OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 29 November 2018 commencing at 10.00 am and finishing at 2.10 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen (Deputy Chairman) Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Hilary Hibbert-Biles Councillor Laura Price District Councillor Nigel Champken-Woods District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Jane Hanna OBE (In place of Councillor Alison Rooke)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle

Officers:

Whole of meeting	J. Dean and S. Shepherd (Resources) and Rob Winkfield (Adult Social Care)

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.

52/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Jane Hanna attended for Cllr Alison Rooke and apologies were received from Councillor Sean Gaul and Anne Wilkinson.

53/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillor Hilary Hibbert-Biles declared a personal interest in Agenda Item 6 'Health Visiting and School Nursing Services' on account of her former membership of the Oxfordshire Health & Wellbeing Board in a capacity as Cabinet Member for Public Health at the time when the contract for School Health nurses in the county's primary schools was commissioned.

Councillor Monica Lovatt declared a personal interest in Agenda Item 9 – 'New Governance of the Oxfordshire Health & Wellbeing Board' on account of her membership of the Health Improvement Board which is a sub-group of the Board.

Dr Alan Cohen declared an interest in Agenda Item 9 also on account of him being a trustee of Oxfordshire Mind.

54/18 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 20 September 2018 were approved and signed subject to the following amendments:

- In relation to page 18 – the interim Director of Public Health, Val Messenger, came up to the table and undertook to circulate to members of the Committee a more correct meaning to the words 'the Government was doing well in tightening the screening of obesity using non-legislative means and there was an increasing gradual awareness amongst the population';
- In relation to page 13, line 3, to correct '650 new homes' with 6,500 new homes'; and
- In relation to the top of page 19, sentence 1 – to delete 'cardio -diabetes' and correct to 'people with severe mental illness'.

There were no matters arising.

55/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The following requests to address the meeting had been agreed:

- Didcot Town Councillor Cathy Augustine (Agenda Item 9);
- Councillor Jenny Hannaby (Agenda item 9);
- Maggie Swain, on behalf of Save Wantage Hospital Campaign (Agenda Item 11); and
- Councillor Jenny Hannaby, Local Member (Agenda Item11).

56/18 FORWARD PLAN

(Agenda No. 5)

The Committee considered the latest Forward Plan, as amended since the last meeting (JHO5).

It was **AGREED** to:

(a) reinstate GP Federations onto the Plan, in particular in relation to smaller practices and their survival; and
(b) make the 'Social Prescribing' item broader to encompass housing leisure services in order for the Committee to look at it 'in the round' – and to ensure that this is a major item on a future Agenda.

57/18 HEALTH VISITING AND SCHOOL NURSING SERVICES

(Agenda No. 6)

The Committee welcomed the following representatives from the Health Visitor and School Nursing services in Public Health, OCC:

Val Messenger – Deputy Director of Public Health
Donna Husband – Lead Commissioner,
Emma Leaver – Service Director
Pauline Nicklin – Head of Service
Nicky Taylor – Operational Manager, Health Visiting
Angela Smith – Operational Manager, Health Visiting
Helen Lambourne – Family Nurse Partnership Supervisor
Margaret Fallon – Operational Manager, School Health Nursing

Each presented their part in a series of slides as attached to the Agenda at JHO6.

Questions asked by members of the Committee, and responses received, were as follows:

- How is performance measured? - There are key performance indicators included in the contracts, performance of which is managed by Health and the Performance Scrutiny Committee, OCC. There is a Public Health Outcomes Framework which is broken down into various categories. Sometimes the issues are hard to link to a specific activity and therefore not in contract management;

- How are inequalities tackled? - Equal access to all is offered, the service adapts to the needs of individuals, for example, health visitors offer the service where it is most suitable and convenient for the user and it offers a delivery of the service in the home itself, particularly in rural areas. It also uses interpreters where needed;

- Where are the nine centres for Health Visitors located? - the county is divided into 9 localities and within each there are 7 teams. For example,

