Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 7 July 2011 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman -

Councillors:	Jenny Hannaby John Sanders	Don Seale C.H. Shouler	Keith Strangwood Lawrie Stratford
District Councillors:	Susanna Pressel Jane Hanna	Hilary Hibbert-Biles Christopher Hood	Rose Stratford
Co-optees:	Dr Harry Dickinson	Ann Tomline	Mrs A. Wilkinson

Notes: ***There will be a pre-meeting at 9.00 a.m. for members of the Committee only***
Date of next meeting: *15 September 2011*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk
Committee Officer - *Roger Edwards, Tel: (01865) 810824*
roger.edwards@oxfordshire.gov.uk

Peter G. Clark

Peter G. Clark
County Solicitor

June 2011

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Election of Deputy Chairman

3. Declarations of Interest - see guidance note on the back page

4. Minutes (Pages 1 - 12)

To approve the minutes (**JH04**) of the meeting held on 19 May 2011 and to note for information any matters arising from them.

5. Speaking to or Petitioning the Committee

6. Public Health

10.15

The regular report from the Director of Public Health on matters of relevance and interest.

7. Restructuring the NHS - update following the end of the listening exercise

10.35

The Government's "listening exercise" has finished and the report of the NHS Future Forum was published on June 13. Following this, the Prime Minister announced a number of changes to the NHS Bill. Among the main changes are:

- Scrapping the primary role of the regulator, Monitor, to promote competition - and focusing on improving patient choice instead
- Relaxing the 2013 deadline for new GP commissioning arrangements to be introduced - a National Commissioning Board, based in Leeds, will control budgets until GP groups are "able and willing" to take over
- Strengthening the power of Health and Well-being Boards to oversee commissioning and giving patients a greater role on them
- Retaining a lead role for GPs in decision-making, but boosting the role of other professionals such as hospital doctors and nurses alongside them

Ronan O'Connor, Director of Communications and Patient Information for the Oxfordshire/Buckinghamshire PCT cluster, will explain what effects the changes might have on the structure of the NHS in Oxfordshire.

8. Bicester and Henley Community Hospitals

11.15

Ronan O'Connor will provide an update on progress in developing the new community hospitals in Bicester and Henley.

9. The South West Oxfordshire Whole Systems Pilot (Abingdon & Vale) (Pages 13 - 20)

11.35

The "Whole System Pilot" is testing a new health and social care model of urgent care that aims to provide care closer to home for patients who might otherwise have gone to hospital. The pilot provides services for adults within the pilot area.

The aims of the pilot are to –

- improve co-ordination across health and social care services to provide high quality, responsive and timely access to urgent care services when needed – in and out of hours
- provide assessment, diagnosis and care in or very near to the patient's own home wherever clinically appropriate in order to reduce admission to acute hospital
- facilitate prompt supported discharge from acute hospital
- support patients in maintaining their independence and links with everyday activities and contacts with family, carers, friends etc.

The pilot began in the autumn of 2010 and Anne Brierley, Quality, Innovation, Productivity and Prevention (QIPP) & Transition Manager and Colin Thompson Director of QIPP & Performance for the Oxfordshire/Buckinghamshire PCT Cluster will present the attached report (**JHO9**) on progress to date and future steps.

10. Dental Health Inequalities Amongst Children

12.05

In his Annual Report for 2010, the Director of Public Health for Oxfordshire pointed out that the last national survey of 5 year olds (2007/2008) indicated that although Oxfordshire as a whole was better than the England average, children living in Oxford and Cherwell had higher than the National average levels of tooth decay. This compared unfavourably with children in other areas of the county and underlined the familiar pattern of inequality seen in Oxfordshire.

Nicky Wadely, Deputy Head of Primary Care Contracted Services at the PCT, will provide an update on dental services and dental health inequalities and describe what has been done in recent years to improve access to NHS dental services. A paper (**JHO10**) will follow.

11. Oxfordshire LINk Group – Information Share (Pages 21 - 22)

12.45

The regular update from the Oxfordshire LINk is attached (**JHO11**). Adrian Chant and Sue Butterworth from the LINk will be in attendance to answer any questions that

members may have.

12. Chairman's Report

13.00

13.15 Close of meeting

Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

The duty to declare …
You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

Whose interests are included …
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

When and what to declare …
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

Taking part if you have an interest …
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

"Prejudicial" interests …
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

What to do if your interest is prejudicial …
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

Exceptions …
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

Seeking Advice …
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 May 2011 commencing at 10.00 am and finishing at 2.15 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Susanna Pressel (Deputy Chairman) Councillor Jenny Hannaby Councillor John Sanders Councillor Don Seale Councillor Lawrie Stratford District Councillor Rose Stratford Ann Tomline Dr Harry Dickinson Mrs A. WilkinsonDistrict Councillor Elizabeth Gillespie
Co-opted Members:	Mrs Ann Tomline Dr Harry Dickinson 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	**Officer Attending** As listed on the agenda

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

22/11 ELECTION OF CHAIRMAN FOR THE 2011/12 COUNCIL YEAR

(Agenda No.)

