was outside its remit of listening about existing services. However, HWO had recently appointed a project officer with a public health background who could assist with demand management. For example, HWO would be looking at the 111 service and its impact in a bid to understand the alternative ways to help people in providing their own support;
- In response to a question to Rosalind Pearce about whether HWO had a policy on home visits to patients by GPs, Paul Roblin, Local Medical Council, who was in the public gallery, informed the Committee that it was inappropriate to have a policy as each individual practice and GP had to make an assessment as to what was required. Over time there had been a move away from routine visiting. It was the best option if the patient could attend the surgery to access not only the GP but the equipment and support staff, but if not, the patients and triaging staff needed to use their own judgement on when a home visit was necessary. A member put forward the view of a Chipping Norton PPG which expounded the benefits of connecting people and letting them know what was the usual practice used by the surgery, via its website. He encouraged all GP forums to be much more active in a similar manner. He believed that HWO could apply some leverage on PPGs; and
- A member asked Rosalind Pearce for a view by HWO of the need to pre-book a place at a workshop on future planning of primary care in Witney and its surroundings, which had resulted in a feeling of exclusion. She responded that she understood it was due to the size of the venue.

The Committee thanked Rosalind Pearce for the report and for her attendance. It was **AGREED** to note the report.

58/17 BANBURY HEALTH CENTRE (Agenda No. 8)

Information was sought by the Committee from the OCCG on its plans for future changes and consultation for Banbury Health Centre. The following reports from the OCCG were considered:

- Delivering primary Care at scale in Banbury (JHO8)
- Consultation Plan – Banbury Health Centre (JHO8)

The meeting was attending by the following representatives:

- Julie Dandridge, Ally Green and Dr Paul Park – OCCG
- Paul Roblin – Local Medical Council

A powerpoint presentation was given by Ally Green and Julie Dandridge on proposals for the practice.

Ally Green stated that the OCCG had learned from experience, had engaged with patients already via the PPG. They had also talked to members of the Community Partnership Network and shared the draft plans to consult online. The OCCG had also listened to feedback and had revised their consultation plans and options accordingly. Ally Green that the CCG had wanted to engage with HOSC early about the way it intended to consult.

The Chairman thanked Ally Green and Julie Dandridge for the presentations. He pointed out that the 8am – 8pm offered by the Centre was the result of a unique contract set up in 2009 as a Darzi Health Centre and it was a facility which was very much welcomed by patients. He began the discussion by asking why was it necessary to move away from these compelling characteristics when it had served the community so well?

Dr Park stated that he was one of the founding GPs of the Centre and had judged it to be a good place to work and gave good primary care service to patients. The question to be considered now was how the opening hours could be retained alongside the expansion of services in north Oxfordshire giving capacity in Banbury to treat unregistered patients, give coverage by the Neighbourhood Access Hub, plus a GP Out of Hours service. In addition, how to take north Oxfordshire forward in terms of health inequality issues with the catchment area containing two clusters with deprivation of illness, disease, cancer and stroke.

Responses to questions from the Committee were as follows:

- Would Windrush and the drop-in centre at Bradley Arcade shops be included in the consultation? – Julie Dandridge responded that Woodlands and West Bar surgeries would be integrated in an innovative piece of work creating a pathway for other practices to join in. She added that each practice was the GPs own business and each must agree the right way for their practice. However, proposals would allow individuals to join together to decide how to provide services. Dr Park pointed out that Bradley Arcade was a branch surgery of Windrush Surgery;
- In response to a report about a certain amount of scepticism amongst the public that the Banbury Health Centre would be closed and the need for new GPs and trainees in the area, Dr Park agreed that there was a need for training practices and larger practices could encompass this;
- A local member of the Committee declared himself in support of the assimilation of smaller practices into larger practices which would offer the best IT services and deliver the best benefits for patients. However, his view was that he would like to see the retention of Banbury Health Centre where they were registered. He recognised that there were cost implications for retaining the centre as set out in the report, but did not feel that these were much higher than those for West Bar. He asked if there had been any discussion with Cherwell District Council (CDC). Ian Davies, Director of Operational Delivery, CDC, who was invited up to the table to respond, stated that CDC did not have any specific plans for the future of