West Oxfordshire has teams in central Witney, Carterton and Chipping Norton. Additional services are also provided in Charlbury;

- How do Health Visitors connect with people? – They establish good therapeutic relationships with people early, in order for relationships to be built. For example, if there are concerns regarding a person's mental health during their ante-natal period, the health visitor may do the liaison work and carry out joint visiting with other professional to assist that person in their transition to another service;

- How does the service support children with a fluidity of gender? - The service is experiencing a growing need in this sphere and it has trained nurses to both help the children and also to assist teachers with how to respond to it;

- What about the people that are not being seen – 73% of mothers attend antenatal classes, but what about the other 27%? – The service is offered to all people working with midwives. Some mothers feel that they do not require the service and there is an element of choice in that. There is a system in place for health visitors to work with midwives to identify those mothers they are most concerned about and they do endeavour to track them down. There is also contact with primary care colleagues. Thus, included within the 73% of antenatal contacts are some for whom there is some concern;

- Up to 63% of women breastfeed their babies until they are 6 weeks old. Compared to other countries this is low – how can numbers be raised, given that many mothers are returning to work earlier? - If one compares Oxfordshire with the national figure (47%), Oxfordshire is exceeding this. Those mothers who are still feeding at 6 weeks tend to continue until 6 months (6 - 8 weeks statistics includes combination and exclusive feeding). Work is ongoing with employers to encourage them to provide the right facilities to enable mothers to continue doing so. The Oxfordshire Midwifery Team is also supporting baby-friendly initiatives. **The Committee requested a break-down of the statistics in order to ascertain how many mothers were exclusively breastfeeding rather than combination feeding;**

- A member asked if there was a set of national standards and any external accreditation where assessors could talk to the mothers? - there is very little evidence of health promotion as it is not possible to do randomised control trials. The tendency is to work with the users themselves to ensure that any messages go out. The service does its best to evaluate this to ensure that groups are targeted. It is also ensured that clients are directed to accredited websites for information;

- A committee member pointed out that there was no mention of drugs and alcohol education included within the work the school health nurses carried out in schools? – It is better to glean this kind of knowledge when working

on a one to one basis with the child. OCC's Drugs and Alcohol Team work closely with schools and delivered training to school nurses;

- What is the difference between school health nurse support workers and school health nurse assistants? Is there a difference in where they are being used? – SHN assistants is a new support role, at NHS/Agenda for change a band 3 support worker is responsible for height and weight measuring, for example – and they do not do any follow up on the results. They will also lead on the health education side. School Health nurses are a band 5, and qualified School Health Nurses are qualified nurses with enhanced training;

- What is the strength of partnership with Children's Social Care? – There is a very good relationship with social care colleagues, at all levels. Health Visitors and School Health Nurses have a separate but very clear role and work very closely with Children's social workers, both at leadership team level and with social workers on the ground. Looked After Children (LAC) are top priority - and school nurses know who the vulnerable children were. Social workers are also linked with schools;

- If a child suffered from, for example, epilepsy, how were transitions dealt with? - whose role was it to lead with the Education Health Plan? - Multi-professional teams worked around the family and the child is tracked and monitored, so that the child can achieve its aspirations. All LAC Children have compulsory, six monthly assessments completed on them. The school health nurses hand over to secondary school nurses on transition. Strong links are forged with specialist nurses (with epilepsy/allergy clinics, for example) and with OUH, in order to ensure a close working relationship between all nurses. SEND holds all to account and provides a link and knowledge base;

- The Committee asked if there was anything the Committee could assist with in respect of supporting the continuation of funding for the training of school health nurses? – Health Education England allows the organisations to train. Notification has been received that 15 School Health Nurses and Health Visitors can be put forward for training but it is not sure if it would be possible to do the same next year. The service was moving to an apprenticeship model for Health Visitors from 2020. Good staff were being developed in Oxfordshire and innovative work was in train to keep staff developed. The Committee will be approached for assistance in maintaining the movement forward with the apprenticeship model for 2020 if needed;

