OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Friday, 30 September 2016 commencing at 10.00 am and finishing at 1.30 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods (Deputy Chairman) District Councillor Jane Doughty
Co-opted Members:	Moira Logie and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Julie Dean and Katie Read (Corporate Services)
Part of meeting	Nick Graham (Corporate Services)

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

56/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from District Cllr Susanna Pressel and Dr Keith Ruddle.

District Cllr Ian Corkin attended and took part in the Committee as a representative from Cherwell District Council but not in a voting capacity, as the vacancy had not been filled formally as yet.

57/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

58/16 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 3)

The Chairman had agreed to the following speakers, all of whom would make their address at the start of Agenda Item 4:

- Valerie Ingram - Administrator of ‘Save our Horton’ Facebook page
- Keith Strangwood – Chairman, ‘Keep the Horton General’ Group
- Dr Peter Fisher FRCP – Member of the Public and retired consultant in General Medicine at the Horton Hospital
- Sarah Ayre – retired midwife

59/16 EMERGENCY CLOSURE OF CONSULTANT-LED MATERNITY SERVICES AT HORTON GENERAL HOSPITAL
(Agenda No. 4)

Prior to consideration of this item the Committee was addressed by the following speakers:

Valerie Ingram

Valerie Ingram informed the Committee that she was the administrator of the Facebook page ‘Save our Horton’ and communicated with just over 16,000 members on a daily basis. It was her view that Banbury and the catchment area was growing at an unprecedented level and key to the Core Strategy was sustainability, adding that to allow the maternity unit to be downgraded even temporarily was contrary to those principles.

She stated that Oxford was not close to Banbury and very difficult and expensive to get to. She added that in 2008, the Independent Reconfiguration Panel had deemed that the distance between Banbury and the JR was too far and not safe, stating that this was as relevant today as it was then and in fact transport had worsened nowadays making it even more difficult to access services.

She informed the Committee that a recent FOI request made in June had revealed that a blue light run from Banbury to the JR revealed an average time of 43 minutes, which did not take into account loading times at either end. Furthermore that an emergency C Section, category 1, was recommended to take place within 30 minutes; and the clock did not begin ticking until the doctor had agreed the procedure, adding additional time to be factored in, but which was not included in the Trust’s contingency plan. She added, moreover, Chipping Norton Midwife –Led Unit (MLU), when in difficulties, tended to send their patients to the Horton as it was easier to access. The outcome of this would be that this option would be removed, thus increasing the risk to patients, and overloading the JR. She further stated that the JR had been on divert on two occasions the previous week and Warwick had the week before, thus highlighting existing pressure. She added her view that GPs and ambulance staff in the Banbury area were not happy with the proposals.

Valerie Ingram also suggested that downgrading to an MLU would possibly see the removal of the on call 24 hour House Consultant anaesthetist, thus bringing into

jeopardy the Children's ward and Accident & Emergency. The Trust has made no guarantees that this position would remain and FOI requests had gone unanswered.

She stated that, in her view, recruitment had been 'lack lustre and appalling' and it had taken letters from Facebook members to get the adverts back onto the system.

She referred to a proposal that had been made to the Trust which would utilise existing facilities, retain staff and utilise the services already in Banbury, which had been refused. At the Trust's recent AGM the Trust had commented that agency staff would be employed if staff did not wish to be moved to Oxford. She commented that the same should then happen for the doctors, that locums could be employed in Banbury in the interim period until doctors could be found. She concluded by stating that the residents in the Banbury area wanted equality of care and 'were being treated as second class citizens and expendable collateral.'

Keith Strangwood

Mr Strangwood began by referring to a petition (which was not submitted to the meeting) which was in circulation and which had accrued around 18,000 signatures to date. He also referred to the Trust's statement that there was no alternative to the temporary closure of the Hospital's Obstetric service, due to safety reasons, stating that the risk to mothers and babies was an even greater risk. He added his view that the advertising for the vacant posts was 'more than inadequate' as it had only appeared in NHS Jobs and no other site up until the end of September, and the first serious attempt at advertising in the British Medical Journal did not happen until August 2016. Mr Strangwood also referred to the pressure on the JR of the additional 1,000 births. He asserted that the 'whole proposal', including the lower number of births at the Horton had been engineered by the Trust. He concluded by requesting the Committee to refer the temporary closure to the Secretary of State.

