OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 7 July 2011 commencing at 10.00 am and finishing at 12.55 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Susanna Pressel Councillor Don Seale Councillor C.H. Shouler Councillor Keith Strangwood Councillor Lawrie Stratford Councillor Val Smith Councillor Hilary Hibbert-Biles District Councillor Dr Christopher Hood District Councillor Rose Stratford Dr Harry Dickinson Ann Tomline Mrs A. Wilkinson Oxford City Councillor Susanna Pressel
Co-opted Members:	Dr Harry Dickinson Mrs Ann Tomline Mrs Anne Wilkinson
Other Members in Attendance:	
By Invitation:	
Officers:	
Whole of meeting	Roger Edwards; Dr Jonathan McWilliam; Dr Shakiba Habibula
Part of meeting	
Agenda Item	As listed on the agenda

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.

36/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

An apology was received from Councillor Jane Hanna (Vale of White Horse)

Councillor Zoé Patrick attended for Councillor Jenny Hannaby.
Councillor Val Smith replaced Councillor John Sanders.

37/11 ELECTION OF DEPUTY CHAIRMAN

(Agenda No. 2)

Councillor Dr Christopher Hood (South Oxfordshire District Council) was elected as Deputy Chairman for the 2011/12 Council year.

38/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 3)

Councillor Rose Stratford declared an interest with regard to item 8 as Chairman of the Bicester Hospital League of Friends.

Councillor Lawrie Stratford also declared an interest with regard to item 8 as a member of the Bicester Hospital League of Friends.

39/11 MINUTES

(Agenda No. 4)

The Minutes of the meeting held on 19 May 2011 were approved and signed.

A number of matters for information arose from those minutes:

1. **Family Intervention Service** – Jonathan McWilliam agreed to ensure that information on this service was sent to Councillor Pressel.
2. **Early Intervention hubs** – members requested a report to come to the January 2012 meeting on the health aspects of the hubs.
3. **Chipping Norton Hospital** – Councillor BIles requested that the matter of the employment of nurses at Chipping Norton Community Hospital should be referred formally to the Secretary of State and that he be requested to ask the Independent Reconfiguration Panel (IRP) to review the situation.

   The context to this was that the South Central Strategic Health Authority had expressed support for the PCT decision that any nurses employed in future at the hospital should automatically be employees of the Orders of St John (OSJ). Because of their position the SHA would be unable to mediate as requested following the HOSC's decision in March to ask them to do so. Furthermore the Secretary of State had written to David Cameron repeating the SHA's position and stating that he did not feel it was appropriate for him to get involved in what he saw as a local matter.

   A discussion took place during which some members expressed a number of views a flavour of which is given below:

   - The action of the PCT was a unilateral breach of an agreement and therefore how could they be trusted in future?

- If nurses were to be employees of the OSJ the hospital could become just part of the care home.
- The HOSC was extremely disappointed at the action of the PCT in going against an agreement.
- There was no evidence that the health of patients would suffer and the PCT and SHA both say that the contract specification would ensure that would not happen. Would it not therefore be appropriate to wait and gather evidence before referring to the SoS?
- There is no evidence of substantial service change.
- The concerns of local people had to be considered.
- There was no intention to cast any reflection on the reputation of the OSJ.

Following the discussion a vote took place on a proposition that there should be a formal referral to the Secretary of State. The proposition was **lost** with 2 members in favour and 7 against.

A second proposition was then considered that there should be an informal referral to the SoS and that he be asked to invite the IRP to act as an honest broker, consider the issues and principles involved and try to come to some sort of judgement on the best way forward. A vote took place and the proposition was **agreed** by 7 votes to 2.

4. **Work Programme** – it was agreed that this should be an item on the agenda for the September meeting together with outline scoping documents.

