OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 10 November 2011 commencing at 10.00 am and finishing at 1.25 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair Councillor Jenny Hannaby Councillor Don Seale Councillor C.H. Shouler Councillor Val Smith Councillor Keith Strangwood Councillor Lawrie Stratford Councillor Susanna Pressel District Councillor Rose Stratford District Councillor Martin Barrett District Councillor Elizabeth Gillespie
Co-opted Members:	Dr Harry Dickinson
Other Members in Attendance:	
By Invitation:	
Officers:	
Whole of meeting	Roger Edwards Jonathan McWilliam
Part of meeting	
Agenda Item	**Officer Attending** See agenda

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/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

62/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from District Councillors Christopher Hood and Hilary Hibbert-Biles and Mrs Ann Tomline and Anne WIlkinson.

Councillor Elizabeth Gillespie substituted for Councillor Hood and Councillor Martin Barrett substituted for Councillor Biles.

63/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillors Rose Stratford and Lawrie Stratford declared an interest as members of the Bicester Hospital League of Friends.
Councillor Dr Peter Skolar declared an interest as a member of the Townlands Hospital League of Friends.
Councillor Jenny Hannaby declared an interest as a member of the Wantage Hospital League of Friends.

64/11 MINUTES

(Agenda No. 3)

The minutes of the meeting held on September 15th 2011 were agreed and signed as a correct record of the meeting.

The following points were made:

Item 56/11 – Councillor Strangwood commented that nobody from the NHS had been present at the meeting and so it was not possible for HOSC members to ask questions about changes to the gynaecology service at the Horton General Hospital.

Councillor Hannaby asked when the proposed review of Alcohol services was likely to begin. The reply was, as soon as possible.

65/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There were no requests to speak or petitions to present.

66/11 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health for Oxfordshire presented his report on the development of the new Health and Wellbeing Board (H&WB). Dr McWilliam stressed that the Board would provide an excellent opportunity for providing joined up solutions to health and social care issues. The Board must not be allowed to become a talking shop but must deliver change and set and ensure the achievement of realistic and meaningful targets.

The HOSC would have a key role in scrutinising the work of the Board and ensuring that the focus on improving healthcare for the residents of Oxfordshire was maintained and that positive outcomes were achieved.

It is expected that the Board would have three main themes:

i. Prevention
ii. Breaking the cycle of deprivation
iii. Joining up finances

Of the four supporting Boards three; Children and Young People, Adult Health and Social Care and Health Improvement, would meet before March 2012 and clarify their membership, terms of reference and aims. The Public Involvement Board, to be chaired by the Chair of HealthWatch, would be developed over the next year. It would be important to take care to involve as wide a range of stakeholders as possible in the development of the Board.

Finally Dr McWilliam stated that the Boards would not be adding layers of bureaucracy but would use existing mechanisms wherever possible.

During the subsequent question and answer session the following points were made:

- Minutes of the H&WB and supporting boards should be made available to the appropriate scrutiny committees and H&WB minutes should be included with the HOSC agendas.
- Dr McWilliam would be invited to a future HOSC meeting to give a presentation on “prevention”.
- To ensure that the Board is effective it should be expected to produce a work programme containing “practical deliverables” with local targets that could actually make a difference. The programme should contain the names of accountable officers/members together with dates for achieving targets.
- The HOSC should examine the programme and monitor the achievement (or not) of the targets.
- Concern was expressed over whether or not the Board was fully representative of the whole County. It was explained that the membership of the Board had been decided by the County Leaders’ Group (the Leaders of the County, District and City Councils).
- Concern was also expressed that the new set up would lead to increased costs with more meetings and officer and member time and resources being used. It was pointed out that the level of bureaucracy should not be increased as the Children’s Trust and the Health and Wellbeing Partnership would be abolished and the Adult Health and Social Care Board would use existing management groups to undertake much of the work. Members remained sceptical.
- It was noted that the Leader of the County Council was to chair the H&WB. Members of the HOSC questioned whether this was appropriate in view of the level of work that would be entailed on top of the Leader’s already heavy workload. Would it not be more effective to have a Cabinet Member for Health?
  It was pointed out that the Cabinet Member for Adult Services was responsible for both social care and health issues. However it was questioned whether, bearing in mind the additional level of responsibility that the County Council would have in future for health issues, one person could successfully combine responsibility for both.