Dr Peter Fisher

Dr Fisher informed the Committee that when he worked at the Horton he was one of 10 consultants. On his retirement there were approximately 40. The hospital had been allowed to develop an integrated service with the area's GPs. This was no longer as effective since many consultants had been moved to the JR. Later the OUH had moved these staff to the JR. He added that it was very significant that the number of applicants for posts as Clinical Research Fellows in Obstetrics had fallen since the beginning of 2015, but advertisements for a different type of middle grade staff had not been placed until April 2016. As a result, the earliest the service could re-open was January 2016. He concluded that throughout there was uncertainty and the people in north Oxfordshire were bewildered. There were a series of questions that needed to be answered and the only way to receive answers was via referral to the Secretary of State.

Sarah Ayre

Sarah Ayre explained that she had been employed as a midwife at the Horton Hospital up to last year. She wished to convey the concern felt by the midwives who had successfully served mothers and babies in the north of the county, for the

wellbeing of the mothers and babies affected by the proposal. The midwives strongly supported all models of care which supported the Horton. They also feared that the new proposals would not be a temporary measure. They felt that the contingency plan was unsound. A main area of concern was that, despite the presence of a 24 hours a day ambulance, the JR was too far away from the Horton for safety. She added that the staffing levels outlined in the contingency plan ignored NICE guidelines and the Trust was ignoring crucial timings required to provide the service safely. She urged the Committee to refer the contingency plans to the Secretary of State for a full and frank examination of the proposals that were both 'insulting and negligent'.

At the start the Committee were advised of the following by Nick Graham, Chief Solicitor, OCC. He advised that this was an emergency closure on the grounds that it was a threat to patient safety and welfare; and therefore the duty to consult did not apply. However, he advised that under the legislation, the Committee had the powers to still refer to the Secretary of State if it was not satisfied with regard to the adequacy of the reasons given for emergency. He further advised that some of the proposals might be caught up in the broader context of future change for which a major consultation was planned to take place in the New Year. He advised that this would not prejudice the Committee's ability to make a referral.

The following representatives attended:

- Paul Brennan, Director of Clinical Services, OUH
- Andrew Stevens, Director of Planning & Information, OUH
- Veronica Miller, Clinical Director, Women's Services Directorate, OUH;
- Catharine Greenwood – Consultant in Obstetrics & Fetomaternal Medicine, OUH;
- David Smith, Chief Executive, OCCG

Paul Brennan began by giving an update on the situation. He reported that the recruitment process was ongoing, and as soon as a full complement of staff were in place, then the Unit would be re-opened, together with a definitive agreement with SCAS for a 24 hours a day ambulance to be situated at the Horton. He further reported that currently the Trust was down to three doctors, making it unsafe to operate the Obstetric service. Since the last meeting of this Committee, four doctors had been interviewed and had all been offered and had accepted their post. However two of the doctors were not registered with the General Medical Council and this would take a minimum of 6 weeks. Victoria Prentis MP had offered to assist with the process as far as she could. One of the doctors required a period of induction to enable him/her to work independently. The outcome of this was that 2 doctors would not be available until the New Year to carry out operations. He added that a further advertisement was out at the moment and the closure date was that day, 4 applications had been received to the advert. He added that the most risky area that of the special care nurses, which was a difficult area to recruit in across the country. An advert was out at the moment. Once all the doctors were able to operate independently and the special care nurses recruited, then the Trust would re-open the Unit.

Mr Brennan gave his reassurance that the 24 hour ambulance was an additional vehicle which had been secured by the Trust in response to concerns raised by the public.

In response to a question, Mr Brennan confirmed that the salary range and banding for the consultants posts comprised a percentage increase in salary and a £5k premium to make them more attractive.