Banbury Health Centre building if it was to be closed. The Council regarded it as a local asset and would seek another tenant if it was vacated. Julie Dandridge stated that the OCCG would be willing to work with CDC to understand the costs of the building, adding that NHS premises business tended to be very complex. Dr Paul Park pointed out that the assimilation of the Centre with Woodlands Surgery would also address the health inequality concerns in that it was ideally situated near public transport links and it also accommodated an emergency dentist and a substance misuse service on another floor;

- A member commented that PML was a crucial factor for future development, asking how responsive it could be and how flexible and transparent was it? In addition, could it be understood where the drivers for decision making were being made? For example, if tenants were being sought, it would be important to know how secure the tenancies were and if they would cause difficulties regarding use. Paul Roblin responded that the modern scenario required organisations to look for economies of scale where larger units of delivery could also offer satellite working to provide resilience, as against the more vulnerable smaller units. Julie Dandridge added that the GPs now wanted to change from the historic model to one that was salaried. In relation to the issue of transparency, and the need to understand the governance of a larger organisation so that the public could have a meaningful interaction with discussion, Paul Roblin stated that the market would offer different solutions and anybody providing public services needed to provide this transparency. Whilst understanding this concern Dr Roblin stated that he did not agree that PML would have a dominant status and there was no reason why Oxford GP Federation could not give services to Banbury as well as Oxford;
- A member asked the OCCG to remember the principles of inequality and, in particular, that extended hours were central to Darzi. He made a plea that this Committee and the OCCG keep the future use of the premises high up on the agenda. Dr McWilliam commented that the principles of Darzi were at the forefront of Health policy at the time, however, things had moved on with a 5 year forward view of the Government. However, he stressed the importance of this Committee keeping a handle on people's differences and to encourage Health to have sight of this in the local design;
- A member asked if there could be an emphasis in the consultation document on the availability of appointments at Woodlands and West Bar practices if lists were to be dispersed. It was also vital that transport links be good. Ally Green responded that the OCCG had completed a transport survey of patients who used the Centre, the results of which would be included in the consultation document. This survey had indicated the high cost to patients of the current location due to the fact that there was no free parking for staff or patients. However, it was situated next to the station. The consultation document would also describe the population profile.

JHO3

- In response to a comment by a Committee member that, whilst the consultation methodology was good, consultation meetings should be open to all and the premises should be large enough to accommodate all who wished to attend, Ally Green stated that the OCCG was aware of the need to engage the PPGs at the other practices as they were in a position to encourage engagement at those practices. This would be included in the consultation document itself. Furthermore, the OCCG would always arrange open meetings in conducive settings to encourage maximum engagement activity. Transport links and other forms of access would always be considered. It was anticipated that premises situated in the centre of Banbury would be utilised;
- In response to concerns voiced by a member about the future increase in population in the area and fears about the closure of a fully functioning surgery with access to public transport, Julie Dandridge assured the Committee that the physical estate would be taken into account by the locality planning, ensuring also that buildings had room to expand and were fit for purpose.
- In response to a question about whether the 8am – 8pm opening hours would be part of the consultation, Julie Dandridge stated that the OCCG would be bringing in extended hours. Currently this facility was only available to six thousand people in Banbury and an extension into the rest of the patch was required. If it was found that a 9am – 5pm was required in a certain area, then an explanation for that would be given. She added that sometimes staff were reluctant to work the additional hours, particularly on a Sunday and it had been found that appointments were currently not being used on a Sunday by patients. In this event, more appointments would be made available on a Saturday;
- A member of the Committee asked what would be delivered that was not currently delivered, what was the OCCG doing about workforce requirements and how would it manage increasing population needs? Ally Green responded that this information would be included in the consultation document which was currently being worked on. This would include information on gaps around options for extended hours and information on how the OCCG intended to deal with the growing population in the face of practices who currently had no capacity to expand. She added that re-procuring the Banbury Health Centre in its current form would not deliver a solution for a growing population. Dr Park added that a larger model specifying more flexible GP practices would be more attractive to GPs and their staff. The model would contain better facilities for clinicians, pharmacists etc. Moreover, it was hoped that the patients would not notice the changes – they would be receiving their usual GP service. He added that none of the Banbury practices had handed in their notice in the face of the impending changes;
- A member asked if there was any prospect of, or interest from other Trusts to enter into primary care, in light of the fact that GPs had now entered into the acute care field. Dr Roblin pointed out that the lack of expertise in the

