OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 September 2018 commencing at 10.00 am and finishing at 3.10 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen (Deputy Chairman) Councillor Kevin Bulmer Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Laura Price Councillor Alison Rooke District Councillor Nigel Champken-Woods District Councillor Sean Gaul District Councillor Monica Lovatt District Councillor Susanna Pressel Councillor Jeannette Matelot (In place of Councillor Mike Fox-Davies)
Co-opted Members:	Dr Alan Cohen, Dr Keith Ruddle and Anne Wilkinson

Officers:

Whole of meeting	Strategic Director for People; J. Dean and S. 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.

39/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Jeanette Matelot attended for Councillor Mike Fox-Davies.

The Chairman took this opportunity to welcome new members Cllr Hilary Hibbert-Biles and Cllr Sean Gaul to the Committee.

40/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Cllr Hilary Hibbert-Biles declared a personal interest in Agenda Item11 – 'Annual Report of the Director of Public Health 2017/18' on account of her former office as Cabinet Member for Public Health and Education.

41/18 MINUTES

(Agenda No. 3)

The Minutes of the last meeting were approved and signed as a correct record subject to the following:

- Minute 34/18 – 'Update on implementation of recommendations from the Oxfordshire Health Inequalities Commission', page 14, paragraph 5, line 3 to add in the words 'health issues' after the word 'familiar';
- Minute 35/18 – 'Stroke Rehabilitation' Services – Pilot Report' – page 15, paragraph 3, line 1, to add the words 'along with the local MP', after 'Committee';
- Minute 36/18 - 'Transition of Learning Disability Services' – page 17, paragraph 2, line 7, to delete the word 'Leader's' and to add 'Leader'.

There were no Matters Arising.

42/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The following requests to speak had been agreed:

- Cllr Brenda Churchill, speaking as a patient of Cogges Surgery and as Mayor of Witney (Agenda Item 8);
- Cllr Rosa Bolger, speaking as local Member for Witney East (Agenda Item 8);
- Julie Mabberley – speaking on behalf of the Wantage Hospital Campaign Group (Agenda Item 9);
- Councillor Jenny Hannaby, speaking as a local Member for Wantage – Agenda Item 9; and
- Joan Stewart speaking on behalf of 'Keep our NHS public (Agenda Item 9).

43/18 FORWARD PLAN

(Agenda No. 5)

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

With regard to the item 'School Health Nurses' - this was amended to 'The impact of school health nurses in ***primary and*** secondary schools and future service plans'

A member suggested that the Committee look at the County Council's response to the Green paper. The Chairman agreed to take this forward to the Planning Group.

44/18 UPDATE BRIEFING - EVALUATION FRAMEWORK & BEST PRACTICE EXAMPLES

(Agenda No. 6)

In April 2018, following a presentation on the progress of work being carried out in response to the CQC Local Area Review, this Committee had asked Oxfordshire System Leaders to develop an evaluation framework to measure how actions taken in response to that review would improve outcomes for people who accessed services.

At the June meeting of HOSC Oxfordshire System Leaders had reported that there was no national framework for measuring the performance of actions plans developed as part of the CQC's programme of local system reviews. Similarly, the Department of Health & Social Care had not yet developed a performance framework for measuring a health and social care system in its entirety. It was also noted that a number of performance indicators were already being measured and reported on and it was from these that a performance framework would be drawn together.

Also at the June meeting the Committee had received a presentation highlighting some innovative approaches to delivering services, together with an example of how Oxfordshire was learning from best practice elsewhere. The Committee had requested that System Leaders returned to this meeting with some additional examples of how best practice was being incorporated into the work.

The Committee welcomed Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG); Kate Terroni, Director for Adult Social Services, Oxfordshire County Council (OCC); and James Underhay, Director of Strategy & Communications & Deputy Chief Executive Officer (South Central Ambulance NHS Foundation Trust) to the meeting.

Kate, introducing the item, stated that since the CQC inspection, discussions had been underway on how to draw together the Action Plan and how to evaluate it in order to allow its scrutiny; and what proposals to take forward to the newly created Oxfordshire Health & Wellbeing Board on 15 November 2018 to allow the delivery of a new HWB vision. She added that there were many actions which are to be done differently with regard to the pathways, the culture and the narrative of the system. Kate stated that all leaders had worked together and through more joint roles in order to make the experience better for patients and residents of Oxfordshire. Kate stated that although the targets set in the paper presented appeared conservative, these were et centrally and locally. Moreover, the system was working towards a more ambitious progress.

Examples given by the presenters of changes made included:

- Following a two - day event, a proposal was made to create the first system post, that of a single Winter Director with a single team;

- For the workforce, best practice had been followed and funding had been awarded to develop a system of care certificates which would be portable across agencies, particularly targeting the under 24's;
- The Ambulance Service was working nationally with NHS England, putting together a home delivery plan, which would comprise of therapists who were better equipped to pull together and deliver the best service for patients. This work had been piloted in Reading;

Louise Patten reported that the CQC were returning to Oxfordshire on 5 November 2018 to undertake a follow up review. In all 20 reviews had been undertaken, looking at how patients moved through the system and the CQC were keen to return to visit 3 systems to hear about what had been achieved and where it was heading: Oxfordshire had been chosen as one of these. She added that ministers were pleased with Oxfordshire's progress. It had been suggested that the visiting team might wish to meet with the Chair of Performance Scrutiny Committee or HOSC, but this was to be confirmed.