RESOLVE – to elect Councillor Dr Peter Skolar as Chairman for the 2011/12 Council year.

23/11 ELECTION OF DEPUTY CHAIRMAN FOR THE 2011/12 COUNCIL YEAR

(Agenda No.)

This being a joint committee the Deputy Chairman is chosen from among the members from the District and City councils. Not all of those Councils had identified their representatives on the Committee at this time and therefore the election will be delayed until the next meeting.

24/11 CHANGES OF MEMBERSHIP
(Agenda No.)

It was reported that Councillors Shouler and Strangwood would replace Councillors Hallchurch and Owen on the Committee for 2011/12 and that Councillor Hilary Hibbert-Biles would replace Councillor Hilary Fenton as the District Council member from West Oxfordshire.

The new members were welcomed and the outgoing members were formally thanked for their contributions to the work of the Committee.

25/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

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

Councillor Elizabeth Gillespie attended for Councillor Christopher Hood as the representative from South Oxfordshire.

26/11 DECLARATIONS OF INTEREST - SEE THE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

27/11 MINUTES
(Agenda No. 3)

The minutes of the meeting held on 10 March 2011 were approved and signed.

With regard to minute 15/11 item 2 – Family Intervention Project, members asked for more detail of the project. The following applies:

The Family Intervention Project (FIP) was set up in 2009 to offer support to those families in Oxfordshire with very difficult social problems relating in particular to offending. It is a multi-agency programme involving County, District and City Councils, the police the PCT and colleges. It provides key workers and a programme to support families to make positive changes, through setting up a Family Intervention Programme, which is agreed with family members.

The type of support offered varies depending on what the family needs, but might include:

- Help to change patterns of offending or anti-social behaviour
- Help to address issues with drugs and alcohol
- Help with parenting and family relationships

With regard to Minute 16/11 – Chipping Norton Hospital Staff Employment Conditions: Councillor Biles reported that the new hospital had been formally opened by the Prime Minister.

Councillor Biles then asked whether a reply had yet been received from the Strategic Health Authority. Roger Edwards reported that there had been no reply and that, once received, any reply would be circulated to the Committee as soon as possible.

28/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

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

29/11 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health, Dr Jonathan McWilliam, reported on a number of items:

"NHS Architecture" – The PCT has been "clustered" with Buckinghamshire and Sonia Mills has been appointed as the cluster Chief Executive. Directors would be appointed later that week and the cluster would come into being formally on June 1st. The Director of Public Health for Oxfordshire would remain unchanged.

There would be a Cluster Board with powers delegated from the PCT Boards. The Cluster Board is expected to run until the end of 2013 although that could change following the Government's "listening exercise" over the NHS reforms.

Current PCT staff would move to either the Cluster; the GP Consortium or the County Council if in Public Health.

Clusters would be expected to set up commissioning support organisations to assist GP consortia to get up and running. The shape of these organisations would be expected to become more clear soon. Clusters would also be involved with the creation of the Health and Wellbeing Boards. Various options for the Boards are being considered during the pause in the progress of the NHS Bill. The Director of Public Health is taking soundings across Oxfordshire to ascertain the views of interested bodies

Older People and Carers – The annual PCT allocation for support for carers will increase from £250k to £750k. £480k of this will be allocated for carers breaks. The

rest will be used to help carers through the valued “Caring With Confidence” courses which are also provided to young carers.

Cancer care – The time to get results from cervical smear tests had been reduced from 4 to 6 weeks to 14 days.

Tooth cleaning – Children in disadvantaged areas have poorer dental health. The PCT has been working with the Co-operative Society to provide lessons in dental hygiene for children in schools in the disadvantaged areas.

TB – Oxfordshire has the lowest rates for TB in the Thames Valley area (9 in 100,000 of the population). The PCT has put more effort into detecting cases and is continuing to work in particular to deal with inconsistencies across the County.

The Director’s statement was followed by a question and answer session. The questions were answered by Dr McWilliam and his deputy, Dr Shakiba Habibula.