   It was suggested that the South Central Ambulance Service be invited to the September meeting to talk about how they have achieved their improved performance and specifically their performance in Oxfordshire. The latter to include full data on response times broken down by District. Councillor Biles agreed to provide the Committee with some appropriate areas for questioning.
5. **Link Report on Care Homes** – a question was asked about the outcome of the discussion of this topic that had taken place at the Adult Services Scrutiny Committee. The member asking the question was directed to the minutes of the Adult Services Scrutiny Committee.
6. **Demography and Ageing Successfully** – concern was expressed that this item would not again be addressed until the November meeting. It was explained that the delay was caused by a change in the officers responsible for the project and the need for the strategy to be rewritten. It was agreed that, if there would be room on the agenda, officers should be requested to come to the September meeting.

40/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 5)

There were no requests to speak to the Committee or to present petitions.

41/11 PUBLIC HEALTH

(Agenda No. 6)

Dr McWilliam reported first on the national picture with regard to the restructuring of the NHS. The Government's "listening exercise" has been completed and a number of amendments will be made to the NHS Bill.

Proposals for Public Health are largely unchanged. PH in Oxfordshire (and elsewhere) will continue to be a single county organisation; i.e. not clustered. Public Health England will provide the national view. It is still planned that Public Health would transfer from the PCT to the local authority for April 2012 but Public Health England will not come on line until April 2013. However the Public Health White Paper is yet to be published and until then there will be uncertainty about the precise roles of the national and local bodies.

Health and Wellbeing Boards (HWB) will have a strong role in driving collaborative commissioning and could be the lead commissioner for some services. Clinical Commissioning Groups (CCG) would be able to delegate to LAs the power to develop integrated services. The Joint Strategic Needs Assessment (JSNA) and joint strategies will be very important in this context. It will be important to involve the public and others in decision-making whilst at the same time ensuring that the HWB is able to be a flexible and strategic body.

Immunisation was the next topic covered. Dr McWilliam reported that Oxfordshire is the top PCT in the South Central area for the proportion of the relevant population being immunised and is continuing to improve. One of the keys to success has been the employment of a nurse to monitor progress in the immunisation of individual children and enquire about any that have not been done.

On the subject of exercise, figures indicate that Oxfordshire is "the sportiest and most active county in the country". The County Council, the NHS and District Councils have all worked together to contribute to this success.

Dr Habibula then introduced members to the Oxfordshire Health Profile for 2011. The information presented uses 32 indicators to show how the health of people in Oxfordshire compares with the rest of England. Oxfordshire was shown to be not significantly different from the average for England in 6 of the indicators, significantly better in 23 and significantly worse for 3.

Dr Habibula provided some clarification to the latter group as follows:

i. Physically active children; related to in-school activity only and so did not take account of the other activities that children undertook. This was borne out by the significantly better than average figures for obese children.
ii. Incidence of malignant melanoma; Oxfordshire has a much better rate of detection of malignant melanoma than other places.
iii. Road injuries and deaths; this is very close to the national average and, because numbers are very small, they can be distorted very easily by one or two large accidents.

A number of questions followed.

Q The figures on immunisation are very good. What is level of "herd immunity"? (Herd immunity means that the greater the proportion of individuals who are

immunised and therefore resistant to a contagious disease, the smaller the probability that a susceptible individual will come into contact with an infectious individual and so it provides a measure of protection for individuals who have not developed immunity).

A Not sure about the level of herd immunity but, as rates are so good for immunisation, it is likely to be high.

Q Are service people more affected by malignant melanoma than other members of the population?

A There is no detailed information on service people but the high incidence is more likely to be related to prosperity and holidays in the sun.

Q Could more information be provided on self harm and high risk drinking?

A Yes, information will be provided.

A number of questions were asked on the subjects of breast feeding and diabetes. It was agreed that more detail would be brought to the next meeting.

Members requested that the Oxfordshire health summary information should be provided by District and it was agreed to provide this to the next HOSC meeting in September.

42/11 RESTRUCTURING THE NHS - UPDATE FOLLOWING THE END OF THE LISTENING EXERCISE

(Agenda No. 7)

Ronan O'Connor, Director of Communications and Patient Information for the Oxfordshire/Buckinghamshire PCT cluster updated the Committee on the latest position with regard to NHS restructuring. The 152 PCTs in England have been grouped into 50 clusters. Each cluster has a single executive team drawn from the constituent PCTs.