Andrew Stevens stated that he had worked for the Trust for 17 years and had been proud that Obstetrics had been kept going at the Horton since the loss of the accreditation in 2012. He added that other Trusts in the south of the country had lost their service, notably, Buckinghamshire, Berkshire and Gloucestershire. Furthermore, for training posts, the vacancy rate of just below 25% was replicated across the county. He added that the problem of safety had to be faced, if there were an insufficient number of doctors then the service could not be provided.

Catharine Greenwood stated that she had worked on the labour ward for over ten years. She added that other units had closed across the area, for example, in Royal Berkshire. That service had been transferred to the Horton or to surrounding areas, such as Basingstoke.

Veronica Miller referred to the costs to run the neonatal network which had not come over. There was in the region, an improved network and beds would be made available for premature babies, level 3.

A member asked why the numbers of births had reduced from 1723 in 2013 to 1466.Veronica Miller explained that a national guide to complex pregnancy which had to be adhered to. The rise in 2013 had been the result of a period of refurbishment at Chipping Norton Hospital. Catherine Greenwood also explained that the recognition for training for the Horton had been removed in 2012. Sometimes even consultant-led services did not meet the needs of women at the Horton and they had to go to the JR anyway. She added that there had been a reduction in numbers for higher risk births going to specialist teams as a result of national guidance.

When asked about whether the JR had ever been on divert, Catharine Greenwood stated that she had not known it to happen. A member asked if some mothers had not been given the option to use the Horton, which might have then lowered the birth figures. She asked if the Unit would remain in Banbury in the future. Veronica Miller responded that the maternity service was proud that mothers were given choice. She added that nowadays pregnancies were more complex for a number of reasons and there had been many studies and much evidence on the subject of keeping mothers safe and about how to look after them. The Horton did not have specialist teams in situ and it worked across the county when it needed to gain access to them.

With regard to the issue of recruitment a member asked why, if it was known that a consultant was to retire or leave, that a recruitment agency had not been approached? Mr Brennan responded that nobody had resigned in 2015 and the first doctor had resigned in February 2016. He added that the Trust had gone to the Agency and asked them to fill 4 posts. Unfortunately they had been unable to provide any suitable applicants. In response to a question, Mr Brennan explained that currently, 3 doctors were in place for the next week, but 1 of these was leaving, 4 doctors had been recruited and required induction training, 2 required registration with the GMC and 1 required a visa application. Therefore reopening would be in the

New Year at the earliest. Furthermore, whilst he was pleased that 4 posts had been offered, it had to be recognised that, in reality, doctors were applying for multiple jobs. They preferred to go to Units where there were more births. Many wanted to become consultants following the Article 14 Caesarian route. With there just being 3 births a day, the Horton could not provide the training and expertise they needed. The Trust was trying to rotate doctors through the JR to make the post more attractive for doctors. When asked if they were recruiting applicants with a view to reopening the Unit, Catharine Greenwood responded that they were. Appointees might need to work at the JR in the first instance, but when there were sufficient numbers appointed to the Horton that would be their main place of work.

A committee member asked for some idea of other options considered, for example, the question of the rotation of staff from the JR – and whether this could be with agency doctors. Mr Brennan responded that doctors at the JR were in training and therefore not permitted to go to the Horton as it was not accredited for training. Andrew Stevens reported that funding for the innovative post ‘Clinical Research Fellow’ (CRF) which had been created to try to keep the Obstetric Unit going since 2012, came out of the Research budget. He added that there were no CRF’s now – the OUH was recruiting to Trust posts only. A member asked if there were other acute rotations at the Horton likely to be at risk in the forthcoming year. Mr Brennan responded that there were no rotas at risk at the moment, although it was impossible to predict the Deanery questioning viability for training. He added that a future area of concern might be the Accident & Emergency Department, but there were no problems there at present. David Smith stated that the OCCG was satisfied that, at this stage, this emergency action to close the Unit down had been taken because there was no other option. The Trust could not recruit doctors.