Following the discussion members **agreed**:

i. In view of the large workload involved, the HOSC would recommend that, at a future date, a new Cabinet post would be created of Cabinet Member for Health.
ii. The HOSC would wish to see a report in twelve months time that would indicate the level of resources being devoted to the bureaucracy then compared with now.

Dr McWilliam was thanked for his presentation and members wishes the new Board well.

67/11 APPROPRIATE CARE FOR EVERYONE (ACE) PROGRAMME

(Agenda No. 6)

Prior to the presentation of the report Councillor David Turner, member for the Chalgrove Division asked a question specifically related to Watlington Care Home. Cllr Turner wished to know when the proposals in the ACE report were likely to be developed such that it would be possible to identify specific implications for parts of the community, e.g. Watlington Care Home. He also asked whether the private sector should be represented on the Programme Board.

Mr Sinclair replied that there was no timetable set but that regular reports are being made to the Creating a Healthy Oxfordshire (CAHO) Board and that Councillors would be kept informed of progress.

With regard to the Board; the aim had been to have a small and effective group that included commissioners, providers and clinicians.

Mr Sinclair then presented his paper. He stressed that the aims of the ACE programme were for more people to be cared for at home with a consequent reduction in the number of beds in use in both acute and community settings.

Beds need to be used more effectively and there is a substantial piece of work being done to identify how this could happen. Work is also being done to identify ways in which people could be helped to maintain their independence, to improve the use of pooled budgets and to improve communications.

Delayed Transfers of Care (DTOC) has no single cause and the present situation of high numbers of blocked beds could get worse before it gets better. Extra investment is not yet delivering change and new services which are being developed have yet to show benefits. However, rather than just concentrating on getting numbers down, the ACE programme is aiming to deal with the fundamentals that cause the delays.

Partners are now working more closely together to achieve common standards and criteria that all can subscribe to. There is also a common aim to bring about a change to the present risk averse attitudes that prevail.

The system needs to be simplified and clarified so that the understanding of GPs and others working in the field can be improved.

The intention is to concentrate on people and the quality of service rather than just numbers. What services should be provided within the funding available and where those services should be to provide the most good are overriding criteria.

Following the presentation members asked a large number of questions. Mr Sinclair and Ms Trevillion undertook to produce a written summary of the questions and to provide answers to them. The answers have been provided and are shown below:

Councillor David Turner

1. **Bed based intermediate care (Watlington specifically). When will we and providers know (particularly the Watlington care home) what the intentions of the Council and the PCT are in relation to the intermediate care beds?**

   As part of the ACE programme we are reviewing the type, volume and position of community beds that will be required to support the population of Oxfordshire for the future. This will not be a quick job to do and we will let you know how and when this work will happen.

   We also know that we currently have not got good use of the existing community bed services and we are aiming to do a short piece of work to improve this and we will be expecting to talk to you and the providers involved very soon.

2. **Why are the care home sector not represented on the ACE Programme Board?**
   The ACE Board membership consists of senior managers from the four statutory organisations Oxfordshire County Council, Primary Care Trust/Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust, and Oxford University Hospital NHS Trust. These are the four organisations that have statutory responsibility for the delivery of services for older people. It is not the intention to extend the membership or this partnership to a range of other providers including the care home sector because the board consists only of statutory providers. If we included the care home sector we would need to include all the other health and social care sectors and the voluntary sector. It is the Boards intention that the range of health and social care providers alongside patients and the public and the voluntary sector will have the opportunity to be engaged and be involved in the work of the programme over the coming months and an engagement and communication plan is being developed.

Councillor Charles Shouler

3. **Definition of who goes into an Intermediate Care Bed?**

The majority of people who use an intermediate care bed are people who are being discharged from acute or community hospitals who will benefit from a period of support and rehabilitation before returning home (for the majority of people) or going into a care home.

They are also used to support people to avoid admission to acute hospital where people require additional support and rehabilitation to be more independent at home.

4. **On point 3 of the report what does 'adjusting present capacity levels in acute and post-acute care' mean?**

   As part of the review of the number of beds – acute (the JR and the Horton) and post-acute (community hospitals and intermediate care beds) we will be reviewing whether we have the right number in the right place delivering the right type of service for the older population of Oxfordshire. The general view at the moment is that we have more beds – both acute and community – than our comparator areas and their level of delays are not as high as Oxfordshire's.