Clusters have three principal functions:

- Delivery of the PCTs Operational Plans and driving clinical service change for 2011 to 2013 and ensuring financial stability for the handover to Clinical Commissioning Groups (GP commissioners) in 2013.
- Ensuring and supporting the development of Clinical Commissioning Groups (CCGs) and transferring other current cluster functions to the new organisations yet to be established i.e. the National Commissioning Board, Public Health England, Health Education England, Health and Wellbeing Boards, public health to Local Authorities.
- Creating the relevant commissioning support organisation for CCGs post PCT abolition.

The new executive team structure for the Cluster is as below:

Chief Executive: Sonia Mills (formerly Oxfordshire)
Finance Director: Matthew Tait (formerly Oxfordshire)
Medical Director: Dr Geoff Payne (formerly Buckinghamshire)

QIPP & Performance Director & Quality Assurance: Colin Thompson (formerly Buckinghamshire)
Communications & Patient Information Director: Ronan O'Connor (formerly Oxfordshire)
Reform/Governance & People Management Director: Jane Dudley (formerly Buckinghamshire)

It continues to be the plan that PCTs will be abolished in 2013 but clusters will continue after that. The NHS Commissioning Board will exist in shadow form from October 2011 and formally from October 2012 but with limited functions until April 2013. The 13 SHAs in England will be abolished in April 2013 rather than 2012 as planned originally but they are soon to be formed into four clusters which will continue after April 2013. HealthWatch organisations are to be in place by October 2012.

GP commissioning groups will now be called Clinical Commissioning Groups. There will be two lay members on each CCG one of whom must be chair or vice-chair. Each CCG must also contain a hospital doctor and a nurse from outside the local health economy. The timeline for authorisation of CCGs has been relaxed so that they are able to come into being as they develop the confidence to operate.

There will be a big drive on the "no decision about me without me" ethos.

A number of questions followed:

Q What does "Patient Information Explosion" mean?
A Better information available for patients with records on line etc
Q Under the "any qualified provider" regime, how would cherry picking be avoided?
A Clarity is still awaited from the new NHS Bill but HOSCs would be involved in some way.

43/11 BICESTER AND HENLEY COMMUNITY HOSPITALS

(Agenda No. 8)

Richard Darch, Project Director and Riana Relihan , Project Manager, attended to provide members with a progress report on the development of the planned new Bicester and Henley Community Hospitals. Mr Darch reported that there had been a number of delays caused by events outside the control of the development team. For example the NHS had changed the authorisation process for capital projects that now have to be at SHA rather than PCT level.

However the Cluster Board is committed to the projects and they will now go ahead rapidly. A paper was circulated that showed September 2012 as the planned date for signing contracts. Mr Darch then stated that he would anticipate a 12 month building period after that with the hospital being ready to open in September 2013 – a promise greeted with some scepticism by HOSC members.

A number of questions followed:

Q With regard to Bicester Hospital, what will the tenders actually ask for? Will the new hospital take account of increasing population growth? Who is likely to respond to the tender?

A The new hospital will comprise full replacement of existing ambulatory care services with 12 intermediate care beds. Bidders will be asked if they wish to build on the existing hospital site or locate elsewhere in Bicester. Co-location with other premises would also be considered.

The evaluation of the number of beds takes account of the planned growth of the town and the aim that fewer people should be treated in hospitals.

The Chairman then asked that the full needs assessment should be sent to Councillor Shouler and Ronan O'Connor undertook to do that. Further questions were then put:

Q Will all services and the beds be on one site?

A Yes.

Q What has gone wrong with communications; the most recent newsletter was published in September 2010 and there have no minutes of the Community Hospital Engagement Forum (CHEF) published since December 2010.

A Mr O'Connor undertook to look into the matter and ensure that the minutes are published.

Q Will Mental Health services be included on the site?