primary care field was a problem and that working closely was not the same as integration into, and the running of a premises. Dr Park added that there were advantages and disadvantages to this and agreed that primary and secondary care needed to understand each other better but that it could be something for the future. Oxford Health were already working with GPs, but acute care practitioners would require a detailed knowledge of primary practice;

- A member asked for assurances that if patients were to be dispersed, they would not be left to drift and would be transferred to another surgery. Julie Dandridge responded that the OCCG were interested to hear from patients if the patient transfer process had denied them their patient choice. Dr Roblin stated that there would be a need to check the regulations in respect to this.

The OCCG was urged by the Committee to ensure engagement with CDC before the consultation began to answer questions on locality, rents, transport, future plans for the building etc. Julie Dandridge stated that this would be part of the consultation. She also confirmed that the final options would be considered by the Primary Care Commissioning Committee at the end of March, early April. The OCCG would be happy to discuss the outcomes of the consultation if time permitted. She confirmed also that the practices would decide what they considered right for their area. Dr Park added that the OCCG would take the opinions of rural practices also in relation to what was appropriate for their areas.

The Chairman thanked all for their attendance, stating that the Committee was looking forward to seeing the draft consultation document and incorporating their comments into it, as part of the decision - making process. He asked that timing be allowed for the draft consultation document to be shared with the Committee at its next meeting at the beginning of February.

59/17 MANAGING THE IMPACT OF WINTER ON OXFORDSHIRE'S HEALTHCARE SYSTEM

(Agenda No. 9)

Prior to consideration of this item, the Committee heard addresses given by Sarah Lasenby and Larry Sanders.

Sarah Lasenby expressed her general concern about winter care, believing that the present NHS systems were denying patients their health requirements. She made the following specific comments:

- Earlier this year Accident & Emergency had found itself so stretched it had introduced GP triage in hospitals. In her view, beds had been taken away before the outcomes of the changes had been evaluated in the knowledge that there were staff resourcing problems;

JHO3

- In her view the ambulatory units were working very well and it was a good scheme. Innovation was good but not when patients were being put into side corridors on trolleys because there were no beds for them; and
- She expressed her concern regarding the proposed transfer of services from the Horton Hospital to Witney.

Larry Sanders commented that he respected the work that was going on into innovations in the NHS, the outcomes of which held many interesting ideas. However, reading between the lines he believed it could not work and crises could happen. This was due to the lack of Government funding and the worsening of the manpower situation with shortages of social care workers and GPs. He believed that it was the responsibility of elected members and various professionals working in the services to speak out; the latter having a dual responsibility to patients and the public, as they were the people who knew the most. He made reference to the bed shortages in the UK being the second worst ratio in its European group. He also stated that in his view the lack of future sustainability of the Health system in Oxfordshire was based on constant reductions of beds which amounted to 300 lost. Moreover, it was his view that there had been no attempt to measure the problem of unplanned admissions or re-admissions, due to premature discharges. He made a plea therefore for people to speak out about their concerns, particularly those who had inside knowledge; and to look at the issues affecting the issues that arise, an example of this being unplanned admissions.