Councillor Jenny Hannaby

5. **Why have these actions not happened before now?**
   Our view is that Delayed Transfer of Care (DTOC) is a symptom of system not working well and therefore we have changed the approach to addressing it as a whole system issue. In essence this means starting with how the patient/service user experiences services and making sure that the services in place enable that person to get back on his/her feet and return home as effectively as possible. This will require us to ensure the care pathways are appropriate, coherent, accessible and delivered to the right capacity for the population.

Councillor Rose Stratford

6. **What is hospital at home service?**

   Hospital at home provides a service that rapidly responds to patients who need extra support and care and they can be treated in their own home, rather than being admitted into a hospital. Patients who require extra care will be assessed in the community for example by a GP, or by a unit such as the Community based Emergency Medical Unit in Abingdon Community Hospital, and if appropriate they can then be referred to Hospital at Home.

   The Hospital at Home team will also support the early discharge of patients from hospital who require sub-acute care (more intensive care) in the home. This care is provided on an average for seven days, but can be up to fourteen. The service aims to support efforts to tackle DTOC by reducing not only the need for patients to be admitted into hospital but also supporting them to return to their homes. The Hospital at Home service is currently running across the whole County.

7. **What is the role of the end of life care matrons?**

Their role is to proactively identify people who may be within the last year of their life who have had three or more unplanned admissions to hospital and to work with people on crisis planning thus reducing disruptive emergency admissions. In addition, the matrons educate, inform and support primary care professionals about End of Life Care and act as champions for equitable access from areas of deprivation, minority ethnic communities and patients with non-malignant conditions who are at the end of their lives.

8. What do the community beds provide? Do they provide respite?

The Community beds currently provide:

- Community hospital services – a range of sub-acute medical support for people who no longer need acute hospital services but still require some medical support and support to improve independence before either going home (for the majority) or move onto a care home.
- Intermediate Care Services – in nursing homes with additional rehabilitation support for a period up to 6 weeks to support people to increase and improve their independence at home. This is mostly as people are discharged from hospital before going home but can be an admission from home.

They are not normally used for respite as there are other specific respite care services available.

Dr Harry Dickinson

9. What alternatives are there for housing for older people?

There are a range of alternative housing options that are being looked at for older people but the main area of development is Extra Care Housing (ECH) and the County Council is working with the district and city council to increase the number of extra care facilities that will support people who can no longer manage in their own home but who do not need to go into a care home.

Most of these are new build facilities where people have the option to buy or rent a single or double self-contained flat with communal areas, often with optional meal facility, on site minimal care support and the option of increasing this care support as people’s needs change.

There are 277 ECH flats currently in operation in Oxfordshire and this will rise to 407 by April next year. Eight further, new schemes have recently been awarded HCA (the Homes and Communities Agency, the national housing and regeneration agency for England) capital grant and we are confident this will increase ECH capacity to a total of 880 flats by 2015. In addition there are good prospects for further schemes which do not have HCA grant but can be supported by OCC grant which could add a further 275 units by 2015. This would give a grand total of over 1,000 ECH flats being developed between 2007 and 2015 although planning permissions, etc. still need agreement.

The provision of equipment and adaptations in peoples own homes is also critical here and both the PCT and the Council see this as a priority area of work and investment.

Cllr Keith Strangwood

10. What about the standard of and quality of care workers?

This is a critical area and as more people choose their own care workers via the use of a personal budget this becomes even more important. The ACE Board will be looking at this as part of its work and the new Joint Commissioning function in the County Council will be looking at this area as part of its new responsibilities.

There is some evidence that shows where people are able to choose or be supported to choose the people who come into their home to provide their care support that this is a more positive relationship for both the carer and the cared for.

Jonathan McWilliam

11. Would be good to have an analysis of why the DTOC figure is so high and has not been resolved yet? Why are there all these 29 services? What are we doing about long term solutions?

The way that the NHS has traditionally approached the 'hot spot' areas such as long waits for care, high emergency admission rates etc has been to bring in solutions to address those specific problems. Where problems have not been solved, other initiatives have been introduced sometimes not taking in to account the whole picture and creating a layered effect on service provision. This has resulted in a number of service overlaps which from the point of view of GPs and patients/service users seem confusing and not easy to access.