- How does cross – border work take place over the borders? – This is an ongoing challenge. If a client is seen in Henley, they are seen by Berkshire midwives. Regular meetings take place between midwives in different counties every 6-8 weeks to ensure that each is aware of who they are working with, regardless of borders. There are also links with GP colleagues over the borders. Birth notifications come via the Child Health Information Service to ensure knowledge of babies from birth;

- Mental health and children is a priority area nationally with concerns that children waiting for the Child & Adolescent Mental Health Service (CAMHS) is nowhere near target. What are the issues causing it? Is there anything you would put into your services to assist the process, if you had the finances with which to do it? – Mental wellbeing is a real issue and the system is currently looking at a Public Health England Prevention Concordat in a bid to make mental health a priority. A bid has been submitted to provide additional capacity to support school health nurses in their ability to intervene and give them access to CAMHS. Early anxiety and distress amongst younger children, leading to behavioural issues; and emotional distress amongst teenagers, is a big issue. There is currently work taking place looking at the impact of social media on children and young people. Had funding been available then there would be a wish to put it into work around resilience amongst primary school children. The Kingfisher Team (CSE) was currently working with primary school teachers to educate them. Parents had a significant role to play in providing their children with protection and resilience to problems encountered with social media and more study in relation to this role could be undertaken.

Councillor Hilary Hibbert-Biles concluded the discussion by pointing out her view that the Family Nurse Practitioners service should be expanded because it did a very good job. In addition, since the School Health Nurses and Health Visitors service had come into the local authority, some good work had taken place and continued to take place.

The Chairman thanked all for their attendance and for an excellent presentation.

It was **AGREED**: to

(a) request the information documented above in relation to target/performance measures for breastfeeding;
(b) refer the issue of where the division lies between scrutiny of health services in HOSC and in OCC's Performance scrutiny to ensure that effective scrutiny is taking place on both sides; and
(c) request service officers to let the Committee know if there was anything the Committee could do to help in furthering any requirements needed in the service, as documented above.

58/18 HEALTHWATCH OXFORDSHIRE

(Agenda No. 7)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) was present to present her report (JHO7) on the views gathered from members of the pubic and the latest activities of HWO.

She reported on the work HWO did around Healthshare and the information given to HOSC's sub-group. Most of the recommendations given to the CCG had been accepted and put into practice by the CCG and she expressed her thanks to the CCG. She also pointed out that the report did not cover responses received from the

CCG and Wantage Town Council with reference to Wantage Hospital, most of which was on HWO's website. She added that HWO had not found out anything that was not already known, and hearsay had been reinforced by discussion with many people on the subject.

Rosalind Pearce was asked if HWO had undertaken any further work on dentistry since the last report documenting this. Rosalind Pearce reported that HWO had now taken the investigation wider to include countywide access to NHS dentistry, including that offered to care homes. She undertook to send a copy of the wider report to members of the Committee. She pointed out that a new NHS dentist was opening up in Bicester in recognition of the commissioners need to address the lack NHS dentists within the county.

Councillor Lovatt expressed her appreciation to HWO for organising the pop-up shop in Abingdon which had attracted approximately 100 people, with no advertisement beforehand. She also expressed her thanks for the work underway on the Musculo - Skeletal (MSK) service and in respect of Wantage Community Hospital by both HWO and this Committee. She agreed that it was a success and added her aim to employ the use of pop-up shops on a wider basis in the future.

The Committee **AGREED** to thank Rosalind Pearce for the report and for her attendance.

59/18 CHAIRMAN'S REPORT

(Agenda No. 8)

The Committee **AGREED** to receive the Chairman's Report (**JHO8**) which included updates on Health and Social Care liaison and the MSK Task Group.