Q. What is the expected net loss of staff from the PCT due to the cost reduction exercise?
A. It is too early to say as the restructuring is still taking place.
Q. Could the HOSC be provided with regular updates on dental issues and NHS health checks?
A. Yes.
Q. Are children included in the figures for TB cases?
A. Yes
Q. How was the improvement brought about in the speed of providing results for cervical smear tests?
A. By working closely with the Thames Valley Primary Care Agency to bring about improvements in administrative processes.
Q. From what age are smear tests administered?
A. From the age of 25. That is the recommendation from a national body as there is no evidence that lowering the age limit would lead to greater success in detecting cases.
Q. Of the reported cases of TB how many were home originated and how many immigrants entered the country with TB infection?
A. Dr Habibula stated that she did not have the information to hand but would provide it in writing.
Q. How is the help for carers provided and does the PCT work with the County Council in providing help?
A. Yes, the PCT and the County Council work together in assessment and evaluation. GPs sign up to participate in the scheme with 77 (out of 83) practices across Oxfordshire taking part. GPs are given funding using a formula that takes account of the practice size and the composition of the local area. The service is based on the needs of the carer rather than the patient. Each carer would receive £750.

The Committee commended the work outlined in the report especially the improved carer funding.

30/11 CHILDREN'S CONGENITAL HEART SERVICES - CONSULTATION ON PROPOSALS FOR CHANGES TO SERVICE PROVISION IN ENGLAND
(Agenda No. 6)

The discussion was opened by Simon Jupp and Teresa Warre from the South Central Specialised Commissioning Group. Teresa Warre summarised the proposals in the Safe and Sustainable (S&S) consultation document. Simon Jupp went on to commend the work that has been done by the Oxford Radcliffe Hospitals NHS Trust (ORH) and the Southampton University Hospital NHS Trust (SUHT) in creating the South of England Congenital Heart Network. He also recognised the work done by parent groups in highlighting a number of concerns and questions left unanswered by the consultation document. He pointed out that some questions might only be able to be answered at the national level.

Professor Ted Baker then spoke on behalf of the ORH. He expressed concern that S&S had concentrated on congenital heart disease to the exclusion of those children who had other forms of heart problems. The ORH is worried that the wider picture is being forgotten and that the whole range of services provided in Oxford could be put at risk by the S&S proposals. For example, there is no reference to emergency access in the consultation document and that relates to many children who do not have congenital problems.

Professor Baker accepted that the ORH on its own does not have sufficient mass to provide a cardiac surgery service. By working with Southampton and the wider network however, sufficient mass has been developed. The network being developed provides not only the cardiac service but also the necessary support to maintain the other critical services in the children's hospital.

The S&S document refers to networks but does not develop the theme. Oxford and Southampton are building a wide network and are already attracting additional work.

Generally the consultation document leaves many unanswered questions and it is the view of Oxford clinicians that Option B, provided it includes the network and not Southampton on its own, is the only option in the consultation document that would serve the needs of patients in Oxfordshire and the surrounding area.

Dr Paul Roblin supported Professor Baker's comments. The consultation should, he stated, look at the overall service and not just at one specific aspect as this one does.

For Young Hearts Caroline Langridge stated that they considered the consultation to be flawed due to the exclusion of Oxford from the consultation and the lack of a question such as, "Do you agree to cardiac surgery in Oxford being closed own". By not asking the questions S&S appears to be creating a de facto acceptance of the situation.

Young Hearts considers that the assessment by Professor Kennedy of the JR is biased and the fact that the effects on other services is ignored calls into question the seriousness of the consultation.

Young Hearts accepts that Oxford would struggle to match the requirement for 400 cases a year. However the network would provide the required numbers, safeguard all other services at Oxford and lead to a better service overall.

Ms Langridge finished by stating that Young Hearts:

1) Objects to the closure of paediatric cardiac surgery at Oxford.
2) Objects to the decision to exclude Oxford from the consultation.
3) Supports the Southampton/Oxford network.

There then followed a number of statements by parents of children who had received care, and continued to need care, at the John Radcliffe. They made the following points:

The consultation meeting held at the Kassam Stadium was inadequate with many questions going unanswered.

Children with congenital heart problems usually continue to require treatment as an adult. The transition from children's services to those for adults is best managed on one site or between medical teams from the same hospital. Relationships between patients and clinicians can then be developed over time. The proposed reconfiguration risks jeopardising those relationships. Relationship building is particularly important for children with learning difficulties.

It is also very important for a mother whose baby is born with a heart problem to be able to stay with their baby. That would be made much more difficult by some of the configurations suggested in the consultation document.

Patient choice has been ignored and no consideration appears to have been given to the additional costs and difficulties that would be experienced by parents/carers if the Oxford set up were to close. Only parents who are on benefits would receive help with increased transport costs. The support of the family is vital to the young patients and parents, carers and other family members go back and forth to hospitals and some would need accommodation. In most cases no help would be provided towards the additional costs. This despite the fact that the estimated cost of the S&S proposals is £60m.