In response to a comment from a Committee member about the need for the newly formed Health & Wellbeing Board to recognise the need for openness and public transparency, Dr McWilliam responded that the members of the Board had taken the thrust of the CQC recommendations very seriously which was to work as one system to oversee its Strategy and to hold it to account. To this end the Board had taken on a programme of organisational development, the process for which had involved independent facilitators to assist them to define its role. The next meeting of the HWB would take place in public as usual. He added that one of the proposals for its new organisational development was to hold a Reference Group which would comprise of workshops for the public to engage with and discuss key issues in the HWB programme. The public will be able to see the emergence of this at the November 2018 meeting. Louise Patten added that the Health & Wellbeing Board would be measuring progress, not merely signing it off.

Responses to a series of questions from members of the Committee included the following:

- The latest DTOC statistics for Oxfordshire were at 79 against nationally set targets. Assurance was given to the Committee that there would be no complacency. Reference was made to the HART (Home Assessment Reablement Team) team administered by the Oxford University Hospitals Foundation Trust (OUH) which had been created specifically to assist people with a high level of needs to receive assistance within their home environment;

- With regard to the issue of 'Oxford Weighting', Louise Patten stated that lobbying was in progress for equal weighting with London. She pointed out that Oxford Health and OUH were already offering incentives for clinical and nursing staff. Kate Terroni added also that the hourly rate paid to care staff in Oxfordshire was already the highest rate in the country. This was also reflected in the banding rates for residential homes;

- Kate Terroni was asked about those current staff who had not undergone the new certificate training course. She responded that there was always an expectation that staff would have undergone some kind of training when they come into employment, and, in reality a new employer would often want a person to redo any training already undertaken. She added that this was an opportunity to work with Health Education England on a new plan, which it was hoped would be in existence in 6 – 9 months. It was hoped also that existing care workers would be able to apply for the certificate;

- When challenged by a member of the Committee that it appeared that a large amount of work was being undertaken which would have no direct influence on patient outcomes, Kate Terroni stated that the CQC Action Plan was premised on single path commissioning which would require one single conversation and ultimately lead to more coherent planning for a person, rather than the person themselves having to navigate a pathway.

- When asked if there was a process of measurement in existence which would highlight whether this method was having a beneficial impact on patients, Kate Terroni gave an example of a very different way of working which was to the benefit of the patient first and foremost. 'Stranded' hospital patients were being worked with by an integrated team of practitioners prior to discharge in order to support their leaving in a timely way with the maximum support. Lou Patten added that this also meant that outcomes for patients could be measured in more of a timely way;

- A member sought reassurance that the Joint HWB Strategy had not been fully finalised and refreshed to align with patient experience, asking if there would be services which the Committee could focus on when scrutinising, which would align with those that the CQC were also looking at. He also pointed out that all the system leaders, or their representatives, were not currently around the table for this item. Kate Terroni responded that all the system leaders were now members of the HWB and would be present at meetings, adding also her assurance that close working was in existence. She pointed out that this item was more about the theory, but the next item, the Winter Plan, would illustrate how system leaders were working in practice. Dr McWilliam gave his assurance that the new, overarching, high - level Strategy would be discussed at the next meeting of the HWB. Moreover, the HWB would address the work of the Integrated Service Delivery Board whose remit covered the work under the pooled budget umbrella. He added that there would be no shortage of dashboards to measure in this system of working. Work was already moving at great speed, for example, the Health Improvement Board and the Children's Trust were looking at its current and future priorities and how it could align with the HWB. At the end of this process there would be a need to stitch everything together in order to obtain end to end priorities in a format which made sense for all, including the public and that also took account of that the CQC wanted to see. The public would have a hand in shaping this process via the Reference Group. He commented finally that this would not be a straightforward task as there were issues to address requiring further work such as how to improve the DTOC stats, housing etc; and

- A member pointed out her view that bullet point 4 under 3.1 of the report presented which stated that 'many of the actions in the CQC Action Plan are strategic in nature and it would be very difficult to link them to specific impacts on people' needed to be refreshed to take account of the premise that any strategy anywhere should have direct measurable impact on patients at the end of the day. She asked also if people would be assessed at home without a knowledge of what was needed? Kate Terroni responded that home first was best practice, together with possible short stays in hospitals, therapy or interventions.

It was **AGREED** to:

(a) thank all for attending; and
(b) request the representatives to return in the new year to present the CQC feedback;
(c) also to request the representatives, when they return, to give some indication of how outcomes have improved given all the hard work undertaken; ensuring that targets identified are nationally set where appropriate, and, alongside this, to identify what the trajectory is for the local Oxfordshire system.