60/18 NEW GOVERNANCE OF THE HEALTH & WELLBEING BOARD

(Agenda No. 9)

Prior to consideration of this item and Item 11, the Committee was addressed by Councillor Cathy Augustine, Didcot Town Councillor and Oxfordshire delegate to the national Steering Group of the 'Keep our NHS Public' (KONP) campaign and County Councillor Jenny Hannaby.

Councillor Cathy Augustine stated that, in her view, despite the role of this Committee, unscrutinised change was happening now, at a pace, and without adequate public consultation. It was her concern that this made evaluation and scrutiny of the bigger picture for Oxfordshire almost impossible. Instead, the focus was on a loss of services in specific localities, which in her view was an attempt to confuse and distract, without recognition of the cumulative and domino-effect across the county. She added that HOSC was set up as an independent voice and should decide on its own, independent agenda on behalf of patients and residents. It should not fall into line with those bodies it was scrutinising, particularly in three key areas, governance, transparency and consultation.

She expressed her concerns that, in her view, the Health & Wellbeing Board papers contained 'opaque layers', which indicated a policy of secrecy behind closed doors,

which, in turn made it closed to scrutiny by this Committee. For example, there was alarm that the Integrated System Delivery Board (ISDB), which was the main driver behind the proposed Integrated Care System (ICS), was buried deep within the structure, and, virtually invisible from the scrutiny by elected representatives. Meetings which, in her view determined policy, were in closed session with no public minutes being produced, and there was no democratically elected representative serving on it.

She therefore asked the Committee to examine and challenge this 'flawed' governance proposal.

Cllr Jenny Hannaby shared the concerns expressed by the previous speaker in relation to the ISDB stating that there was a real danger of privatisation 'coming through the back door'. She added that the Joint Management Groups who managed the pooled budgets, only met in public once a year. Transparency and openness was a requirement.

She added her hope that the Health & Wellbeing Board would listen to these concerns. She stated, however, that not all was bad - she was pleased that the Board would be working with the Growth Board in respect of the Healthy Towns initiative as working with the district councils was the way forward.

Dr Kiren Collison, Chair of the OCCG and Vice Chair of the Oxfordshire Health & Wellbeing Board, Kate Terroni, Director of Adult Social Care and Catherine Mountford, Director of Governance, OCCG

Dr Collison stated that this was a good opportunity to explain where the revisions to the Health & Wellbeing Board (HWB) had reached. As was recognised by the CQC last year, and also by the Board itself, the Board was not as valuable as it could have been. A full process review was then undertaken, which began with the engagement and discussion with a wide variety of stakeholders, including the voluntary sector, councillors and the Board members themselves about the way the Board should be going. The outcomes of this was then taken to a special meeting of the Board in May and then to formal approval by the Trust Boards and County Council. It made sense to have more representation by Health on the Board, to represent the whole pathway, from prevention through to hospital care; and thus to give a good mix of views. She added that essentially it was now a new and different Board. There was an awareness that although some groups were not represented on the Board, there was a crucial need to hear their views. It had therefore been decided to create a Reference Group to include representation from the voluntary sector and the care sector, so that nobody was excluded.

Members of the Board had undergone some work to develop and had done so in three facilitated workshops to date to build relationships, how to work together effectively and get a feel for each other's backgrounds. It was felt that to meet in public was not the best way to go about this as it required a different environment in order to get to know each other and, by use of a storming process, to work out priorities, a vision and finally a full Health & Wellbeing Strategy, which was now open for further comment by the public. The Strategy had been the subject of a large

amount of work which followed the residents journey and included cross-cutting themes of prevention and tackling health inequalities throughout.

The four main priorities were:

- Agreeing a co-ordinated approach to prevention
- The residents journey through the health and care system
- To work with the public locality by locality
- Agreeing plans to tackle the workforce issues.