There are concerns that diminishing the service at Oxford would lead to doctors leaving and the effects that would have on the wider service.

Parents whose children have been treated by Oxford physicians working in Southampton have provided glowing reports on the way that the service works.

The consultation document provides no evidence to suggest that services would be better and that more lives would be saved. In fact it might be that the lives of children who require emergency care might be put at greater risk if the closure of cardiac surgery leads to the run down of other services.

Further questions, answers and comments to emerge from the discussion:

Q. What are the likely unintended consequences of cardiac surgery being removed entirely from the JR, i.e. option B not being chosen? Would there be a risk to training status and junior staff employment?
A. (from Professor Baker) S&S gives no indication of what a non-surgical set up might be but catheters cannot be fitted without surgeons and general anaesthetics could be lost with consequent knock-on to intensive care, general paediatric cardiac treatment and training.

Children's services cannot be run one at a time. A combination of Oxford and Southampton would ensure that expertise would be maintained.

Q. Is the reorganisation about improving a flawed service, saving money or for the sake of reorganisation?
A. (from Simon Jupp) It is not about cost cutting and it will in fact go ahead despite added costs. It is about quality, however it has to be accepted that no evidence has been produced on how making the proposed changes would improve quality. 400 cases is deemed to be the minimum number per year but there is no evidence where that figure came from. Having said that, critical mass is important and there should be enough surgeons to run a sustainable service 24/7, i.e. 4 surgeons as a minimum.

According to S&S none of the 11 centres, including Oxford, is unsafe. None of the deaths at Oxford were due to poor clinical performance.

Q. What guarantees could be given in terms of clinical safety if (i) surgery remained at Oxford; (ii) the network was to be maintained and developed.

A. (from Professor Baker) In the long-term, linking with another centre would always be the preferred clinical option as it would provide the necessary mass to ensure that surgeons maintained their skills and that training would be available for junior staff. Oxford would probably have gone down the network route without the impetus of closure. The network would provide the necessary resilience.

Q. How would the network work – would Southampton team come to Oxford?
A. (from Professor Baker) Details are still being worked through and individuals cases would be different and have to have individual responses. Some cases are very complicated and it may be that those would be dealt with at Southampton with more common cases dealt with at Oxford.

Mrs Anne Wlikinson then spoke about a visit she had made to Southampton to see the set-up there. She had found an excellent service with dedicated staff in a lovely environment. There were major concerns that if option B were not chosen then highly trained and experienced surgeons would leave the NHS.

In summing up the Chairman reminded the meeting of what the HOSC looks for in every change of service. That change should lead to: equity of access; equity of outcome and improvement of service. He suggested that the proposals would not lead to an improvement in any of those and in fact access would inevitably be worsened.

Everybody would like to see surgery retained at Oxford but clinical advice was clear that most sustainable way forward would be the network solution that Option B could provide.

The Committee agreed that an interim response should be sent to Safe and Sustainable pending further consultation on the outcome of this initial consultation. The response should comment on the lack of detail and information in the consultation and state a preference for Option B provided that it contained Oxford in the network configuration.

The Chairman then thanked everybody for their contributions to the discussion.

31/11 PROGRESS TOWARDS THE OXFORDSHIRE GP COMMISSIONING CONSORTIUM

(Agenda No. 7)

Dr Stephen Richards reiterated that Oxfordshire would have one GP commissioning consortium. He presented a map of Oxfordshire showing the locality groups of GPs that would go to make up the consortium and the number of sessions that senior GPs would spend working on consortium duties.

Members were informed that the big advantage of the single consortium was that management of very large contracts with major providers (e.g. with the Oxford Radcliffe Hospitals Trust for acute care and Oxford Health for mental Health and community care) would be much more efficient and effective than it would be with a number of consortia sharing the contracts between them.

The recent Government instituted pause or “listening exercise” in the restructuring of the NHS had led to some uncertainty. Issues around governance and accountability were not yet clear and it is hoped that one of the outcomes of the listening exercise would be more clarity in that aspect. The pause will finish at the end of May and a report will be sent to the Prime Minister and the Secretary of State by the Future Forum panel of health experts who have been leading the consultation.

The Oxfordshire Consortium has been holding a series of public meetings across the County to inform and listen to local people. Feedback from the meetings will help inform the composition of the consortium.

Officers assigned by the PCT will assist the consortium with its development and future planning. GPs believe that their strengthened position in the commissioning of services will put them in a position where they will be able to “shine a different light” on service provision and development.