More often than not when planning care for people, because of the complex web of services available, it has led clinicians to default to the quickest and easiest solution, that is, to admit people in to hospital rather than find services to support them at home. Once those people have been treated in hospital the default option has been to discharge people to community hospitals. This has created a bottle neck of people who then become delayed in acute hospitals and then again in the community hospitals. From the community hospitals, people are all too easily admitted from there in to care homes.

The unintended outcome has been the provision of a bed based service with a number of delays at various points in the pathway leading to an aggregated high number of delays.

Councillor Susanna Pressel

12. Why could the DTOC figure get worse before they improve?

We are committed to making a sustainable change to a care pathway that provides the right care at the right place at the right time for people. This will take time as the care pathways need to be changed and delivered differently with the appropriate workforce. Sustainable well planned change takes time to implement. In the interim we expect the figures to get worse firstly due to 'winter pressures' and secondly with the transition to a much more integrated service, the numbers are unlikely to drop dramatically in the short

term. We are, however, of the view that the number of delays will reduce slowly, in a sustainable way.

13. Why is it taking so long to resolve this?

The three main providers of services Oxford University Hospitals Trust (OUH), Oxford Health NHS Foundation Trust (Oxford Health) and Social and Community Services (SCS) currently work together but not in an integrated way. These three providers of care have now given their commitment to a single approach to addressing the problem. They have submitted an 8 point plan which predominantly focuses on delivering the right services in the right place that are integrated at the point of delivery to the patient/service user. This will result in fewer people going in to hospital and when people are admitted there will be a reduced number of people delayed.

Councillor Lawrie Stratford

14. Need to make sure that accommodation is suitable for people?

Yes agreed and the new Joint Commissioning service in the Council will be aiming to prioritise accommodation and housing options for people with care needs within its work.

15. Who determines the number of community beds that are needed?

As part of the review of this area it will be the commissioners from the PCT and the Council who will be undertaking the work and making the recommendations for any changes to the relevant NHS and Council governance bodies. And depending on the scale of these changes will mean different governing bodies will need to be involved.

Councillor Val Smith

16. How can two people get very different support – one coming out of the JR and the other from the city community hospital?

We know this different level of support is happening far too often across the county. The ACE Programme is aiming to achieve a consistency of approach and ways of working across the county.

17. And why is that when people want to go home this does not happen?

For the majority of people supporting a move home from hospital is the main aim. For some people where the risk of moving home is too great then the professionals involved will work with a patient and their family to find a suitable alternative –either care home or extra care housing.

What we do know is that there are far too many people working in health and social care who are too risk averse about supporting people to go home and are waiting for everything to be perfect for a patient to return home – but what that means is that people are delayed and we all know that any period longer than necessary being in an acute hospital is not beneficial particularly for older people

and that getting people home to their home environment once the medical intervention is completed is the best thing for them.

Councillor Dr Peter Skoler

18. **Are we comparing like with like with the counting of DTOC between different areas? Are we all measuring the same thing?**
We have set plans in place to bench mark ourselves against Buckinghamshire services and establish whether or not we are counting delays in the same way. This will go some way in answering that question.

19. **Can you comment about the position of Continuing Health Care?**
This has been addressed in full at the Adult Services Scrutiny Panel on 6th December, 2011.

68/11 OXFORD UNIVERSITY HOSPITALS NHS TRUST - STRATEGY UPDATE
(Agenda No. 7)

At the start of the item the Chairman read out the following statement from Councillor Ann Bonner, member for Banbury Grimsbury & Castle;

"I have been asked by a number of my constituents to contact you to express concern about developments at the Horton General Hospital. In particular they are worried about the proposed changes to gynaecology services and the effect that they could have on single sex accommodation; bed closures and the possibility of the loss of training recognition.

People in Banbury believe that the conversion of G Ward to day cases and the consequent move of patients into E Ward could, as it would be a mixed sex ward, compromise women's privacy and dignity. Furthermore the closure of a number of beds might be seen to increase the threat of the withdrawal of training recognition. Furthermore the views of the staff on the ward are concerned about the whole idea of splitting up the service by locating the inpatient beds in a different area. Local people would like to receive a confirmation that the 6 beds concerned will be protected in that they cannot be used for other purposes without the consent of the Gynaecology Department.

In view of these concerns I would ask you to seek a public statement from the Chief Executive of the Hospital Trust that everything will be done to protect the privacy of women patients. Furthermore a statement should be made that changes to service configuration and bed closures will not lead to any reductions in services provided at the Horton and that they intend to fully honour the IRP requirement to do more to develop "clinically integrated practice" across the whole Trust."