Kate Terroni stated that the key areas for the new Board was visibility and a 'joined up' leadership for Health and Social Care, setting the direction of travel for Health and Social Care services in Oxfordshire, to include the planning and identification of future health social care needs for the county. The ISDB was the 'engine room' to start delivering on the direction set by the HWB, adding that it was already doing some valuable work on the workforce. The sub-groups were performance related and would give visibility to the work which the HWB was doing.

Catherine Mountford stated that the Board had recognised that there was a need to take a wider view of transparency with patients and the public. The core of this work was the development of working together, responding to what was heard from the public and showing its commitment to that. This had been shown, for example, with the Older People's Strategy. It had heard that the public wanted services to be joined up and its structure was a reflection of this. She pointed out that the CCG had held its Board meeting on this day and at this venue, as it recognised the importance of working with other organisations on how to meet health and care needs.

Questions and responses received from members were as follows:

- In response to a question about the earlier suggestions that the private workshop meetings meant that the HWB was secretive, Dr Collison stated that the Board was multi-agency in its membership and it was felt that there was a need to get to know each other properly in order that they could work together effectively. She added that there was no mystery intended, in that they needed to go through a process of storming in order to move forward. Catherine Mountford pointed out that the HWB itself was still meeting in public and Board members required more time to get to know each other on top of the public meetings;

- A member asked if the panel saw any room for more democratic representation on the ISDB and the Joint Management Groups in light of some public concern that there was unscrutinised change taking place at quite a pace? – Kate Terroni responded that the JMG (Better Care Fund) was chaired by Cllr Lawrie Stratford and met in public once a year. The two pooled budgets were managed by the JMGs and oversaw a spend of £350m. They looked at how to achieve the most efficiency out of contracts and they were therefore bound by commercial regulations. There were regular quarterly reports to the HWB for public scrutiny. The ISDB was newly formed and settling in in terms of its membership. Conversations were only just taking place in relation to its clinical voice. There was an

awareness that there needed a little more thought to how to respond to the transparency/visibility of papers. **The Committee was asked for its views on this issue. The Chairman requested members of the Committee to circulate any views via himself on this issue to him in good time and prior to the next meeting in February.** In terms of the concerns expressed regarding democratically elected membership of the HWB, Catherine Mountford commented that this had been signed off by the County Council. This would, however, be kept under review. She added that if there were any particular issues, this would be brought to the Committee and the Trust Board, as was the usual practice. The principle and approach of the new Board was to think together about how the NHS and Social Care was commissioned, provided and aligned and to work together to achieve the best results. For example, to work together on winter pressures to ensure that primary, acute and social care services were all working together for the patients and the public in an integrated way. Dr Collison added that the NHS 10 - year Plan was due out in December and it will provide great potential for looking at best practice across the country;

- In response to a question regarding a wish expressed by the voluntary sector to be involved in the integration of Health and Social Care on the HWB as provider, Dr Collison informed the Committee that following the discussions on the review there had been agreement that there was a vital need for a reference group in order that views from the voluntary sector and other stakeholder groups could be fed in. Kate Terroni added that there was a concern if all stakeholder groups were represented on the HWB it would become too unwieldy. This was a system for all voices to come to the table – it would be the subject of review if it was felt this was needed;

- In response to a question about the meaning of the term 'commissioner-provider collaborative', Kate Terroni explained that this was an area where people worked together at a local level to deliver services, for example, mental health services work involved working with the provider plus voluntary providers. The ISDB had a number of workstreams, for example, IT/ Estate/provider and commissioner collaborative. She added that more work was required in relation to this aspect, for example on how to bring together providers and how to share information with each other;

- In response to a question about how to resolve the tension of using this very radical methodology and listening to what the public considered to be important and gaining their trust and a meaningful inclusivity, Catherine Mountford commented that it was her understanding that the Committee's concerns in relation to the ISDB was not just about the meetings themselves, it was more about how the Board would work when listening to the public's concerns. Dr Collison added her understanding also that it was not just about being evidence driven, it was about how the public perceived services. It was the job of the Board to bring these aspects together and to show the results of this;

- A member expressed concern about the democratic accountability on the Board, and the fact that elected members had not been approached when the new Board was in its embryonic form for discussion and views. Councillors had their ear to the ground and received any worries the public had - Kate Terroni stated that the Board needed challenge from the Committee on delivery and outcomes – and if this proved to be of concern, then changes could be made to its membership on review.