A member asked if there was sufficient staff to look after the increased numbers of babies taken from the Horton to the JR. Mr Brennan responded that 6 members of staff in the Special Baby Care Unit had decided to transfer to the JR to provide sufficient numbers with which to run the service. 3 members of staff had decided to stay at the Horton and 1 was an adult trained critical care nurse and had asked to stay at the dependency unit.

With regard to travel issues, a member of the Committee asked about the safety for mothers and babies when being transferred down the A34, which did not have a good accident record, and also what the travel times were from the Horton to the JR. Catharine Greenwood stated that the Trust had based its plans for temporary closure on NICE guidelines (made public in 2011) which suggested that for low risk mothers, it could be safer to deliver in an MLU as long as this is within 45 minutes of a consultant-led unit – the Horton met this criteria.

A member referred to Appendix 3 of the risk assessment, asking firstly where it was factored in that the clock only started to run when the ambulance arrived at the JR. Secondly, the NICE guidelines used kilometres, not miles, and there was the addition of a leading time of 15 minutes. Catharine Greenwood responded that nobody pretended that a category 1 C section could be offered in the Midwife Led Unit (MLU). She pointed out that mothers in other MLU’s did not have access to category 1 C sections. Mr Brennan added that loading time did not apply as the ambulance would already be there.

A member asked if it would be appropriate to use the air ambulance to transfer women to the JR. Mr Brennan explained that this would not be possible due to flight paths which would have to be put in place. Andrew Stevens stated also that it would be less appropriate for maternity cases because it would take longer to mobilise it and load. Paul Brennan explained that, for people living in Banbury, major traumas, stroke, heart attack were all blue lighted to the JR nowadays. With regard to the route, SCAS had a control system which diverted to the most appropriate route. He added that many ambulances took the route down Banbury/Oxford Road via Islip, and arrived within 40 minutes. A Committee member commented that another route used was via Deddington and along the bus lane to Kidlington, which could take less than 30 minutes. Mr Brennan commented that data provided had shown that on a blue light run from the Banbury area, 88.4% would arrive within 30 minutes and 100% either less than, or equal to 45 minutes.

A committee member asked whether equipment was currently being moved to the JR. Catharine Greenwood explained that it was because women in Banbury were having to travel to the JR. She reassured the Committee that it would be moved back when the Unit was reopened. A clear inventory had been taken. In response to a question about whether the JR would have sufficient theatres, Mr Brennan stated that an extra theatre had been brought in to use for C sections, with a capability of 22 sessions rather than 20 as now. In addition to this two extra rooms (on top of 5) had been converted to clinical use. Two extra delivery rooms were also being created and would be ready the following week. The Trust had moved people out of an office to make space for mothers after they had given birth. There was also capacity for two more rooms to be converted for the same purpose. He stressed that the Trust was doing its best in the face of this emergency.

The Chairman then summed up the evidence relating to the grounds for emergency. These were:

- The timing of the closure, given the imminent reduction in consultants at the unit.
- A recruitment drive that had failed to deliver, although the Trust had not ceased its recruitment efforts. Appointees were being given the option of extending their contracts to make it more attractive.
- There was no pre-determination with regard to the Transformation Plan consultation – maternity services would be part of longer term proposals in the Transformation Plan.
- The question of travel times had been thoroughly explored – 88.4% in 30 minutes and 100% in 45 minutes meets 2007 NICE Guidelines.
- A special ambulance would be available 24 hours a day at the Horton to transfer complex cases to the JR.
- A decline in birth numbers at the Horton was related to an increase in risk factors during delivery and more people being advised to go to the JR.
- Three other free-standing MLU’s in Oxfordshire – the results are safer – less at risk from medical intervention, although 25% transfer to consultant – led units.
- Provision of two obstetric-type rooms plus two extra birthing-type rooms. The equipment had been moved to the JR, but could be moved back to the Horton. This had met the challenges by increasing space and staff.