Following this Councillor George Parish Chair of the "Keep the Horton General" group introduced a number of members of the group. Charlotte Bird, Vice-Chair of the group, then read out a statement and asked a number of questions. The statement and questions were as follows:

Statement for HOSC

Can I ask that any questions that are asked, and any answers given, are minuted please?

1. **Gynaecology.** Whilst we acknowledge that the enhanced range of day and outpatient procedures will be of benefit, we remain concerned about the effect of splitting up services by locating inpatient beds in a different area. This is based on the views of the staff on the ward (formally expressed in their published response) who are best placed to judge the practicalities of the safety or quality of the service.
   The Horton Obstetric Group on 19th October was informed that, contrary to previous statements, the 6 beds to be allocated to Gynaecology **will** be ring-fenced, i.e. cannot be used for other purposes without the consent of the Gynaecology department. **In view of earlier conflicting statements, this position needs to be confirmed.**
   We have raised the question of whether the changes would have any adverse effect on future recognition for training purposes – of vital importance in relation to the linked service of Obstetrics. Whilst the enhanced range of procedures is likely to be viewed positively, the lack of a dedicated ward for inpatients could have the opposite effect. We are aware that responsibility for such recognition is passing from Royal Colleges to Deaneries and is likely to change again in the future. **However, we would urge that before irrevocable changes are made an opinion on this matter be sought from whichever body is currently responsible.**

2. **Consultation.** Although at its last meeting HOSC did not feel that the Gynaecology changes required the full consultation process, the manner in which they have been introduced was criticised.
   This was debated at the CPN meeting on 27th September when an alternative was proposed and agreed. The essential features were that in future, if the ORH managers identified an area of actual or potential problem, they should seek opinions first from interested parties, the staff, general practitioners and public through structures which have been established, **before** producing a plan. **We would ask the assistance of HOSC in ensuring that this change of practice is maintained in the future as it would favour more cooperative working and help avoid negative reactions.**

3. **Cumulative changes.** We are concerned at the possibility of a series of measures, none of which is individually considered sufficient to trigger full consultation but which taken together represent a major change. We are now aware of major changes with orthopaedics. Cllr Keith Strangwood can enlarge upon this now or later during the course of the meeting. However it is an issue that we believe will require a full consultation.
   In addition to the Gynaecology changes mentioned earlier, we are aware of proposals to reduce radiology cover at weekends. Since we know that the number of births is increasing, the need for scans is also increasing – obviously!
   We wish to know how the HOSC plans to deal with such a situation of incremental change.

4. **Overall bed numbers at the Horton.** Reductions have already been made of 10 medical and 7 surgical beds. To this must be added the closure of the Gynaecology ward to inpatients and their relocation elsewhere which reduces the total available by a

further 12. We have been made aware of other changes which adversely affect the bed total.
The justification for this is usually that medical practice is changing so that less beds are required and more recently in the case of the Horton, that these beds to be closed represent those which are occupied by “delayed discharges” and that there are plans in hand to deal with the latter problem.
This ignores the lessons of history, that the problems of delayed discharges has been with us for decades and has defied many attempts at its solution. New attempts and new initiatives are to be welcomed but to expect them to produce rapid results is overoptimistic, particularly at a time when local authority spending on community support services is coming under severe pressure. Moreover the additional funds allocated to the PCT for this purpose are strictly time limited.
To make the reductions in advance of any evidence that the problem is lessening is to invite severe difficulties as we approach the Winter period. At our request, the OH has agreed to carry out regular monitoring and make reports on admissions which have to be refused. Patients who have to be diverted elsewhere, booked admissions cancelled etc.
Bed shortages could involve the Horton incurring penalties for breaching the target for time spent in A&E and this also needs to be taken into account and monitored regularly.
HOSC is requested to help ensure that such monitoring is carried out and the results made public.