45/18 2018-19 OXFORDSHIRE SYSTEM WINTER PLAN

(Agenda No. 7)

The Committee welcomed the following representatives to the meeting:

- Louise Patten and Diane Hedges, Chief Executive and Chief Operating Officer, Oxfordshire Clinical Commissioning Group (CCG)
- Tehmeena Ajmal, Winter Director for Oxfordshire, (joint appointment for Oxfordshire health and social care system)
- Pete McGrane – Acting Clinical Director, Operations Services, Oxford Health NHS Foundation Trust (OH)
- Ross Comett – Head of Operations, South Central Ambulance Service (SCAS)
- Kate Terroni, Director for Adult Social Services, Oxfordshire County Council (OCC)
- Rachel Piri, Lead for Older People Commissioning Mkts, OCC

Diane Hedges gave a presentation on the 2018-19 Oxfordshire System Winter Plan, together with a summary on what worked and what didn't work in relation to last year's Plan. She took the opportunity to introduce the newly appointed Urgent Care Director, Tehmeena Ajmal, who worked to the Chief Executives of OUH, OH, OCCG, SCAS, GP Federation and the Director of Adult Services, OCC, co-ordinator of a Team from all these organisations on a demand/capacity dashboard. This would hold information updated on a day to day basis and sometimes on an hour to hour basis, looking at, for example, how many people were waiting to be admitted, or how many were waiting for an ambulance, so that actions could be taken quickly and patients were supported appropriately through the Winter period, enabling them to recover quickly. Following a review of last year's Plan it had been found that:

- too much time had been spent on the delayed transfers of care and insufficient attention given to caring for people in their own home;

- emergency care and Out of Hours did not necessarily co-ordinate or plan ahead on what may be needed on a day to day basis;
- there was duplication in some areas where three teams were working together – more time with people was required rather than excessive geographical travel.

Tehmeena Ajmal had discussed with Healthwatch Oxfordshire and provider and third sector organisations on how to keep people safe and well and how to work together to ensure there were plans in place for people to receive help when needed, for example for volunteers to go to the shop for the basics, such as milk and bread.

In relation to risks, she added that it was important to ensure that influenza inoculations for front line staff were begun earlier. Also, during inclement weather it was important that each organisation had an instant plan which would ensure that they had sufficient capacity to look after people in their own homes. She was also looking to ensure that nursing staff and therapists could respond quickly when they were needed and with no gaps, by creating overall system plans. There was also a series of projects to best help people to stay at home. Each organisation was asked to identify what could be done with the funding in order to respond to the Winter Plan. This confident style approach enabled the Team to use resources most effectively. She emphasised that hospital beds were available when required.

Diane Hedges informed the Committee that £700k had been set aside by the Better Care Fund Joint Management Group for winter pressures, funded by OCC and the OCCG. There was also an additional level of improved capacity, for example, the preparatory work which was being undertaken with pharmacists and the Out of Hours service prior to the onset of winter.

Kate Terroni was asked to explain further how this new system would work, given the DTOC statistics and despite the excess demand for beds which had been forecasted. She explained that there would no longer be a monthly update, there would be a weekly email summary of exactly what the position was alongside weekly capacity demand. It would in future be a collective decision made by all the Chief Executives to ensure delivery. Sara Randall added that this new process gave a good sense of the current position and what was required for the following week.

A member asked if there was sufficient capacity for those people in domiciliary care who were not on the Health pathway, but who required a bed. Kate Terroni responded that early on in the process she had sat down with the providers and looked at what the allocations looked like at local level and if there was additional capacity to help specifically with winter pressures. She added that she had also been working with providers on a wider basis and had confidence with the joint planning which was taking place. She was also working with third party providers. In addition, a review of short stay beds had taken place to help avoid admission to hospital and looking at the range of options available to people.

A member made a plea for a clearer and easier to understand explanation of the additional projects and how they tied up with the whole.

When asked if there were sufficient staff/ambulances strategically placed throughout Oxfordshire to cater also for people living in the rural areas, Ross Comett responded that they were strategically placed in Adderbury, Kidlington, Oxford and Didcot. They were also placed at standby points and at the main hubs across the county in Wallingford, Abingdon and Bicester. They were controlled centrally in Bicester and were able to be despatched at a constant flow. There would be an array of back fill for any gaps in provision in the form of first responders, with defibrillators, and with the Fire Service. Moreover, there were sufficient ambulances and crews and the service was forecasting for additional staff and reviewing rostas in anticipation of the growing demand. Pete McGrane added that part of the learning process had been that the systems that did well were those that were actively working with the 111 service so as to deploy ambulances in places where they were really required. If this was to be put in place and it could be assured that sufficient ambulances were able to attend, this would not then place undue stress on the service.

A member asked if the ambulances would be suitably equipped to manoeuvre around the narrow roads in the rural countryside, particularly in winter weather conditions. Ross Comett responded that the normal ambulances were very heavy which gave better traction on the roads. There was also a fleet of four by four vans manned by officers who were clinically trained. In times of heavy snowfall or heavy rain where roads were no passable, Fire Service responders, mountain rescue services and air ambulance were also deployed to get help to people.

A member asked how would the necessary supply chain work for patients being cared for at home during adverse weather. Tehmeena Ajmad responded that her team was working with the hospital on the use of nurse practitioners who would bring the appropriate equipment out to the home environment. In addition, Oxford Health was giving a lot of thought to ensuring a quick response. Sara Randall also explained that the Trust had worked with NHS England after 5.3% of bed occupants had been victims of the flu virus last year (which was more than the average of 4.1%). To this end the Trust was ensuring wide advertisement of flu vaccines for patients and staff to cover the winter pressure period.

Tehmeena Ajmad was asked if she had a ‘Plan B’ if the gap should widen in relation to the sufficiency of beds in January. She explained that the Team had been working through various scenarios to ensure a speedy response in the provision of additional capacity where required; and one of the things she was focusing on was how to create more capacity for patients to go home as soon as possible. This was in the form of additional nurses and therapists, as a patient’s health decreased if they remained in bed for too long. She was also looking at creating capacity for more beds, if required, during the winter pressure period.