- Rotation of doctors with the JR had been considered as CRF posts had come to an end.
- High risk patients were advised to go to the JR before they entered labour, so there was less need to transfer complex cases during labour, reducing risk.

The Chairman asked each member of the Committee in turn if each were satisfied with the reasons given for the emergency situation the Trust found themselves in, at the same time advising that if a member was not satisfied, then evidence was required for non-satisfaction. A vote was then taken and it was **AGREED** (by 5 votes to 3) that:

(a) on the basis of the evidence provided by the Trust, not to refer the Trust's decision to temporarily close the Obstetrics Unit at the Horton to the Secretary of State on the basis 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 but to monitor the situation carefully in the meantime; and

(b) to request regular updates on the status of consultant-led maternity provision at the Horton and the recruitment of obstetricians.

60/16 ACUTE BED AND SERVICE RECONFIGURATION

(Agenda No. 5)

Prior to consideration of this item the Committee received advice from Nick Graham, Chief Solicitor, OCC. He advised the Committee to determine the question of whether the closure of the beds amounted to a substantial change in service, and to try as far as possible to reach agreement with the Trust. If this was not possible then it had recourse to refer the matter to the Secretary of State.

The following representatives attended for this item:

- Lily O'Connor – Division Nurse, Medicine, Rehabilitation and Cardiac Division, OUH
- Paul Roblin - Chief Executive, Local Medical Council
- James Price – Consultant Gerontologist & Divisional Director for Acute Medical, Rehabilitation & Cardiology
- David Smith – Chief Executive, OCCG
- Stuart Bell – Chief Executive, Oxford Health
- Andrew Stevens – Director of Planning & Information, OUH
- Cllr Mrs Judith Heathcoat – Cabinet member for Adult Social Services, OCC
- Seona Douglas – Deputy Director for Adult Social Services, OCC

Paul Brennan began by stating his reasons for the proposal not being a substantial change in service. Firstly, the Trust was investing £4m in services to enable Health to support patients in their own home. Secondly, there would be no change in access to services and no change in services provided. Thirdly, integration of non-bed services provided by Oxford Health and by OCCG would continue in order to make services more responsive to patients in the right environment. Finally patients could be managed in the most suitable environment to get the best care needed.

Mr Brennan clarified at the request of the Committee that the original plan in relation to DTOC (Delayed Transfers of Care) was, via the work of the Liaison Hub, to get to 150 beds, 137 was then reached, and it was then agreed to drop down to 55 beds, which took place in July.

Mr Brennan was asked if the Hub had managed to maintain the flow of patients through the system. He responded that this had happened, and more had been done due to investments made in hospital integrated services. The OUH had invested £1.2m jointly with Oxford Health (OH) and the OCCG to keep the Liaison Hub. £1.6m had also been invested in additional nursing and medical staff to run the community services. The Hospital Discharge Team was seeing more patients managed on a non-bed pathway despite rising demand (6 – 8% increase in emergency attendance). He added that taking forward stage 2 had not led to any additional cost to Social Care – there had been no evidence provided of this. He reminded the Committee that phase 2 of the programme had started 4 months ago and half of it had already been implemented, with no additional charge on Social Care.

A member asked about how this wider remit with the Liaison Hub was working out with Adult Social Care (ASC). Lily O'Connor responded that alongside the 55 beds already highlighted, there were 49 intermediate care beds at Chipping Norton, Isis and Watlington, working with Orders of St. John and Sanctuary Care. The Trust was also working with CHC (Continuing Health Care). She added that 18 interim care beds had been funded by OCC and that OUH was working with OCC to ensure that patients were identified. She added that no beds were lying empty unnecessarily.