These questions were followed by a further series of questions from Rob and Jenny Jones, members of the KTHG group, as follows:

- How many more beds are to be closed throughout the Horton General?
- Where is money being spent in OUHT and how will savings be made? I hope that we will be given relevant details of where money is actually being spent within OUHT and what and how savings are to be made at each site and in which areas, Social care, General Acute Care and Specialist Services.
- In the list of the Trust’s Strategic Objectives, the second objective is :-
  To provide high quality, specialist services to the population of Oxfordshire and beyond.
  The Trust’s first strategic objective is :-
  To provide high quality, general acute healthcare services to the population of Oxford.
  In view of this, does the Trust provide care to all of Oxfordshire or just Oxford?
- Residents in the south of the county also have hospitals on the county boundary at Swindon and Reading, in addition to Oxford, at which they can choose to receive treatment. So the services at the Horton are extremely important to provide choice for residents in the north of the county and beyond. Perhaps the residents in the north of the county are seen as a captive market and do not count. How are acute services for the residents in the north of the county to be provided and developed?
- The phrase *‘Reshape “local” services.’* used later on the page sounds ominous, particularly in light of the proposals of 2006. How will the idea of *‘seeking to maximise the use of the better accommodation across the Trust.’* affect the Horton and will it continue to provide “Patient choice” or is this an empty cliché?

- The [Trust's] strategy appears to be pulling in opposing directions. On one hand it talks of treatment closer to home while on the other of services being concentrated in fewer and fewer locations. Does this agree with the concept of Patients' Choice and when there is so little capacity system what choice does the person taking the last place have, and the one after that?
- Milton Keynes has its own acute hospital and presumably it also has its own strategy to deal with the any population growth. Why is it a factor in OUHT's strategy? Or is this the next target for take over and closure?
- The capacity of the Horton Gynaecology Day Case Unit will be around 3000 cases per year. What is the minimum capacity level at which the operation of the unit will be considered viable?
- What is the Plan B if this level is not reached?
- As we go into the winter months with increasing demand for emergency admissions we are told that beds are 'flexed' to address the problems. Is it not the case that no additional beds can be brought into play at the Horton, so 'flexing' just means cancelling elective procedures?
- In point 10 of the strategy the aim is to close beds once the issue of delayed transfers of care (DTOC)has been resolved. Beds have already been closed at the Horton on the expectation that DTOCs will be reduced. How many more are intended to go?
- In view of the mooted major changes in orthopaedics at the Horton, how do the finances work in currently loaning staff to the ISTC? Does it generate a healthy profit? What are the implications of the loss of this profit?

Following the statement and questions the Chairman made four points:

i. That the HOSC accepted in good faith that gynaecology services at the Horton would improve following implementation of the Trust's proposals and that more patients would be treated there. However the Trust would be held to account if these expectations were not to be realised.
ii. That the HOSC expected that consultation would improve through the development of a protocol between the Trust and the Community Partnership Network (CPN). It was expected that service changes would happen only once proper informal consultation had been undertaken with all interested and relevant parties.
iii. The role of the HOSC is to ensure that services are maintained and/or improved. It is not the role of the Committee to seek to protect bed numbers. The HOSC recognises that procedures and methods of treatment are changing with, for example, developments in keyhole surgery. That could well lead to reductions in bed numbers with fewer people having to stay in hospitals and the HOSC understands that.
iv. Management must be allowed to manage and it is not part of the HOSC's job to "micro-manage" the local NHS. However the Committee expects meaningful consultation to be undertaken by the Trust over proposed changes and for commissioners and providers to explain to the public why change takes place.

Sir Jonathan Michael then commented in response to Councillor Bonner's statement that the Trust is fully committed to protecting the privacy of all patients at all times. He also reiterated that the proposed changes to services at the Horton would not lead to

any reductions in services and that the Trust intends to honour the IRP requirement to do more to develop “clinically integrated practice” across the whole Trust.

Sir Jonathan also accepted the importance of developing good communications with people in and around Banbury and agreed to answer the questions raised by the Keep the Horton General group through the CPN.

Sir Jonathan then presented the paper on the Trust’s updated strategy. He explained that the main factors driving change are:

- Quality standards, e.g. single-sex accommodation, that must be met
- The financial position requires savings of 5-6% this year and in the future
- Public expectations and choice.
- Epidemiology and demography
- Commissioner strategies
- Workforce issues
- National and local service reconfiguration
- Any Qualified Provider (AQP) and a more competitive environment
- Shorter stays in hospital due to changes in procedures

He stated that the most useful question to ask is not how many beds are there but are services getting better.