Pete McGrane was asked if it would be more beneficial if a patient, who was unable to be treated at home, was moved from an acute bed to a community hospital, rather than staying in the system. He responded that in the past this was deemed the best solution, however, it prolonged hospitalisation which was detrimental to patient outcomes. This was the clinical experience every day, particularly for a frail patient, with complex health problems. Furthermore, the process of disruption could also prolong their stay in hospital with one week in bed equating to 10 years loss of muscle function. It could also affect people socially. Thus, from a clinical point of view

it was important not to take patients into a community hospital setting, but to put them into the right place.

In response to some Committee members remaining unconvinced of the reasoning behind the assurances given that increased demand for services could be managed effectively, Pete McGrane stated that it was important for the Team to understand which parts the Committee was unhappy with. To this end he offered to return to a future meeting to talk through what could be put in place in relation to Plans C and D.

In response to a question about what facilities were available for older people to obtain their flu jab, Diane Hedges stated that the take-up had been good last year, but this was still deemed not sufficient as more were claiming the jab this year. The OCCG was looking very proactively with the NHS at some possible options, one of which was for pharmacists to undertake the injections and another for eligible patients to receive a text message where possible. She added that the OCCG was also monitoring those GP practices who did not perform as well last year to ensure all patients received their jabs. She explained that there were also issues with supplies of vaccines not getting to some practices.

With regard to a question about whether there was sufficient GP availability across the practices, Diane Hedges responded that the OCCG was still working on directly slotting in GP hubs into the 111 service, and also on enhancing the availability for GP appointments. At the same time the OCCG was also working on resourcing more primary care so as not to de-nude the in-house scheme.

Diane Hedges confirmed that there would be a larger number of community hospital beds available on a short-term basis in recognition of the fact that during the period of winter pressures they would be needed. She explained that the OCCG did not contract on beds, but on the number of episodes. In past years a whole range of beds had been available, some of which lay empty. There was a need for greater and better usage of beds available, therefore greater bed capacity.

In response to a further question about whether the OCCG/Trusts were looking at community beds on a county, not local capacity, Sara Randall explained that each morning there would be a meeting which would take place to decide where was the best place for each person to go. This would be led by OUH, OH and Social Care based on the needs of the patient and the needs of the whole family.

The representatives were thanked for the report and for their attendance.

46/18 CCG: KEY AND CURRENT ISSUES

(Agenda No. 8)

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

Cllr Brenda Churchill, speaking as a Cogges GP Surgery patient, a member of Cogges Patient Participation Group (PPG) and Mayor of Witney, stated that the closure of the surgery came as a shock and had caused the Town great concern. Whilst they were aware that the circumstances of this closure differed from the Deer

Park Surgery closure, the fact remained that there were only two doctors' surgeries remaining in Witney. These struggled to take on an extra 4,500 patients, with the additional problem of shortness of space. With the extra 7,749 additional patients, she asked how they would cope. Moreover, extra doctors would be required at a time when surgeries were struggling to recruit and in circumstances where a large number of houses were being built. She also pointed out that many of the patients at Cogges lived outside of Witney in South Leigh and in several more of the villages to the east of Witney; asking how would patients travel into Witney to see a doctor when there was no bus service serving those areas.

Cllr Churchill also pointed out that, in her view, if some of the IRP ,recommendations regarding Deer Park patients had been taken on board by the CCG then this situation would not have happened. The recommendation to not preclude opening the Surgery again had not been looked at seriously, and, in her view should have been. As a consequence, she urged the Committee not to allow another surgery to close until such time as fully workable business plans could be seen, to ensure that other practices had the capability of taking the 7,749 patients, plus the new patients. She concluded that, in her view, the CCG's Locality Plan was not workable and Witney town now needed the OCCG et al to begin to look at what needed to be done to give the people of Witney the patient care they deserved.

Cllr Rosa Bolger, speaking to save Cogges Surgery, stated that Cogges Surgery was essential to Witney and its surrounding villages. She pointed out that this repetition of the Deer Park Surgery closure was no different to the picture emerging nationwide which, to date, had seen the closure or merger of 200 GP practices. She informed the Committee that a community workshop had been convened to ensure that all voices were heard. The community wanted the GPs to remain at Cogges. Cllr Bolger told the Committee that a positive meeting had taken place with the OCCG, who appeared to understand the importance of keeping the surgeries open in the Town. She asked that the Committee continue to scrutinise this matter and to commit to working with the OCCG to retain the surgery, as a steer towards a better solution. In addition to apply pressure to ensure that the highest bidder was intending to retain services at Cogges, to ensure it thrived, rather than be closed. She also appealed to the Committee not to allow any further closures of practices in the town, pointing out that vulnerable patients needed to be seen in their own community.