Members of the Committee then made a number of points:

The Chairman stated that he would wish to see more accountability to the public. The Health and Wellbeing Board must provide clear co-operation between OCC and the NHS working in partnership.

Councillor Pressel also stressed the importance of accountability and transparency. Will meetings of the consortium board be held in public, she asked, and is there likely to be any change in the relationship between GPs and the public?

Dr Richards replied that the present NHS Bill did not put any obligation on boards to meet in public. However the consortium will be a sub-committee of the new Cluster Board which will meet in public. The main change that patients might see is more explanation of decisions and therefore a better understanding of why particular services have been commissioned or removed.

Alan Webb added that there would be appropriate governance structures around the use of commissioning funding.

Councillor Hannaby asked whether patients would see any change in their doctor's surgery and when/how would they be involved in influencing the future.

Dr Mary Keenan replied that the aim would be to link patient groups and views into future developments. Differences would be the provision of better comparative information to inform choice and a better understanding of just what is available and why.

Dr Harry Dickinson wondered whether leaders of the GP consortium would have enough time for training for their new roles, i.e. their commissioning duties and other new tasks alongside their ongoing roles as GPs. The suggested number of sessions away from their surgeries did not seem to be sufficient to do everything that would need to be done.

Dr Joe Santos replied that the locality leads would not be the only GPs involved in the consortium's work. A large number of GPs, probably around 20% of the more than 540 who work in Oxfordshire, have indicated a willingness to be involved in various projects and the number is growing. GPs would be expected to remain "rooted in their practices" and not become politicians.

Councillor Seale suggested that the listening exercise might lead to a speeding up in the process of change. Would Oxfordshire be able to cope with that?

Dr Richards replied that they would. At present they were aiming for a "measured pace" towards a shadow board by April 2012 with authorisation from the NHS as soon as possible after that and the formal board to be set up in 2013 along with the Health and Wellbeing Board. If they were required to move more quickly they could.

Mrs Ann Tomline wondered whether small rural practices might lose out to larger urban practices with more resources.

Dr Santos and Dr Richards considered that should not happen. They explained that there are already a number of services being developed in local hospitals and local practices and the referral process would not change. In fact the overall aim would be to localise more services rather than fewer.

Councillor Lawrie Stratford referred to the public perception that many GPs are against the proposed changes. He hoped that the changes would be seen to be for the better and referred to the importance of promoting the benefits of change.

Dr Richards agreed that a number of GPs do not support the changes but that number is reducing. He referred again to the growing number who wish to be involved actively and stressed the importance of all working together.

The Chairman thanked all participants in the discussion and asked for the Committee to be kept up to date on further developments.

32/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 8)

The Chair of the LINk Stewardship Group, Mr Dermot Roaf, reported that the Oxfordshire Rural Community Council (ORCC) has taken over as the host organisation for the Oxfordshire LINk from 1st May This followed a tendering process that took place during the early part of the year. The contract will run into 2012, subject to new 'HealthWatch' arrangements being introduced at that time (implementation of HealthWatch has been put back to July 2012). The LINk office base has moved to Jericho Farm, near Cassington.

Mrs Linda Watson, the Chief Executive of the ORCC commented that the LINk has made good progress following a difficult start and has been producing some good work. ORCC will aim to encourage wider public engagement. It should be noted that the LINk budget and support staff levels have been reduced.

Adrian Chant, the LINk Locality Manager, referred to this as a "transition year". He said that the LINk aimed to complete as much of the work programme as possible, undertake the planned Hear Say events and to produce an annual report.

The Patient Voice report on food etc in hospitals has been sent to the ORH and it is hoped that the report and comments would be presented to the HOSC meeting in July.

Councillor Pressel asked how links with councillors would work especially in urban areas. Mr Chant and Mrs Watson replied that there are many LINk members in the City and in market towns. The ORCC has worked in all of those areas and has very good established links with councillors.

There followed a presentation of a report on "Enter and View" visits to Care Homes. The LINk has carried out a series of visits to 36 Care Homes, the criteria being size, locality to evenly cover the County and a range of service providers. The first report will be presented to Adult Services Scrutiny Committee at their next meeting and a second series of visits is being planned.

Comments were made on evident deficiencies in medical care; for example misdiagnosis of Alzheimers Disease. Mrs Ann Tomline indicated that she would wish to attend the Adult Social Care Committee meeting to present her concerns.

33/11 FORWARD PLAN
(Agenda No. 9)

Members considered the projects proposed for the future work programme. Of those in the agenda they asked for more information on what would be entailed by a review of alcohol addiction services and Prisoner access to GPs at Bullingdon prison. The item on physical activity and obesity in young children is to be picked up by the Children's Services Scrutiny Committee. Members asked for an update on the demographic challenge and information on how Public Health works with the military.