The Chairman welcomed the following representatives to the meeting:

- Diane Hedges – OCCG
- Dominic Hardisty – Oxford Health
- Richard McDonald and Dr John Black – South Central Ambulance Service
- Benedict Leigh – Adult Social Care, OCC

The above representatives commented on the issues important to their organisation prior to questioning from the Committee, with reference to report JHO9.

Diane Hedges stated that there was a need to be realistic, the simple opening of more beds being not straightforward. She pointed out the following:

- that the John Radcliffe Hospital was also a specialist centre which meant that demand was even higher than elsewhere. Thus, diversion to Southampton or London hospitals to service specialist demand would be required;
- significant workforce issues and the ensuing patient safety issues meant that beds could not be opened even though it was desired. She added that there was a need to break the cycle by sending home the medically fit;
- the means by which the level of increased need could be met was a complication question. People were living longer with more complex health issues; and
- the OCCG's level of confidence in this Plan was cautious – it would like to see the formation of better ways of managing winter pressures, for example with more in-depth risk assessments in relation to bed closures.

Benedict Leigh echoed the concerns expressed in relation to the rise in demand for social care, recognising that workforce challenge was a particular problem particularly around domiciliary care. Adult Social Care was undertaking the following measures to give support;

- working jointly with the OCCG to fund flu jabs for all workers in a bid to sustain the workforce over the winter months;
- working across the whole system and alongside the OCCG on measures to support workforce recruitment. This was a challenge within Oxfordshire which was a wealthy county with low unemployment;
- working closely with a network of providers to tackle recruitment within Social Care to sustain the other more fragile providers. Also working with other healthcare providers to provide sustainability over the winter period. He added that more than 90% of providers were 'good' or 'outstanding'; and
- purchasing more beds and more home care to manage people's care through the system.

Dominic Hardisty listed the following measures being taken by Oxford Health to prevent pressure on acute care:

- the running of MIU's which could demonstrate that A & E activity could be avoided;
- the running of EMU/RACU in Witney and Abingdon, the latter was a frailty assessment unit where older people could be seen by gerontologists – both of which could have scope for expansion;
- Oxford Health runs Out of Hours services, working closely with the South Central Ambulance Service on 111 services. 111 had been quite fragile last winter, but since then Oxford Health had undertaken some robust work to add resilience, putting the services in a far better position to cope;
- the proposed changes around stroke care had put resources closer to people in the communities; and
- piloting a rehabilitation service at home to test community service provision. This had helped to respond to out of hospital care inquiries.

Richard McDonald spoke of the SCAS transformation. Their core value in innovation was a new way of working to respond to the different expectations of the population. Innovations introduced were:

- as part of the 111 service and as part of a collaboration with Oxford Health, Buckinghamshire and Berkshire, clinicians had joined together to be at the end of a telephone to provide advice;
- stroke patients now had a first - time ambulance rather than a rapid response vehicle;
- patients were triaged in a better way in order that the right response be sent to move them to the right place to give the right care;
- the service would be changing the staff rosters/skill mix/vehicle mix for the winter; and
- trying to deal with patients closer in the communities. With regard to patients living in rural areas, the service was endeavouring to work out the correct

response needs to enable patients to be treated at the correct venue. SCAS had been the top performing service during the changeover period.

Dr John Black, Medical Director, SCAS, stated that there would be more integration on care with colleagues in other Trusts For example SCAS was working very closely with OUH sharing best practice in emergency care, reducing delays and ensuring that patients were treated and admitted appropriately to the correct clinician. This was an opportunity for further co-ordinated care at scale and an opportunity to run the service as efficiently as possible by getting decisions from partners quickly so that there were no inappropriate admissions.