A Oxford Health (formerly the Oxford and Bucks Mental Health Trust now merged with Community Health Oxfordshire) will be the service provider. If bidders consider that other services could be provided on the site then that would be considered.

Q Does the timetable also apply to Henley?

A Yes

Q Who will own the sites once the PCT disappears?

A Whoever the successor statutory body will be. It is hoped that the amended NHS Bill will clarify the position.

Q Who will be accountable if there should be further delays and the PCT and SHA have gone?

A Hopefully there will be no further delays.

Q What is being done to ensure that there will be no hold ups due to planning problems?

A Planners are being spoken to now and their advice sought to prepare the way.

Q How can that happen if it is not yet certain where the hospitals will be built?

A In Henley it will definitely be on the Townlands site. In Bicester alternative sites would be considered if put forward by bidders and planning advice would be sought at that time.

The Chairman thanked all participants for coming to the meeting and expressed the hope that progress would continue to be made. While the HOSC would wish for an update at some time in the future, the Chairman hoped that it would be a routine report on progress and not one that has to be called to explain further delays.

44/11 THE SOUTH WEST OXFORDSHIRE WHOLE SYSTEMS PILOT (ABINGDON & VALE)

(Agenda No. 9)

Catherine Mountford, Deputy Director for Governance and reform in the PCT cluster, presented a report on the "whole systems pilot" being undertaken in Abingdon and the Vale. The purpose of the pilot being to provide increased local urgent health and social care for adults. This is to be achieved by providing access to services closer to the patient's home and closer working between the NHS and Social Services.

There has been a good reaction from patients and staff and some of their comments are included in the report attached to the agenda. There have also been a number of issues raised and actions designed to address these are also referred to in the report.

Following Ms Mountford's presentation members of the Committee asked questions and/or made comments as follows:

Q Why is there no mention of mental health services in the report and why is there nobody with a mental health background in the multi-disciplinary team? Mental health is always neglected. The committee should follow up on this omission.

A The gap in mental health provision has been noted and the aim is to address it in the future.

Q How is Hospital at Home being rolled out?

A For the purposes of hospital at home the County has been split into two; south/central and north. The service in the south/central area is being run by Oxford Health. It started in the Abingdon/Vale area and is now being rolled out to the City. The service is doing this by linking with GP Practices. The service for the North is currently being procured and is expected to be in place from the autumn.

Q When will the new single point of contact number 111 begin and how will it work?

A 111 is expected to "go live" in January 2012. It will not replace 999 but should complement it. The 111 service will be free to call and staffed by a team of fully trained call advisers who will be on hand to assess callers' needs and ensure they receive the right service as quickly as possible. Advisers will guide patients to a locally available service or provide appropriate advice and information. The service will operate 24 hours a day, every day. The number should be used when help is needed but the situation is not life threatening or when there is uncertainty over who to call. It should be particularly useful outside of GP surgery hours and for people who are away from home.

When someone calls 111, there will be an immediate assessment. If the advisers consider that it is an emergency, an ambulance will be despatched immediately without the need for any further assessment. For any other health problems, the advisers would be able to direct people to the service that should be most able to meet their individual needs. For minor illnesses and injuries, the 111 service would be able to provide immediate medical advice. This should be the subject of another report in the future.

Q The report indicates that, while there have been positive outcomes of the pilot, the objectives have been only partially met with a limited reduction in the number of acute admissions and the lengths of patient stays in hospital. What will happen if expectations continue to be disappointed?

A It is true to say that the service is costing more than is being saved by reduced acute hospital admissions and lengths of stay. However, it is still hoped that the system will be productive especially when Hospital at Home is up an running and so it will be given more time.

The Chairman thanked Catherine Mountford and asked for a further report to incorporate Hospital at Home and 111 at the appropriate time.

45/11 DENTAL HEALTH INEQUALITIES AMONGST CHILDREN

(Agenda No. 10)

Nicky Wadely, Deputy Head of Primary Care Contracted Services at the PCT tabled a report which is attached to these minutes. Ms Wadely pointed out that the oral health of children across the County is improving. However the improvement is greater in more affluent areas. She did not wish to add anything more to the report and so the Committee proceeded to make comments and ask questions.