34/11 CHAIRMAN'S REPORT
(Agenda No. 10)

The Chairman took the opportunity to thank Councillor Susanna Pressel for deputising so ably for him during his recent absence.

35/11 CLOSE OF MEETING
(Agenda No. 11)

The meeting closed at 14.15.

..... in the Chair

Date of signing .....

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NHS
Buckinghamshire and Oxfordshire Cluster

Whole System Pilot
South West Locality (Abingdon & Vale)

Update for Oxfordshire Joint Health Overview and Scrutiny Committee
Thursday 7 July 2011

1. Introduction

This report provides an update on the Whole Systems Pilot to provide increased local urgent health and social care for adults.

It sets out the implementation to date; impact of the pilot; patient and staff views; areas of work in progress; as well as future plans for the pilot, and its roll-out across Oxfordshire.

The Health and Overview Scrutiny Committee is asked to note the contents of this report.

2. Context

Whilst funding for the NHS will increase in the next three years, it will increase at a slower rate than previous years. The impact of this is that the NHS in Oxfordshire faces a financial challenge of finding efficiencies of £200m over the next 4 years if it is going to continue to meet the demand for its services within tightening budgets.

Society is changing so health and social care systems need to change to respond to rising demand from an increasing older population, patient expectations and advances in technology and medicines. The challenge is to maintain and improve the quality of care for all patients within the finite resources available. We are doing this in a number of ways:

- improving productivity within the NHS locally, so doing the same but more efficiently and using staff to maximum effect
- through system transformation - changing the way that healthcare is delivered, for example, providing more care in the community to stop hospital admissions and supporting people to look after themselves better
- reviewing clinical evidence and ensuring patients are offered the most clinically appropriate treatments and stopping the provision of ineffective treatments

All NHS organisations in the county along with the Local Authority are working together to address this.

3. The South West Oxfordshire Whole Systems Pilot (Abingdon & Vale)

Within this work a proposal for a 'Whole System Pilot' has been developed which is testing a new health and social care model of urgent care that aims to provide care closer to home for patients who might otherwise have gone to hospital. The pilot provides services for adults within the pilot area.

The aims of the pilot are to –

- improve co-ordination across health and social care services to provide high quality, responsive and timely access to urgent care services when needed – in and out of hours

- provide assessment, diagnosis and care to be provided in or very near to the patient's own home wherever clinically appropriate (to reduce admission to acute hospital, when clinically appropriate)

- facilitate prompt supported discharge from acute hospital (when an acute admission has been necessary)

- support patients in maintaining their independence and links with everyday activities and contacts with friends / family

The pilot is made up of a number of health and social urgent care services working together. Some of these – such as Hospital@Home, and the Emergency Multi-disciplinary Unit at Abingdon Community hospital – are new. Others, (such as ambulance services and social care & therapy support for people to help them live independently after an illness - Reablement), are existing services working differently within the pilot.

A key part of the pilot is improving the co-ordination of all services involved to improve services' response times, the patient's experience of urgent care, and thus enable more people to have urgent care treatment in, or very close to their home, when clinically appropriate.

A list of all the services currently involved in the Whole Systems Pilot can be found in Appendix One.

4. Impact

The development of the pilot has been incremental, with ongoing expansion to GP practices (and their population) included in the pilot, as well as the range and scope of care and treatment that can be provided within the pilot.

At the end of April 2011, there were 7 GP practices within the pilot (representing population of approximately 127,000).During the period 1st November 2010 – 31st March 2011, the pilot has treated 620 patients.

Although all adults in the pilot area are eligible for this increased local urgent care, the whole systems pilot has treated mostly people over the age of 65.

An independent evaluation indicated that the pilot has had some impact on acute hospital admission rates, as outlined below –

	Key Performance Indicators	**Pilot Area** *(compared to same period in 2009-10)*	**Rest of Oxfordshire** *(compared to same period in 2009-10)*
1	Number of admissions to acute hospitals	-6.33%	-0.34%
2	Number of excess bed days in acute settings	-34%	+0.3%
3	Cost of emergency hospital admissions	-8.1%	-3.9%

5. Patient and Staff Consultation on the Whole Systems Pilot

5.1 Initial Patient Engagement

As part of the development of the whole systems pilot, local engagement was undertaken to understand people's views and concerns about the piloted change to how services are delivered, and what it might mean for patients, and their families.

During the engagement process we undertook the following activities:

- A briefing was sent out to all the local stakeholders
- A press release was sent out locally
- An engagement questionnaire was launched
- Meetings were arranged with local groups
- In depth interviews were conducted with local people

Over 200 people were contacted about the consultation. The overall views expressed were-

- Strong preference for being able to access local urgent care services

- Respondents also told us they were happy for their information to be shared when necessary and that GP practices offering follow up care to patients with long term conditions was important to them.