At the conclusion of the question and answer session, the Panel was thanked for their attendance and it was AGREED:

(a) to request the officers to take back to the HWB the comments from HOSC on the make-up of the Board and its transparency and request a response on these;
(b) that members of the Committee send their questions and comments on the Strategy as soon as possible and to request the officers to send a collective set of questions and comments to the Board for clarification; and
(c) to add the CQC follow -up report to the special meeting of HWB on 29 January 2019 to the Agenda for this Committee on the 7 February 2019 meeting of this Committee.

61/18 CLINICAL COMMISSIONING GROUP - UPDATE

(Agenda No. 10)

The Committee had before them a report (JHO10) on the key issues for the OCCG, which outlined the current and upcoming areas of work.

Louise Patten agreed to send to the Committee the draft pilot report following the revision of the CCG's policy for working with the primary sector adoption. This involved a service review of the integrated respiratory partnership. She added that it would be helpful to see if the patient outcomes had been improved in relation to the management of long-term conditions. The Chairman requested that this be considered by this Committee before anything similar to this project is considered.

A member asked what the implications were when a private company was involved in the collection of data. She asked what was the governance around it, how it affected complaints and what would be the impact on health outcomes in the future. Louise Patten responded that much of this information was already included in CCG papers to the Board, provided by the providers, OUH, OH and the statutory voluntary organisations locally. Any issues around data was taken as part of the overarching description pack.

Dr Collison was asked about morale among staff in primary care. She stated that this was a national problem amongst the workforce. GPs were stretched, however certain conditions could now be allocated to nurses. In relation to waiting times for an appointment, not all data was collected in a coherent way. A large amount of work was being produced on the locality plan on this subject and it was thought that the reality wasn't going to be as concerning as originally thought, particularly now that

evening and week-end appointments were being offered to try to resolve the problem. It was important to distinguish between routine and urgent. The Chairman reminded all that there would be an Agenda item on this subject in the near future.

Dr Collison and Louise Patten were thanked for the report and for their attendance.

62/18 REVIEW OF LOCAL HEALTH NEEDS

(Agenda No. 11)

Prior to consideration of this item the Committee was addressed by Maggie Swain (Save Wantage Hospital Campaign Group), Councillor Cathy Augustine and Councillor Jenny Hannaby, Local Member.

Maggie Swain

Maggie Swain made the following points:

- She was a 'passionate advocate' of the Hospital as a result of her mother's past employment there and also in her own capacity as a volunteer up until the time of its temporary closure. Once her mother had become ill she had attended the hospital for regular respite;
- The campaign group agreed with the future plans by the OCCG to restore the overnight beds, which it was understood were linked directly with the pipework, but there were other facilities that could be restored without the need for the pipework to be done;
- In recent years it was the view of the campaign group that there had been a gradual decline in the services provided. These were the removal of X ray, the stoppage of clinics such as Ear, Nose and Throat and of Physiotherapy without consultation, and the temporary closure of the Minor Injuries Unit;
- Besides Grove, there were at least 18 villages/hamlets within a 5 mile radius, most of which had no services or transport; and there was a reliance on Wantage for them. For example, for someone living in Letcombe Basset without transport;
- Since the Hospital's temporary closure in July 2016, money had been spent on the following, none of which had been of any help to the people of Wantage:
    - Securing the building due to the loss of 24 hour cover with the closure of the beds;
    - Moving Physiotherapy into the main area of the hospital, then closing it;
    - Provision of security guards to protect the building; and
    - The conversion of rooms to accommodate NHS staff that had been moved out of the Mably Way Health Centre;

In conclusion, Maggie Swain commented that the Campaign Group were aware that the OCCG had opened a dialogue with the residents of Wantage, but it appeared that nothing would be decided for a further year. This was 'totally unacceptable' as this meant the Hospital would have been temporarily closed for nearly 3 and a half years.