Louise Patten assured the residents of Witney that the CCG had worked with the practice before it had made the decision to give notice on its contract. She reminded the Committee that GP practices were independent businesses that contracted with the NHS. She told the Committee that the OCCG continued to learn from the Deer Park experience and was ensuring that it was covering its statutory responsibility to ensure that Cogges patients received ongoing GP services. Furthermore, the OCCG was able to demonstrate that it had talked together with the community and was working with the constituent systems to ensure that all were working together for the residents. She pointed out that the OCCG could have made the decision to disperse the list, or for a local merger, but, by going out to limited invitation to tender throughout, it had demonstrated its ultimate wish for services to continue on the Cogges site. Louise Patten explained that, by contract law when going out to limited application, local GP providers were to be asked if they wished to continue. If this proved not to be so, then the next step was to ask for wider interest. She assured the

Committee that the CCG would strive to work with other PPG's with the same open and transparent approach. She thanked the PPG for their work in communicating information out to patients, adding that there would be continuous updates provided as the process continued.

Questions from the Committee and responses received were as follows:

- When asked if there would be a need to negotiate with the leaseholders, Louise Patten responded that the CCG could not mandate that services were provided from that specific building because it was privately owned. Talks had taken place with the leaseholders of the premises. The CCG had stipulated the weighting was high on the list when making a decision relating to a local provider.
- In response to a view expressed by a member of the Committee, who was also a local member for Witney, that an important part of the local engagement process with the community was one of understanding the specifics of the model and how it fitted in with the legalities of the tendering process (which was a factor of tension with regard to Deer Park), Louise Patten agreed that it would be reasonable to publish a high level evaluation and then the OCCG could afterwards summarise some of the specifics relating to those from other providers. This Councillor also expressed her view that the experience with Cogges had differed greatly from that of Deer Park, with the OCCG going to greater efforts to conduct early dialogue with the community;
- Another local member for Witney thanked the speakers for their clear and concise statements and also re-affirmed his colleague's view in relation to the improved attitude of the CCG towards the Witney population. He asked if the West Oxfordshire District Council's local plan had picked out any provision for new medical centres in and around Witney, to accommodate the 15k new homes being built, a third, if not more of which were in Witney and its surrounds. He asked the OCCG to be aware of this and to speak to local planners. Another member pointed out that county and district council's timeframes were far larger than the OCCG's and this ten year gap needed to be addressed. Louise Patten agreed that future NHS planning had not previously been done well, however, there was a growing understanding that planning could not take place unless there was also sufficient infrastructure. The OCCG had conducted two meetings with West Oxfordshire planners and was also working with other councils across Oxfordshire - and was beginning to increase its involvement. It had been agreed that there was a need for proper infrastructure governance and there needed to be an improved response in the longer term;
- A member pointed out that one of the concerns with regard to the Deer Park closure was the unstable effect on other practices when GP's either decided to retire early or were approaching their retirement in the longer term, asking what the OCCG was thinking about doing about workforce issues. Dr Collison agreed that there were very real pressures on the workforce both in the local area and nationally. On this basis GP practitioners had been promised 5k extra GPs, which had not yet materialised. In the meantime, it was necessary to make the best use of resources, including that of the workforce. The OCCG was trying to work

out which parts of the workforce could take on the less complex cases such as administration, nursing and therapist staff. In addition, how the OCCG could show support for busy practices, who were, she pointed out, independent businesses, if practices began to creak at the seams. A member suggested that a possible difference could be made by looking at childhood vaccine data;

- Dr Collison responded to a question about what was taking place locally in the short term to acquire more doctors, stating that workforce strategies were being developed across a few centres. In addition, a significant amount of work was being done to encourage trainees to stay in the county. She added that the high cost of living was a very real issue and there was a need to make jobs attractive to entice them to stay. She added that the GPs job was very stressful and people were retiring early with 'burn out'. The situation at Cogges was a real - life example of where this was happening;
- With regard to flu vaccinations, Dr Collison stated that this was going well and work was underway to decide how to work with other eligible adults and children in schools in order to provide then earlier than last year.

With regard to Oxfordshire vasectomy services, Louise Patten was asked how the OCCG could justify removing the NHS service when need for it could be demonstrated, pointing out that it went against health inequality principles and 'breaking the cycle' as demonstrated in the Director of Public Health's Annual report. She responded that the current service had been provisionally flagged up as a real issue concerning staffing. When the contracts were originally set this was based on historic activity and set against the amount of money which was available. Each year providers were having to switch their priorities. Furthermore, it was not unusual for GPs to let people know of the routes that were available to them. Many CCGs had ceased funding these services. In some cases, an Independent Review Panel would make exceptions to the rule. Generally speaking, however, the OCCG would have to look at whether to fund this service. Elsewhere, people had gone to private practitioners.

The Committee AGREED to;

(a) keep the above issues under review;
(b) note the report as a whole; and
(c) Thank the QCCG for the report and for their attendance.

47/18 PLANNING FOR FUTURE POPULATION HEALTH & CARE NEEDS

(Agenda No. 9)

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

Julie Mabberly, speaking on behalf of the Wantage Hospital Campaign Group stated that when she previously addressed the Committee prior to the temporary closure of the hospital in 2016, it had been understood that this closure was subject to statutory

consultation. This had not taken place adding that an engagement exercise was not the same as one of consultation. She pointed out:

- that 650 new homes had been planned for the Wantage area, now the figure stood at 1,000;
- there was a significant percentage of people aged 65 and over and the local NHS was not making the most of the family and friends asset and resources;
- the difference in care in community hospitals to that of acute hospitals was that patients were encouraged to leave their beds;
- it was not understood where the required 142 beds would be situated.