Other issues raised included -

- Transport issues - bus routing but also parking and rush hour traffic were raised in terms of accessing assessment at Abingdon Community Hospital (rather than at the John Radcliffe)

- Joined up working, especially about the way social care would be part of the pilot

- The needs of people with long term conditions were also raised – both in terms of the care they receive in hospital and also in the context of how social care manages their long term need to make use of services

5.2 Patient and Carer Feedback; Experience of the Pilot

Patients and carers who have accessed the local urgent care provided within the whole systems pilot have given positive feedback on their experiences of care, as evidenced by the comments below –

"Thanks very much for seeing XXXX today. I know he's very impressed with your service (as are we!)"

"The Hospital@Home nurses who attended XXX grasped the situation straight away, and acted with great professionalism and sensitivity. Without your intervention we would have been alone and feeling hardly able to cope with the situation…We know the Hospital@Home is a new service and from our experience we know it works…"

5.3 Staff Engagement

To support the development of the pilot, a staff survey and in-depth interviews were undertaken in February 2011 to seek views of staff involved in delivering the pilot on their experiences; progress to date; issues to be addressed.

A total of 21 health and social care professionals responded (out of approximately 40 professionals actively involved in the delivery of the pilot). 61% of respondents felt the pilot was delivering its objectives, with a further 30% expressing the view that the pilot was partially delivering its objectives.

An example of the feedback is as below –

"The service has established good working relationships with local GPs. The provision of a same day comprehensive assessment for elderly patients has worked very well in preventing admissions to the acute medical take - there are clear examples of this almost every day. The presence of a dedicated social worker and therapy team who are able to provide immediate assessment and input has been the key to early discharges. In 5 years working both in primary and secondary care in Oxford, I have never come across a service that provided these things in such a timely manner."

However, staff also identified a number of areas for further development. These can be summarised as –

- Capacity in Hospital@Home and Reablement (social care and therapy intervention to support people back to independent living in their own homes)

- EMU operates Monday – Friday in "office hours" only (gap in co-ordination of community assessment / intervention during out of hours provision)

- Assessment & treatment information getting to the GP practice within 24 hours of discharge (initially within 72 hours of discharge, as per the national NHS requirement)

6. Work in progress

A number of actions have been successfully implemented to address issues raised by patients and staff. These include –

- Provision of dedicated patient transport vehicle to transport patients to and from the EMU (if necessary, and as clinically appropriate)
- A copy of the patient treatment plan is held by the patient, so can be accessed by all health and social care professionals involved in their care
- Expansion of the Hospital@Home service
- Alignment of the Hospital@Home service with the GP Out of Hours service to maximise impact during the evening and weekend period

A number of actions are currently in progress to address the issues identified by patients and staff. These include -

- County-wide actions to reduce patients waiting for long term social care – this will free up capacity in Reablement services, and thus enable more patients to be cared for quickly and locally
- Actions to better co-ordinate community health and social care assessment and intervention to help support patients in their own home during the overnight and weekend period (thus reducing the need for acute hospital admission where clinically appropriate)
- Improved and simplified referral into, and use of End of Life Care services
- Improved link from urgent care services to long term conditions management support, such as case management and self-care education
- Increased support to Care Homes to enable them to care for more patients who are unwell but do not need an admission to acute hospital

The pilot is also incrementally expanding its coverage of GP practices, with 4 additional practices now beginning to take part in the whole systems pilot.

A monthly joint review is held, where all clinical and social care leads review the effectiveness and impact of the pilot, and agree actions to improve any issues identified.

7. Interim conclusions

It would appear that this pilot is currently partially meeting its objectives, and this is translating into a limited reduction in the number of acute admissions, and patient length of stay in acute hospital for the pilot adult population.

However, there are a number of areas where service provision can be expanded, particularly

- during the out of hours period, and
- in ensuring that this locality urgent care pathway effectively and simply links up to proactive services to support patients with long term condition(s), and / or who are in the last year of life.

Professional and clinical leads of those services within the pilot are keen to further develop and refine the services delivered within the pilot, to maximise the number of people who can access urgent care in, or very near their home.

The pilot is planned to run for the duration of 2011/12, with a further formal evaluation towards the end of 2011 of the impact of the pilot.