Questions from the Committee were as follows:

- A member expressed concern that beds had been permanently closed and there would be further closure of beds in the future, in light of DTOC delays in community hospitals. She asked for reassurance that this tripartite, parallel approach model would also work in the community. Diane Hedges responded that in the past with DTOC, other beds were opened and the equivalent beds were opened in the community supported by clinicians and social workers. This was part of the ambulatory approach. She expressed her disappointment at the DTOC outcomes, emphasising the need to be looking at managing a high volume of patients going through the system. There had been a significant increase in the numbers of patients who were seeking treatment and the Health system had been trying a number of pilots recently in a bid to manage this. Dr Black confirmed the significant increase in demand over the last year with up to 8% requiring surgery. His view was that the wider system was working better together to access the services in community hospitals, ambulatory services and social care. There was a determination that patients would be supported at home, as this was what patients desired the most;
- A member declared himself a supporter of the 111 services to assist with winter pressures. There was nothing in the communication plan that directed people to this service, asking why this was. Dr Black agreed that there was a need to value the 111 service, and it was hoped that as people became used to using it there would be more activity;
- In respect of a question about whether the flu jab was a new initiative, Benedict Leigh stated that carers had always received flu jabs; but the free service for the social care workforce was a new initiative, partly because there was a need to support their resilience;
- A member asked if there was anything significant in place for patients with mental health illness during the winter, given that acute beds were fully stretched, and given the restraints on Health with the Act and the rigorous assessment process. Dominic Hardisty responded that there was significant underfunding of patients with mental health problems. He made reference to the 60-90 minute assessment facility if a person presented at the A & E department at the John Radcliffe Hospital. A new tele – psychiatry assessment was also available which was dependent on a

person's needs. The outcomes of this was that the patient was either sent home or sent to a community hospital where the patient was cared for by staff trained in mental health. In some circumstances, a patient may need to go to a specialist mental health ward. He added that the occurrence of a mental health problem did not tend to be seasonal, although, in the same way as physically ill patients, some may suffer loneliness at Christmas.

- Pressure on wards was different for different age-groups, there being a major shortage of children and young people's beds in the south region. NHS England had closed admissions due to acuity of patients. Beds in neighbouring counties were required.
- There was no choice but to admit adults of working age. In nine out of ten circumstances people were admitted within three days, or obtained an out of area bed. Over the past year performance had improved and managers had reduced the spend on out of area beds by 50%. Furthermore, there were few beds for older people with complex mental health/physical health needs. NHS services for older people was good but was not quite there yet for people who presented with challenging behaviour and who required specialist dementia care homes. Dr Black added that ambulance staff were permitted access to the patient records for people who presented with a mental health crisis.
- In response to a question about whether there were alternative services open to patients in the teenage unit at the Warneford or at Abingdon, given the workforce pressures mentioned in the report, Benedict Leigh described three main mitigations which had been put in place: 200 hours per week community reablement given by nursing staff; commissioning of additional interim beds in reablement; and more effective support for reablement ie. in funding for occupational therapy and physiotherapy support. He added that intervention in HART would help patients more quickly.
- A Committee member stated that she had been told by constituents that there was a high call volume for the 111 service and given a message to ring back later. She asked how the staff situation was, particularly at week-ends. Richard McDonald responded that the Trust was in the process of recruiting for local staff, but there was a contingency arrangement with Milton Keynes when busy. If this was busy then the Trust used the national contingency to switch to another provider. A busy message was often in place if it was found necessary, but staff would still answer if they were free.
- In response to a question about what resilience was in place if there was a severe outbreak of flu, Diane Hedges stated that this could be a significant problem and there were a range of choices in place for such a situation. The OUH had taken a full capacity policy which extended a bed on each ward to stretch staff to nurse/treat more numbers. Buckinghamshire and Berkshire hospitals were able to open wards but Oxfordshire did not have the same facilities due to workforce issues. The OCCG had tried to identify when the busy times would be and in this situation would purchase

additional capacity for primary care. Additional home visits would be made by nurse practitioners in primary care on the days they would be required.