There was uncertainty whether there would be a slippage again or even cancellation. A way of gaining trust was to reinstate a service which had been lost.

Councillor Cathy Augustine spoke of her concerns that Phase 1 of the 'Big Health and Social Care' conversation spoke to only 900 people in total, across the whole of Oxfordshire, which amounted to less than 0.5% of the population. In addition, only 46 people responded to the South West Oxfordshire Locality Plan Survey and 4 in Didcot. As a result, Ed Vaizey, MP for Wantage and Didcot also raised a concern in Parliament about the lack of consultation.

She called for the Committee to exercise its powers of independent oversight and scrutiny to challenge NHS England on the imminent Integrated Care Service on the grounds that there may be potential for one large contractor which may be private, and a myriad of sub - contractors, which would be likely to lead to dis-integration.

Councillor Jenny Hannaby declared a personal interest as a volunteer for the League of Friends for Wantage Hospital. She made the following points to Committee:

- Over the years, monies had been spent on the hospital, but not on the pipework which had had a detrimental effect on the Hospital;
- The statistics as set down on page 131 of the paper were 'disgraceful for the residents of Wantage' if compared to the admissions in other community hospitals. The beds had been temporarily closed, thus rendering the statistics to hold no meaning at all. The decision that Oxford Health was making was making, in her view, a 'non-viable' hospital;
- Some people would be unable to travel farther afield to other hospitals for treatment for the reasons outlined by Maggie Swain – Community Hospitals played an important part in offering support to these people;
- She reminded the Committee that Oxford Health and the OCCG had used the hospital from the time the legionella had been cleared up to July when it had been closed;
- Part 2 of the Oxfordshire Transformation consultation had not appeared, which had 'added fuel to the fire';
- Closure costed the taxpayer £180k per annum.

Cllr Hannaby stated that on her view the Wantage residents had been let down and urged the Committee not to support the paper, to take responsibility for mending the pipework and to make the monies available to recruit the staff once more.

This item has been included on the Agenda following the recommendations put forward at the last meeting on 20 September (Minute 47/18 refers) which included proposals for the resumption of services and any necessary consultation on services at Wantage Community Hospital. The Committee had before them two reports entitled 'Planning for Future Population Health and Care Needs' and 'Planning for Population Needs – Wantage'.

The Chairman welcomed Louise Patten, Dr Collison and Jo Cogswell (OCCG), together with Stuart Bell and Peter McGrane (OH) to the table.

Louise Patten stated that the CCG had taken all comments made by stakeholders and the public into account and had produced an improved framework.

Commissioners and providers had demonstrated a clear commitment to work together to meet the health and care needs of residents of Oxfordshire both now and in the future; and to plan and work alongside the public and with stakeholders in an open and transparent way. She drew the Committee's attention to some significant work which had taken place over the past ten weeks in the form of a place profile and draft outline timetable relating to engagement and consultation, if so required. She further stated her appreciation of the fact that residents were concerned about the future of Wantage Hospital, but the work was required to identify in a quicker timeframe, what the local needs were, together with services required.

Stuart Bell stated that the Committee's request to re-instate the pipework was taken back to his Trust Board and revised estimates had been requested. This had amounted to £450k (including vat). He explained that the problems with the plumbing had been due to various additions to the Hospital structure over the years, and therefore, legionella had grown in a haphazard manner. Stuart Bell stated that it would not be appropriate to undertake remedial works before any decisions had been made about the future of services at the Hospital site. However, there was a commitment to make the investment to replace the plumbing for whatever services were identified. He added that the Midwifery service had been kept and the Health Visitors and school nurses had been moved into the Hospital due to the need for more space for primary care. He added that the Trust was happy to continue to use the Hospital's space until such time as it was known what to use the Hospital for in the future.