A member asked whether this reconfiguration would create more bed blocking further down the chain, and whether preventing admission would cause a problem with sick people at home requiring the attention of GP's and ASC. Dr James Price explained that there were many studies which supported this care journey. One particular study focused on the quality of care for older people with emergency care needs, emphasising that it was essential that these services were person-focused and driven by the individual's needs. Early, good quality services were very important. He added that many patients were sensitive to delays in patient care, thus, initial, speedy decision-making focusing on ambulatory care (day care in a hospital, heart centre or other setting) which supported patients at home or closer to home overnight was vital. The historical model that saw patients being admitted to wards after having been assessed by a doctor, then by a ward consultant the next day, was no longer acceptable. He added that for some people who required frequent attention, this mode of care would not be right for them. Then their stay in hospital would be decreased and they would be cared for in their own home. Older people were often admitted due to a lack of timely care in their own home. Evidence had made clear that fewer patients require institutional care via the hospital path. Age UK research had shown that avoiding admission when appropriate made a significant difference to people's lives. Local experience and incremental evidence had shown (over a period of 4 years in Abingdon) an early manifestation of this. Doctors, nurses and social workers were working closely together, and close to the patient's home, to make good quality decisions. Upon going home, OH and Principal Medical Ltd (PML) were giving good care at home. This had been extended to the north and south of the county and in day care assessment units.

It was Cllr Mrs Heathcoat's view that if beds were being closed, there was a need to consult. She asked why move ahead of the Transformation Programme plans for re-designed services? She added that ASC supported people in their own homes where they feel more secure, but asked if there would be increased activity to local primary and social care, as most people would require it.

Seona Douglas added that ASC did a lot of work on a joint basis, stating that it was difficult to quantify what prevention was. If patients were discharged into the community they may require assistance with mobility, cooking etc. Mr Brennan responded that talks about services required were in place. With regard to the prevention agenda, this could not be quantified because there was no resource to say how much it would cost. The Trust's commissioners had not received the modelling to be able to quantify it.

In response to a question from the Committee about what the impact would be on GPs, Paul Roblin stated that GPs supported the direction in travel. The move to daytime hospital care did however need resourcing in order to deliver more activity in the community. Discussions were ongoing on new models of care that may deliver new solutions. However, he warned that in a situation of national austerity, promises may not be delivered. He stated that there was a need to work together as an integrated Health service towards solutions and the direction of travel in terms of the practicality of delivery in the community needed to be looked at closely.

David Smith spoke from the financial position that the NHS was currently in. If one came to the heart of what needed to be done for the Transformation Plan, then resources wold have to be shifted in the GP/ASC direction, and things would have to be done properly. He added that unless there was proper integration of Health and Social Care via a single pooled budget then delivery would not happen. Mr Brennan, in response to the concerns of ASC and OCCG, referred to page 9 of the paper which stated that whilst releasing the beds, the Trust was spending an extra £1.4m on ASC (personal care) over and above what OCC were providing, in addition to the original £1.5m funding into ASC by the OCCG. He also pointed out that OCC's own strategy centred on the increased impact and demand on ASC, if patients stayed in hospital beds longer. All evidence pointed to reduced costs.

Seona Douglas added that there were issues regarding funding into the reablement service. Funding was predicated on 28 beds a week. She asked if it was over and above the 28 beds that was included in the costings for the original contract. She added that Social Care did not know the position at this stage 2 to make that assessment. Paul Brennan commented that OCC had spent £1.5m lower on the Supported Hospital Discharge Service (SHDS. He undertook to provide that information.

Members of the Committee commented that there was no argument with the principles of the changes. However there were concerns around pressures on GPs leading to the closure of a number of surgeries across the county, together with pressures on community hospitals. There were concerns about the sufficiency of staff to run Witney EMU, for example. In light of the interaction with ASC today, there did not appear to be a united front. There was also concern that the public had not had

the opportunity to speak about the further closures of beds and the impact of this. There was also concern that it was not understood by the public.

Stuart Bell, OH, pointed out that in circumstances that were in reverse to the national trend, to date the plans had largely worked out and patients had been moved to a more appropriate setting. He stated that this was the best means possible of being able to release resources to assist people in their own homes via community services and ASC, and to unlock potential investment in primary care. Questions to be answered centred around how to release the resource in patient care? What sort of contractual and work place models exist to do it? What are the issues around moving staff from acute to EMU's? All these answers would be included in the next stage of the Transformation Plan. When the formal consultation was launched there would be permanent change to consult upon. Mr Bell assured the Committee that there would be a united front, adding that the biggest issue was that of staffing – and that staff could be deployed under the new Transformation Plan.