- In response to a question about whether the SoS bus would be rolled out elsewhere from Oxford, and if so, would adequate measures be put in place to direct extra clinicians to the Horton Hospital, Richard McDonald stated that this had been trialled in Oxford but it had only treated 8 patients during the past week. It had been restricted to Oxford due to the high population concentration and number demand. However, three clinicians to 8 patients was not deemed to be the best use of resources. Moreover there was not the appropriate level of activity in Banbury or Bicester for this ambulance service. Diane Hedges added that a national emergency care improvement team had observed that there was a need to be much tighter in matching staff to the anticipated patient footfall. The Team had also stated that it would expect to see more consultants on the ground. It had also implemented primary care streaming in order to increase capacity and to ease the pressure on consultants.

At the conclusion of the question and answer session, the Committee considered what action could be taken. Dr Cohen advised that the Committee had been appraised of a clear set of new interventions and new ideas and it would be helpful to know in the Spring which had proved to be most effective.

The Committee AGREED to thank all representatives for attending. Members welcomed the system-wide approach on reporting in respect of beds, including acute and community. The representatives were requested to:

- (a) return and present an evaluation of the innovations once the winter was over and which were the most effective;**
- (b) give a presentation on plans for next year; and**
- (c) request Diane Hedges to check the number of beds currently available compared to the same period last year;**
- (d) request Diane Hedges to look at staff sickness levels overall and to report back.**

60/17 CHAIRMAN'S REPORT

(Agenda No. 10)

Prior to consideration of this item, a statement produced by Jane Southworth on behalf of Deer Park Medical Centre Patient Participation Group (PPG), was read out by the Committee Officer, Julie Dean in her absence.

The statement made the following points:

- The Deer Park PPG felt duty bound to again voice their objections to the failure by the OCCG to properly implement the recommendations of the Independent Reconfiguration Panel (IRP). It was their view that the work the OCCG was currently undertaking on the wider Locality plan for West Oxfordshire (related to Phase 2 of the Oxfordshire Transformation Plan), had

nothing to do with the plan envisaged by the IRP, following the referral of the of the closure of the Centre to the Secretary of State. This was to produce a separate plan for primary care in Witney and its surrounds;

- The need to produce a separate plan for primary care in Witney and its surrounds, in accordance with the IRP report, was highlighted by this Committee at its 14 September 2017 meeting, the Chairman requesting the OCCG to produce a plan or 'roadmap' of the actions it was taking and timeframes, which would be a separate piece of work from the detailed locality work. The Committee had agreed to the setting up of a working group to do this. She asked if the working group had met;
- The PPG called upon the Committee to enforce the OCCG's duty to implement the IRP's recommendations fully and correctly. Despite the OCCG representative assuring the Committee that they would do it as a separate piece of work, it had not happened. She pointed out that the OCCG had been recommended by the IRP that the public and patients be 'at the heart' of this project 'in assessing current and future health needs, understanding what the options are and co-producing the solutions'. The public and patients of Witney had not been involved in producing this plan, to date, within the six-month timeframe as envisaged by the IRP. Furthermore, the PPG remained concerned that no independent person had been appointed to oversee and review the OCCG's compliance with the IRP plan;
- OCCG had declined to meet with the Deer Park PPG to enable it to share their proposals for the reconvening of GP services at or near the Deer Park Medical Centre. The IRP had recommended that this possibility should not be precluded;
- She also made reference in the statement to the two locality planning workshops held recently in Witney and Carterton which the PPG would not regard as 'public open events'. People were required to pre-book and as a result of it being fully booked, some people had been turned away. There was also a change of both venues, causing confusion. The 'round table' format of both events was not agreed with the patient forum groups with no patient group input as to its format; and
- She stated that in her view there was public mistrust of the OCCG and public dissatisfaction with the level of GP service in Witney which she stated was already overstretched (with significant housing growth already in progress and a reported 6 week waiting period for a GP appointment at a Witney surgery).