Cllr Hannaby, local member for Wantage, spoke of the 'invisibility' of Wantage Hospital stating her view that the 'new plan' presented to Committee would not be implemented quickly. She called for a comprehensive online consultation plan to which the public could give their comments. It was her view that, had legionella not broken out, the situation would not be as it was currently. She stated her belief that the OCCG had taken this as an opportunity to close the hospital, commenting that Wantage Hospital was a vibrant hospital which had served the community well. The Hospital also gave employment to a large number of people in the area. She urged the Committee to help the people of Wantage in their campaign to keep it open until such time as the health provision was decided for the area. She asked for equal treatment with other towns in Oxfordshire, expressing her fear that this kind of proposed engagement for the county would begin to split communities and one town against the other. Furthermore, it was her belief that the Hospital needed to be open to assist with the winter pressures. She concluded by stating that if the consultation was not open and transparent, it would be unsuccessful.

Joan Stewart, speaking on behalf of 'Keep our NHS P,ublic' campaign commented that at first glance, the framework suggested a gentle move towards approval. However, it was her view that beyond the window dressing, the intention was still the same which was to mask underfunding and the provision of few hospital beds. She added that in the past there would have been a consultation, but this review was not in the same vein. She asked if the proposed options would be deliverable. She pointed out that an audit of the community hospitals had already been carried out in 2016, and, in her view, the primary care locality plans were already in motion and underway. She asked where was the interconnection of the community hospitals, warning that a domino effect could ensue alongside greater fragmentation, with a potential for localities to be pitched against locality. She asked where in the paper was the evidence of greater integration of health and social care, despite the much publicised systemic delivery. She warned that in her view this paper was premature and there was a need to reconsideration.

Louise Patten and Dr Collison (OCCG) and Pete McGrane (OH) attended for this item. Louise Patten stated that phase 2 had been suspended and it had been decided not to consult until the needs of the local population was known. After that, a dialogue would be conducted with the public. Until then plans for a formal consultation could not be developed. Moreover, there had been much talk about how committed each organisation was to working as a system and about the need for discussion with the planners. The NHS, the community and the County Council were going to work together looking at the wellbeing of the people of Oxford. It was also

about working together with the voluntary sector to deliver this. She pointed out that the Health & Wellbeing Board owned this paper and this process. What was being presented here was a draft to glean the comments of the Committee on whether the system leaders had got the process right and whether it was sufficiently clear.

She continued that the frustrations voiced by the public had been heard, ie. the lack of transparency, lack of trust and their wish to be involved. There was a need to conduct intelligent conversations with the public, setting out to everybody what the needs were, and then armed with that information, state what the process would be. This would be conducted with a shared understanding of working together to develop that solution. She added that certain services would have to be provided at scale as the costs would be too high to provide for a small number of people coming through the door. Certain services would need to be provided in towns and there would be a joining up of towns and localities. This was about having an honest conversation. With regard to the consultation process, the OCCG would take on board the wishes of the public, for instance, not to hold forums or public meetings when mothers and children could not attend. It had been understood that online, ongoing engagement was the favoured approach.

She added that the review would look at the health and care needs of the local population and what would be needed in the future, whilst taking into account housing growth. Moreover, the review of services and assets would need to describe services in local towns, for example, looking at GP practices and how to co-locate services there. Dr Collison added that the OCCG would try to ask the question about whether it made sense clinically and was it evidence based? The OCCG had some evidence of growth and size of the population in an area, and, for example, the growing numbers of older people in an area, but more knowledge was needed. With the huge advances in technology the OCCG needed to ask itself whether it should operate within the current system or did it need to do more. She explained that there were three principles of emerging good practice. These were:

- integration of health and social care;
- delivery of more care closer to home; and
- not keeping patients in bed for too long.

She informed the Committee that Dr Ian Sturgess, Director of Improved Healthcare, had been invited to Oxford to advise on how to design models, encourage integration etc. It had been found that there was much potential going forward and good examples both around the country and locally, for example, the integrated delivery teams close to EMUs (Abingdon) and RACUs (Horton) could assess and treat patients. Another example given was around diabetes care/prevention which could be conducted by specialist nurses within communities rather than in hospitals. This was evidence of an up-to-date method of working out people’s needs and a good way of delivering care. The OCCG was looking forward to working with the public on the development of pilot services, which could lead to full consultation on any service change.

Questions from members of the Committee were as follows:

Louise Patten was asked whether capacity would make it necessary to run the consultation at one locality at a time, or concurrently. If it was the former, she was asked if it might prove to be 'an eternity of engagement'? She responded that she did not know at this stage but to conduct it properly would take a lot of time. Dr Collison also spoke of a wish to set up a framework which would be applicable to anywhere in the county which would begin with what was needed, and then looking at what could be done at local level on a smaller scale and then what would be required at a county level.