Ian Davies, Chairman of the Community Partnership Network, then spoke to the Committee. Mr Davies explained that the role of the CPN is to look across the wider issues of health in Banbury and the surrounding area – not just the Horton. The CPN will act as the consultative body for changes in health services including those relating to the Horton. Change will be looked at in the broader context of health services in the north of the County. The CPN will monitor what happens at the Horton and will liaise with the HOSC as necessary.

The nature and timing of consultation must, Mr Davies said, be got right in the future. The CPN will wish to be closely involved in developing a consultation protocol and discussions are already going on with the Trust over the best way to do this.

Councillor Keith Strangwood then asked the following questions. He also asked that the questions and answers should be recorded in the minutes.

Q. Are bed numbers relevant to staff availability? A. Yes, insofar as staff numbers relate to the nature of the unit and the safe and proper care of patients. Staff numbers are monitored regularly.
Q. Does the flexi bed system work? A. Beds have to be used flexibly e.g. more would be used in the summer for elective procedures than in winter when they would be needed for e.g. flu.
Q. Are staff being reduced via retirement etc, i.e. natural wastage and not being replaced? A. It is inevitable that staff numbers have to be looked at in meeting financial targets. However the safety of patients is always paramount.
Q. I have recently received reports that there are in the pipeline changes at Banbury Horton re Pathology? Can you confirm or deny this? A. Changes are being

considered to provide some services more cheaply. However the service will be retained at the Horton.
Q. Can you confirm or deny that 2 weeks ago the ORH PCT awarded a contract to Ramsey Healthcare, to the disappointment of the Nuffield, who were unsuccessful in their bid? A. The commissioners decided to award the contract to Ramsey in preference to the OU Trust which now includes the NOC.
Q. Can you also confirm or deny that ORH chief executive and team, have now decided to terminate the secondment of all staff to the TC at Banbury Horton? A. Following the awarding of the contract to Ramsey Healthcare secondments have been terminated in order to strengthen service provision in Oxford.
Q. If this is so? Then has this not been a stand alone decision by ORH/OUH with no proper consultation? A. The orthopaedic service provided to patients will not be affected; it is a staffing issue and so there is no need for consultation.
Q. Can you also confirm or deny? The alleged withdraw of secondment will take place from Jan 1ST 2012? A. Yes
Q. If these alleged changes are planned? will any orthopaedics be carried out at Banbury Horton? A. There will be no change to the pattern or level of service.
Q. If this is true? It would not be possible to maintain Trauma without Orthopaedics, no Trauma means no full cover A and E? Hence, minor injuries unit only? A. See previous answer

There then followed a series of questions from members. In response to a question about mixed sex wards Sir Jonathan Michael stated that the Trust continues to work hard to eliminate mixed sex accommodation and is being successful in their aims.
A question was then asked about whether there were sufficient female obstetricians at the Horton General to be able to deal with the numbers of Muslim women giving birth there. Andrew Stevens replied that all women who wish to have a female doctor attend to them would be able to do so.
Sir Jonathan the responded to a question about nutrition and dignity of older patients by accepting that there had been some criticism in a recent CQC report on nutrition at the hospital. The CQC had found that the John Radcliffe Hospital was meeting the standard relating to treating people with respect but that some improvements were needed around the provision of food and drink. A strategy for improvement is now in place and a system of regular ward visits is occurring to ensure that patients are able to get access to their food and drink.
The following points were then made in response to a question about the reablement programme. Discussions are ongoing with Oxford Health and the Nuffield Orthopaedic Centre in order to develop further the reablement programme. The OUH Trust is also involved in the ACE programme and the trust will provide more support at home for patients as part of an enhanced discharge programme.
On the subject of the national consultation on paediatric cardiac surgery, Sir Jonathan expressed some disappointment that the result of the consultation has been delayed by the recent court decision in the case brought by the Royal Brompton Hospital. The link with Southampton is working well and they are now developing a joint paediatric neurosurgery service with the centre in Oxford.
A comment was then made welcoming the suggested enhanced monitoring role for the Community Partnership Network in the north of the County. It was hoped that this would lead to more light being thrown onto positive developments rather than concentrating on negative aspects. Sir Jonathan agreed with this and stated that the Trust is committed to open communications and transparency.