Councillor Pressel stated that she found the information provided in the paper to be very disappointing. The statistics for Oxford City are not good and fifteen of the wards shown in Annexe 1 of the paper show very poor access. Access in several areas appears to be getting worse.

The numbers of children receiving fluoride varnish and the “Lucky the Lion” numbers are derisory when compared with the total number of children. What is being done to improve matters for the greater number of children? Could individual children be targeted in the same way as they are for immunisations?

Ms Wadely pointed out that a lot of work is being done that is not listed in her paper. In Oxford City there are 10 dentists that have space for more NHS patients. The PCT is continuing to work in areas of deprivation and the next survey should show greater improvement. That report could be presented to the Committee if members wished it.

Councillor Smith commented that the spread of NHS dentists in Oxford is good and that the use of Children’s Centres to push the message about oral hygiene will help. However a whole education process is needed as many parents who have neglected their own teeth in the past will continue to neglect their children’s teeth.

Councillor Lawrie Stratford asked whether there was any connection between dental problems and ethnicity. He also wondered whether toothpaste could be made more appealing to children.

Ms Wadely replied that she would investigate whether there is any correlation between ethnicity and poor teeth. She also pointed out that dental treatment for children is free.

A members asked what plans there were for evening surgeries to take place to make it easier for working parents to take their children to the dentist. This is a particular issue in rural areas.

Ms Wadely replied that contracts for dental services that are now being procured do in fact require evening openings as the PCT is looking to increase the number of surgeries opening in the evening.

The Chairman thanked Ms Wadely for attending and asked for a further report in twelve months time.

46/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 11)

The main topic related to the proposals in the NHS Bill to replace LINks by HealthWatch.

HealthWatch England will be a statutory, distinctive part of Care Quality Commission (CQC). Its aims will be to:

- provide leadership, advice and support to Local HealthWatch
- provide advice to the NHS Commissioning Board, Monitor and the Secretary of State
- have powers to propose a CQC investigation of poor services

Local HealthWatch is being created by developing the role of existing LINks.
It is intended that local HealthWatch will:

- ensure that the views and feedback from people who use health and social services, carers and members of the public are integral to local commissioning
- provide advocacy and support to people and help them to make choices about services
- provide intelligence for HealthWatch England about the quality of providers

Local HealthWatch organisations will be funded via local authorities and will be accountable to local authorities for operating effectively and providing value for money. Local authorities will have the responsibility for putting in place different arrangements if a local HealthWatch organisation is not operating effectively.

At least one representative of local HealthWatch will sit on the Health and Wellbeing Board helping to ensure that the consumer voice is integral to the wider, strategic decision-making process across local NHS services, adult social care and health improvement.

HealthWatch should give local communities a bigger say in how health and social care services are planned, commissioned, delivered and monitored to meet the health and wellbeing needs of local people and groups, and address health inequalities. It will strengthen the voice of local people and groups, helping them to challenge poor quality services.

HealthWatch will have an important role to play in supporting everyone in the community, but particularly those who are vulnerable or often unheard. Local HealthWatch will provide information about health and care services and about the choices people can make. From April 2013 it will provide support for people to complain about the quality of NHS services.

The Department of Health will make additional funding available to local authorities to support local HealthWatch.

From April 2013, local authorities will commission NHS complaints advocacy from any suitable provider and the service will be accessed through local HealthWatch. The LA will also have responsibility for funding the PCT Patient Advisory Liaison Service (PALS) which will be subsumed into local HealthWatch.

On the subject of the LINk work programme, it was reported that the LINk priorities group would meet soon to identify work priorities and these would be reported to the HOSC accordingly.

47/11 CHAIRMAN'S REPORT

(Agenda No. 12)

The Chairman reported on a meeting with the Chief Executive and other managers at Oxford Health.

48/11 CLOSE OF MEETING

(Agenda No. 13)

The meeting closed at 12.55 p.m.

..... in the Chair

Date of signing .....