Cllr Monica Lovatt, the Vale of White Horse District Council representative on the Committee, expressed her pleasure at the plan to engage locally with the people of Wantage and asked what was going to happen and how long it would take. She also commented that she was aware of the OCCG's engagement on planning matters. She asked if they would consider starting with Wantage as it was a very rural area and was growing fast. Louise Patten responded that the OCCG had tried to set out a timescale for the Wantage gateway. She added that all of this process was not new, it was how Health planned, but it would be a much more integrated approach with other services and communities. A lot of data was already being gathered in local plans. By December, the OCCG would try to identify gaps in services in this area and if some services could be provided locally in Wantage. She added that by March the OCCG would be looking at service solutions and there would be clarity on the needs of the locality, the dialogue with the planners having been completed. She added that there were two aspects to the work, one of which was those services which could be looked at as a focused piece of work, not necessarily linked to overnight beds. The decision had been taken with Thame Community Hospital not to go to overnight community beds and to look at the different services being provided in the hospital. She gave the example of the rehabilitation services being provided at Townlands Hospital, Henley, where patients did not stay overnight and transport was available. She reiterated that service gaps did not mean overnight stays. Cllr Lovatt responded that the residents of Wantage and its surrounds were looking for modern, up to date facilities and quality care.

Louise Patten was asked if the consultation would begin by February or March 2019, as, by then the OCCG would be clearer on the design of services. She reported that the OCCG would first decide on services and buildings and it was envisaged that consultation could be more fluid. If, however, there was a significant service change, such as a reduction in service, then consultation would be more formal. A member asked if consultation had already taken place in relation to some services and whether engagement would be putting more water between the original reductions in service and the revised models; adding that it was important that this was clarified for meaningful public scrutiny purposes. Otherwise it would make it increasingly difficult for the Committee to scrutinise. She added that a significant engagement exercise would be required and, in her view, it needed to be looked at as a whole. Louise Patten responded that it would be undertaken locality by locality, so enriching an understanding of what people wanted for their area. However, many services would require a look at all localities together before deciding the best way forward. This would be linked to usage of services. Wantage Hospital, for example, would require a formal consultation process because it would have to be wider than the needs of

Wantage itself, as the beds were part of a larger network. She gave the example of Townlands Hospital in Henley as an example of an area where hospital based services were looked at together with local services and then tuned with those facilities which were loved by the public.

Louise Patten was asked when the point of full consultation would take place, to which she responded April/May 2019, as there was a need to look at the wider localities across Oxfordshire to do so. It would be linked to a sustainable future, but not linked to beds.

With regard to Wantage Hospital, members asked how long would it be before formal consultation, as a significant time had gone by since its closure. Louise Patten responded that all services were linked to community hospitals. If sufficient local engagement was not to take place then a legal process would ensue and all would be back at the beginning. She assured the Committee that the OCCG could develop a vibrant future for the buildings which could help to cement this local asset into the community. On the future of Wantage Community Hospital, the conversation had not yet taken place about what could be provided in Wantage.

Members joined in expressing concern for the residents of Wantage at the lengthy term of temporary closure of the Hospital beds. At the time the temporary closure had been predicated on formal consultation within 6 months. The Committee now understood that funds to treat the legionella had been set asiide. Pete McGrane reported that the money had been set aside based on the assumption that there was a need for long term planning for the site. He added that it would also give an opportunity to look at services for a much broader spectrum of the population, such as services for mental health, diabetes, respiratory diseases etc.

Following further discussion, it was AGREED (unanimously) to:

(a) thank all for their attendance and inform the OCCG that this Committee had taken on board the comments made about the outline framework of planning for the future population needs of the county and generally recognised the good work that was in progress, together with the need for wider consultation on some services;

(b) urge Oxford Health to release and spend the capital sums invested in relation to Wantage Hospital in this financial year, in order to make good the fabric of the building where necessary; and

(c) RECOMMEND the OCCG to accelerate this action so that by the next meeting of this Committee on 29 November 2018, it would be in a position to move forward with concrete proposals for Wantage Hospital which would include either the resumption of some services or a public consultation on the future of the Hospital.

48/18 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 10)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO), reported the views gathered from members of the public and the latest activities of HWO (JHO10.)

She reported that she was pleased to see Health and Social Care working together in a closer way and its impact on DTOC statistics.

Cllr Lovatt reported that the Committee's Task & Finish Group had met the previous week and had valued the information received from Healthwatch Oxfordshire on the patient experience of the Healthshare and MSK service. The Group would be publishing its recommendations in due course. Cllr Pressel made reference to the evaluation of the survey on breastfeeding support, to which she had had an involvement, together with the literature for the public to be found in GP and dentists surgeries. This had revealed that NHS England would be looking to produce information sharing leaflets.

When asked about the outcomes of the workshop on dentistry, Rosalind Pearce reported that NHS England had not been able to send anybody to the meeting; and there had also been limited availability of other NHS representatives who had been scheduled to attend. The meeting had focused mostly on carers and dental services in care homes. She added that HWO had worked with the local dental network on how recent toolkits could be re-designed. It was hoped that, in six months' time, there would be a beneficial outcome for patients.

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

49/18 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2017/18

(Agenda No. 11)

The Director of Public Health, Dr Jonathan McWilliam, presented his independent Annual Report for 2017/18 (JHO11). The Committee was asked to receive the report and to consider any key issues which it would like to see taken forward in the year ahead.

Dr McWilliam highlighted the following for 2017/18:

- There had been good signs of organisations such as health, housing and planning working together to highlight solutions to be worked for together. For example, the work undertaken with residents in Barton and Bicester;
- Many indicators had seen an improvement, such as those for smoking (though there was a need to maintain an oversight in particular on smoking amongst manual workers);
- Positive work was ongoing with mental wellbeing, for example, good work was taking place by school health nurses and work with the military and veterans;

- Infectious diseases were doing well, but there was a need to be on our guard for any new infections.