8. Next Steps

There has been significant learning from the South West Oxfordshire Whole Systems Pilot in how to better co-ordinate urgent health and social care services to improve patient experience, provide local alternatives to acute admission (where clinically appropriate), and maximise effectiveness of all services. This learning is in the process of being applied across Oxfordshire. This includes –

- The development of existing urgent care services (in and out of hours, in both health and social care) to provide a locality integrated care pathway in the north of Oxfordshire (using the Horton District General Hospital for acute input). The aim is for this to be in place in the autumn of 2011

- The roll out of Hospital@Home across the county during 2011/12

- Incorporation of local urgent care pathways into the plans to implement the Single Point of Contact for Urgent Care (111 number) in line with Department of Health requirements

Appendix One: List of Services Currently Part of the South West Oxfordshire Whole Systems Pilot

Service Name	Service Function within Pilot
Abingdon & Vale GP practices	• Refer patients to the EMU, as clinically appropriate • Liaise with clinical teams providing local urgent care • Provide ongoing primary care to patient
Emergency Multi-disciplinary Unit (EMU)	• Multi-disciplinary team consisting of geratology consultants, GPs, nurses, therapists, social care professionals • Based at Abingdon Community Hospital • Provides holistic assessment of patients who are unwell, and may need hospital admission (within 4 hours of referral) • Co-ordinates and supports delivery of treatment (day case, short admission to Abingdon Community Hospital, or treatment at home from a combination of health and social care services, as clinically appropriate) • Supports prompt discharge from acute hospital admission, if this has been necessary
Hospital@Home	• Seven day a week service (within 4 hours of referral) • Provides urgent nursing care for people in their own home for people who are unwell
Out-patient Rehabilitation	• Provided at the Well-being Centre in Abingdon • Combination of therapy (physiotherapy, occupational therapy) to provide rehabilitation to people following admission to acute or local community hospitals
Reablement	• Provides support to people in their own home to regain their skills and confidence in the activities of daily living following acute or community hospital admission • Seven day a week service
Abingdon Community Hospital	• Provides short term in-patient admissions • Access to X-ray
Adult Social Care	• Provides assessment of social care needs for people referred to the EMU • Co-ordinates delivery of social care support to help people stay at home, or return home from hospital, following illness
Ambulance Services	• Ambulances will bring 999 patients to the EMU (rather than the John Radcliffe) if this is clinically appropriate
Patient Transport Service	• Dedicated patient transport vehicle to transport patients referred by their GP to and from EMU if necessary and clinically appropriate
GP Out of Hours Service	• Provides out of hours urgent primary care, including out of hours medical support to Hospital@Home

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Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting
Thursday 7 July 2011

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. Further Health and Social care issues will be prioritised during this year.
N.B. The following more concise update refers to LINk projects which have a Health remit only, unless there is crossover with Social Care services

LINk Host

Following the appointment of Oxfordshire Rural Community Council as Host for the LINk, a meeting with a representative cross-section of LINk participants, project group leads and former Stewardship group members has been held to form a new Core group for this transition year. This larger Core group will meet quarterly alongside more frequent sub-group meetings to agree work programme priorities and finance for LINk projects. The elected Chair of the Core Group is Sue Butterworth, with Anita Higham as Deputy Chair.

The LINk Annual Report for 2010-11 will be published by 30th June and circulated appropriately.

Ongoing Health projects and engagement:

Health Hearsay update from Nuffield Orthopaedic Centre.

Following the event for Outpatients held in November 2010, the first update from the NOC on what work has been carried out from the five priorities identified, is due this month. At the time of writing this had not yet been received. Copies of the update will be available at the meeting. The full report is available from the LINk office.

'Have a Say' Fund – Community Chest

Of the 11 grant funded projects, reports have now been received from: Patient Voice (survey of the quality and accessibility of hospital food); Crisis House (engagement with mental health service users and carers); Neurological Alliance (consultation event); Family Support Network (Older carers' support needs). Interim reports on progress have also been received from Community Glue (community lunches for mental health service users), Oxsu'n (representation of views to mental health service providers), Ryder Cheshire Volunteers (leisure and learning needs and identifying health needs for those

with physical disabilities). Reports will be available at the meeting and from the LINk office on request.

Podiatry
An information resource, comprising an attractively designed booklet, dynamically updated website pages, via social networking and other means of communicating information about Foot Care, is now available and is being widely circulated. The PCT, Age UK and local Podiatry & Chiropody practitioners have supported the project and LINk will be asking for feedback from the information supplied.

Community Mental Health Teams

This project, to find out more detail and information from service users, carers and the providers about the issues around long waiting times still being experienced for those waiting for CMHT appointments, CBT or other 'Talking Therapies', was put on hold at the start of the year due to the imminent redesign of this area of mental health provision. An interim report has been produced and the LINk will decide whether to continue this work after listening to views at the next Mental Health 'Sounding Board' meeting.

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Update 16/06/2011