The Committee were in favour of the principles of the reconfiguration programme, but felt that the OUH were no yet in a position to carry it out. It was aware also that the GPs were also in favour, but the way they were organised at present made it impossible due to lack of resources .It was understood that the forthcoming Transformation Plan consultation would have a knock on effect. However, if the consultation was delayed until after the OCC election, there would be no decision made for a year. It also recognised the difficulty in recruiting carers and asked who would be responsible to be with patients at home during the night? Mr Brennan responded that it had been a challenge, but to date 47 carers had been recruited, predominantly from the retail sector.

A member asked what would be the effect of bed closures on the Nuffield Orthopaedic Centre? Mr Brennan explained that this was an evolving programme and needed a reasonable conclusion. Paul Roblin stated his view that the redeployment of existing hospital staff into the community based model was not practicable. Lily O'Connor commented that patients could be looked after in their own home and that the Plan was individual patient-based. Those patients who expressed an anxiety about it would not be placed into the service. However, many patients did ask for outreach into their own home. She reassured all that this would be set up, planned, recorded and monitored in the Liaison Hub.

A member asked where the care home providers for the Banbury area would come from as in Banbury, 5 doctors had left one surgery alone and it took 2-3 weeks to set up a GP appointment. Mr Brennan commented that if the care provider had closed down then that was an issue for OCC. Beds were provided at Chipping Norton Hospital. Paul Roblin commented that there was no question that the GP service was in crisis. He did not believe, however, that this was linked to hospital configuration and hospital beds.

A member asked about travel time once home care had been introduced. Paul Brennan explained that the Liaison Hub would still run at the JR, and the SHDS service would operate from bases in the north and south of the county to enable staff to do the work at home.

A question was asked about Out of Hours cover and medical nursing care services. Lily O'Connor responded that this would continue 7 days a week and there was no expectation that others would take the service. It had been found that packages of care had been reduced. It was expected that patients cared for at home would be more mobile and mortality would be lower. They would reach independence sooner or they might not even need the service any more.

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The Committee asked what would be the impact of launching a consultation if 50% of stage 2 had already been implemented. Paul Brennan responded that one further change was essential to make in the following week and then a series of changes would be made later this year and early next year.

A member of the Committee suggested that success at stage 2 would be good evidence to include within the Transformation Plan consultation next year. An added benefit of this would be that it could then be articulated more clearly to the public. Paul Brennan agreed that this was a good point and if this was the view of the Committee, it could be an advantage of engagement. To consult on stage 2 now would only serve to confuse the public.

David Smith commented that if the Committee stipulated that there must be full consultation now, the OCCG would have to write the consultation document for submission to the OCCG Board in November. This would run into, and overlap the main Transformation Plan consultation which was scheduled to begin on 4 January 2017.

Paul Brennan was asked if consultation was required now would it stall all the good work already taking place? He agreed that it would, and services would be sat with empty beds. He suggested that, as a compromise, the Trust would agree to a short period of consultation. Paul Roblin expressed the view that this would divert attention from delivery of the full provision and that the STP already contained a large element of what had been discussed.

Dr Price put forward the view that to delay would be a problem for patients and carers.

In considering the way ahead the Committee **AGREED** (unanimously) that OUH's plans for acute bed and service reconfiguration constituted a substantial service change that required consultation.

To this end, it was **AGREED** with OUH that the scope of the 'Rebalancing the System' pilot be extended to incorporate this proposal and that no changes would therefore be made that were irreversible. The pilot outcomes would be used as evidence to support the transformation consultation in January 2017. Should the Transformation Plan consultation be delayed further, the OCCG would hold a 12 week consultation on this proposal, starting in January 2017, to fully understand the impact on providers, partners, patients, the public and staff.

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Date of signing