Questions from Members of the Committee and answers received were as follows:

In response to a question asking which services would not require a consultation process prior to delivery, and could thus be delivered more speedily, Louise Patten stated that if there was a significant service change then formal consultation would be required. For example, there would have to be if specifically addressing overnight bed provision. However, should there be services to which improvements would be made then formal consultation would not be required. All change had to be based on evidence, which required some analysis. The Chairman clarified for the Committee that what the NHS termed 'engagement', the local authorities called 'consultation'.

A member commented that whilst she recognised the need for services in Wantage and Grove as soon as possible, it may be advantageous for members of Save Wantage Hospital Campaign Group to visit the new Townlands Hospital in Henley-on -Thames to see the more up-to – date services provided there. Stuart Bell stated that Townlands was working very well and it was his view that if a community hospital was to have a secure future, then this was the way forward, as this was the way in which services were developing. He added that he would be pleased to invite people along to see the newly developed outpatient services which included 14 specialities, with consultants from the Royal Berkshire Hospital coming out to Henley, if that would be helpful. He stated also that this Hospital was now able to provide a wider set of services and also supported the nursing home from the hospital. He pointed out that the Hospital did not start off with these specialities, this had grown.

Stuart Bell also pointed out that the beds created at Abingdon Community Hospital were dedicated for patients suffering from a stroke, in a specialist ward, giving better

outcomes as a result. He added that the drive now across the world was to support patients in their own home for improved clinical outcomes, bed-based care causing more harm than good for frail, bed-based older people. Ten days in bed was the equivalent of ten years loss of muscle function.

In response to a question, Louise Patten confirmed that there would be an evaluation framework as part of the process. She added that an evaluation was also about what people felt about their services and this information would also be built in, to enable this to be shared with the system.

A member asked if the CCG felt it had a legal duty to consult when services had been temporarily closed on a long-term basis? Louise Patten undertook to circulate a legal view to the Committee.

A member commented that the public did wish to engage and thanked the CCG for this, however, there was a need for clarity about the precise locality in which the paper was directed. The paper talked about discussion with stakeholders around the locality of Grove and the surrounding villages. However, residents were concerned about the population growth in that area, which was 45k in 10 years. Louise Patten replied that work had already been done with stakeholders to establish the need for GP practices. With regard to services, there was a need to define the population needs in relation to population size and what was required. Therefore, the first tranche was about defining that particular locality. The CCG had listened to the frustrations voiced by the public about not being listened to with regard to the establishment of services in the past and was addressing that. In response to a further question asking for clarity on what population was the basis for the papers, Jo Cogswell explained that it was the CCG's intention to work locally to determine this whilst engaging with the public and the community, and developing in a transparent manner. Louise Patten added that definitely by May 2019 the CCG would have some idea of what services could look like. The CCG was already talking to other services and looking at providers in relation to what could be done. This timetable was reasonable, especially as it was the first time the framework would be used, but there was no wish to over-promise and under-deliver.

The Chairman, responding on behalf of the Committee, stated that Members had been very disappointed to read the report, in that its request to accelerate the timescale had not shortened the proposed timeframe for decision. However, it was felt that the overall approach for health and care needs was a good one. He added that the Committee was keen that there was no further delay and so proposed, and the Committee **AGREED** (unanimously) the following:

(a) that this Committee is not prepared to endorse the plan for the Wantage Locality against the current timetable and to request the CCG to come back to the next meeting of Committee with a shortened timetable;
(b) to request the legal officers at NHS England to scrutinise their interpretation and advice in relation to the issue of purdah as a reason not to embark on the process and the impact of this on the timescales for the work to begin; and
(c) to form a task and finish group in relation to Wantage Hospital.

..... in the Chair

Date of signing .....