Two questions were asked about the possible outcome of the strategic review. One asked whether there would be any changes in the provision of drugs. Andrew Stevens sated that, while the Trust always looked for the most economical means of providing drugs such as by using generic rather than branded medicines, patients would always continue to receive the drugs that they needed.
The second questioner commented that they were fortunate to live in Oxfordshire with the high quality of care available and asked whether patients would notice any difference following the formation of the new trust. Sir Jonathan replied that the strategic review was looking at services not costs although they always had to consider carefully how money was being spent. Patients should notice no difference immediately but it was hoped that care should improve as a wider range of skills became available throughout the new trust. Furthermore, with more staff available, the out of hours care should improve.
Finally assurance was sought that there was sufficiently close working between the OUH and the mental health trust and that patients with physical symptoms and who are also mentally ill are having their multiple needs recognised and treated accordingly. Sir Jonathan stated that there is close co-operation and that a new appointment has been made within the University of a Professor of Psychological Care with a particular emphasis on engagement.

The item ended with the Chairman thanking everybody who had contributed to the discussions.

69/11 CHIPPING NORTON HOSPITAL STAFFING

(Agenda No. 8)

The Chairman reminded the Committee that the issue they were now dealing with related to whether or not a review of the service provided at the new Chipping Norton Hospital should take place two or three years after the opening of the hospital; i.e. in June 2013 or 2014. The original agreement had been that the review would be after three years and that any staff employed during that time would be given the option of being employed under NHS terms and conditions of service rather than those of the Orders of St John (OSJ) who manage the hospital. The PCT had sought to remove that condition altogether but, following objections from the HOSC, were now offering a review after two years with all new recruits, if they wished, being on NHS conditions during that period.

Alan Webb, representing the commissioners of the service, opened the discussion by stressing that the quality of care had to be the paramount consideration; that there was no intention to downgrade services at Chipping Norton and that managers from the OSJ were talking to local GPs about the type of service that they, the GPs, would wish to see provided. Since the hospital opened there had been no complaints recorded and a number of compliments.

The commissioners were committed to the review of care quality and the service specification. They would wish to work with HOSC members on the terms of reference and specification for the review. The review findings would be applied to all community hospitals in Oxfordshire.

Olga Senior, from NHS South of England (the clustered SHA), stated that they share the view of the PCT. They had undertaken their own survey since the hospital opened and had also found no complaints about the present service. They consider that the contract and specification that the OSJ was working to was “robust” and would help to ensure a high quality of service provision. It was clear that in future GPs, via the Oxfordshire Clinical Commissioning Group (OCCG), should have a pivotal role in deciding on what level of service should be commissioned. Quality must come first.

During the subsequent discussion the following points were made:

The commissioners would always ensure that staff at the hospital, regardless of who employs them, would be properly trained, qualified and supervised. There should be no difference between the safety and quality of the service provided at Chipping Norton than that provided in any other Oxfordshire hospital.
The service specification is part of the contract with OSJ and that enables the commissioner to have quite a measure of control.
Staff are managed by a clinical manager.

At the end of the discussion the Committee **AGREED** to the two year period for the review; i.e. the review would take place in June 2013. It was further **AGREED** that Councillors Hilary Hibbert-Biles and Lawrie Stratford should represent the HOSC in working with the commissioners on the review.

70/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 9)

The regular LINk report was presented by Adrian Chant. There were no questions.

Alison Partridge then updated the Committee on the latest position vis a vis HealthWatch. She explained that the County Council had a responsibility to establish HealthWatch by October 2012. It would have a wider remit than the LINk and the HealthWatch role would, by 2013, include advocacy and complaints. A widespread consultation process is going on to agree a commissioning model.

Ina answer to questions about the scrutiny and governance of HealthWatch Alison Partridge told the Committee that the contract would be with the County Council which would therefore monitor the quality of service and activities undertaken by Oxfordshire HealthWatch. HealthWatch England would also have some role but the finer points of the governance arrangements have yet to be worked out.

71/11 CHAIRMAN’S REPORT

(Agenda No. 10)

The Chairman reported on the following meetings in which he had taken part:

- Toolkit meeting on gynaecological services at the Horton General Hospital
- A meeting with the PCT to discuss the provision of a new Townlands Hospital in Henley

- Oxford Health – informal "catching up" meeting with the Chief Executive and others
- A meeting with Nicola Blackwood MP for Oxford West and Abingdon and Simon Burns MP Minister of State for Health Services to talk about health services in the area

72/11 CLOSE OF MEETING
(Agenda No. 11)

The meeting closed at 13.25.

.... in the Chair

Date of signing ....