Cllr Pressel highlighted a number of issues and Dr McWilliam responded as follows:

- Healthy new towns – how are we spreading the learning? Dr McWilliam responded that Public Health was taking part in discussions in relation to this;
- The need to integrate health issues into local planning? – Dr McWilliam stated that organisations were doing much better in relation to this as compared to ten years ago, though this still needed to be monitored;
- The lack of support for breastfeeding mothers in the communities, some baby cafes were struggling – Dr McWilliam commented that the amount of support for this was unknown;
- Health inequalities needed to feature prominently in all strategies – how was it monitored? Dr McWilliam stated that more targets could always be produced, but all strategies had inequalities written into them and this was being worked on at the moment by the Health Inequalities Commission;
- How can this Committee lobby the Government for a minimum price for alcohol and a watershed in advertising fast food to be set at 9pm? Dr McWilliam stated that in his view 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;
- How to survey and target the pockets of areas in Oxfordshire where oral health was poor – does it go far enough? – Dr McWilliam agreed that the national survey of oral health in children did not reach wide enough;
- STI's, are very high in Oxford - how do the statistics compare with comparable cities? – Dr McWilliam responded that Oxford was comparable with similar cities and urban areas;
- Dementia statistics had risen over the last 10 years. It was understood the Oxford City figures were lower, are they increasing at a different rate? - Dr McWilliam responded that it was too complicated to draw conclusions as it involved different lifestyles;
- When would staff be recruited to the Healthy Living Team? – Dr McWilliam stated he was not aware of any problems;
- Tests for tongue-tie in breastfed babies? – Dr McWilliam responded that this would be included on the list for exploration. He undertook to circulated information on this issue; and
- The need for the take-up of health checks to be improved? – Dr McWilliam stated that Oxfordshire did well comparatively. There was, however, no facility to send reminders. Public Health worked with various groups to advocate take up.

Dr Clarke asked how were the MRSA figures arrived at. Dr McWilliams responded that they were reported nationally from hospitals. Any record on community acquired strains was far more pathogenic. He agreed to circulate a more detailed response to this.

Dr Cohen suggested the inclusion of a further group in relation to cardio-diabetes, and also stated his view that much could be improved if inequalities were targeted in a much more targeted way.

Dr Ruddle expressed his appreciation that mental health issues had been included in light of the large rise in teenager mental health problems. He asked how this was taken forward in terms of priority judgements in Oxfordshire? Dr McWilliam responded that it was the 'cinderella' of services and had been included in his report for the past 4/5 years. It had also been well raised by councillors and the public and this had helped enormously. He added that there was good clarity in the communities and good advocacy groups.

At the end of the discussion it was **AGREED** that the following recommendations go forward for Cabinet: to

(a) ask Cabinet to consider lobbying the Government for a minimum price on alcohol and a watershed of 9pm for the advertising of fast food on TV; and
(b) **RECOMMEND** Cabinet to ensure that there is an evaluation of the Healthy Towns project when it comes to an end and also to ensure decisions are made on how to spread the learning arising from the project.

The Committee thanked Dr McWilliam for all his good work over the years as Director of Public Health for Oxfordshire and in his role as adviser to the Committee and wished him well in his retirement.

50/18 OHFT STROKE REHABILITATION SERVICES PILOT REPORT

(Agenda No. 12)

The Committee welcomed Dominic Hardisty, Oxford Health, and Sara Bolton, OUH to the meeting.

Dominic Hardisty gave a summary of the report JHO12 stating that:

- All the evidence had been very positive and looking at patient flow outcomes had been found to be the correct way forward;
- There were problems with staffing, particularly with nurses. OH were trying to resolve this, using agency nurses for the present; and
- It was their view that this change of service constituted a substantive change.

Dominic Hardisty was asked how many patients there were from outside the southern part of the county. He responded that he did not have this data to hand but would circulate this. He added that what was required was the best possible care and if this required travel for some patients for approximately 20-25 days then it had been found that they willingly undertook this.

He was also asked how it fitted in with the wider locality plan for West Oxfordshire and were the general purpose beds open at the same time? He responded that the

Stroke pathway did not stray into premises of local services and it was a countywide provision.

The Committee AGREED (unanimously):

(a) to thank Dominic Hardisty and Sara Bolton for the report and for their attendance; and
(b) that the indications from the pilot had been good and that this service be accepted as a substantive change and it should continue in its present form.

51/18 CHAIRMAN'S REPORT

(Agenda No. 13)

The Committee had before them the Chairman's report (JHO13).

Cllr Monica Lovatt gave a report on the MSK Task & Finish Group which had now met three times. The first meeting was to hear the views of patients, GPs, HWO and the Local Medical Council. The second to hear clinician's views and the third to hear the view of the previous provider.

Attendees were asked to share their views of the new service, how they had experienced any differences from the former service, what worked well and was there any room for improvement. She added that the Group now needed to digest what they had heard and to draw together the evidence. It would then be publicised as part of the Chairman's report to the February meeting. She thanked her colleagues on the Task & Finish Group and Sam Shepherd, Policy Officer, stating her view that the Group had set the framework and guidelines for future Task & Finish Groups.

The Chairman thanked Cllr Lovatt for the report agreeing that this was a very good and encouraging example for future Groups to follow.

The Committee AGREED to receive the Chairman's report.

..... in the Chair

Date of signing .....