The Chairman, on behalf of the Committee, commented on the statement agreeing that the situation had continued for far too long but that, for reasons of patient safety, the surgery needed to remain closed. He also made reference to the fact that Northamptonshire CCG had agreed to use Oxford Health as a referral for 111 services. He also informed members that he had personally written to Northamptonshire's HOSC pointing out that the public would have to travel 20 miles to see a doctor. No response had been received as yet.

Diane Hedges, OCCG, attended for this item. She stated that the IRP had requested the OCCG to provide a plan for Witney and its surrounds in six months. This was in the course of production to a deadline of the third week in January 2018. She added that the primary care plan needed to cut across the county, looking at the needs of each locality and taking the emerging plans for that locality and supporting them with resources. She stated that the OCCG was meeting its requirements, was taking forward the plans for Witney and its surrounds, within the proper timescale; but was taking account of the whole system and available resources. She reported that there were a number of events planned, including a meeting with Witney Town Council that evening and a meeting with Deer Park PPG.

The Chairman asked if there had been any developments with regard to the appointment of the independent person from NHS England. Diane Hedges responded that they still awaited an allocation and as soon as this had taken place the OCCG would convene a working group.

The Chairman pointed out that the Committee had asked the OCCG to review the process followed during the closure of the Surgery, including engagement and availability, and this had not yet been carried out. Diane Hedges responded that the lesson learned was to expect the unexpected in the procurement process, adding that the OCCG should have expected the problems and further reflection was now needed on the fundamental issues to get right each time.

A member of the Committee commented that OCCG's reaction to the spirit and letter of the IRP's recommendation on the nature and engagement of the public was disappointing. Early and continuous engagement with the public and patients was required. Moreover, it was doubtful that public meetings held in November on the locality plans constituted early engagement. Diane Hedges responded that there was a significant amount of engagement being carried out. In respect of the Deer Park PPG, she expressed her fear that they would be disappointed because the level of engagement was not about the Deer Park Medical Centre alone. The OCCG had to plan for a population of 80k patients and it was not possible to find viable providers for such a small population. It would cause extra pressure on the GP population in light of the growing need in Witney and in light of the high level of GPs thinking about retirement. There was a need to think creatively across the practices in Witney. She wondered whether HOSC's view on engagement was reasonable, stating that more round table events had taken place in a bid to develop that level of co-production. This showed that the OCCG was in this mindset. She reminded the Committee that a decision had already been taken about Deer Park surgery and that the OCCG would be interested to hear about any solutions that the Committee may have to this situation.

The Chairman commented that the issue was not about the number of meetings that had taken place, and he appreciated the efforts that had gone into arranging extra meetings. It was more about making the process followed a priority. The impression that the OCCG was giving was that engagement was not a priority, that the work had been done and the timescale had lapsed.

A member pointed out that there appeared to be a contradictory process for each of the Deer Park and Banbury Health Centre presentations, asking what process was

being followed for patients in the Banbury location. Diane Hedges responded that discussions were taking place in the north locality, as had happened for Witney and its surrounds, emphasising that each locality had a different set of circumstances.

Ros Pearce, was asked for a HWO viewpoint. She responded that the process of engagement on the part of the OCCG regarding locality planning for primary care appeared to be going well. She added that the meeting between the OCCG and the Deer Park PPG had now been arranged, which was what the IRP had asked for.

In response to a report from a member of the Committee that the midwives in the midwife-led unit at the Horton General Hospital were not being permitted to ask anybody at the Hospital for assistance with mothers who were presenting with complications, Diane Hedges advised that reference to clinical policy was needed which stated that these patients had to go to the John Radcliffe Hospital as soon as possible.

On the conclusion of the discussions with was AGREED that:

- (a) the Chairman's report be noted; and**
- (b) in respect of Deer Park, the Chairman would write to the OCCG giving the Committee's views on the situation and asking for an urgent response.**

61/17 ITEM FOR INFORMATION

(Agenda No. 11)

Noted.

..... in the Chair

Date of signing