OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 January 2010 commencing at 10.00 am and finishing at 12.40 pm

Present:

Voting Members: District Councillor Richard Langridge – in the Chair

Councillor Tim Hallchurch MBE
Councillor Jenny Hannaby
Councillor Ray Jelf
Councillor John Sanders
Councillor Don Seale
Councillor Lawrie Stratford
Councillor Susanna Pressel
District Councillor Dr Christopher Hood
District Councillor Jane Hanna
District Councillor Rose Stratford

Co-opted Members: Dr Harry Dickinson and Mrs Ann Tomline

Officers:

Whole of meeting Julie Dean and Roger Edwards (Corporate Core)

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

1/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Councillor Dr Peter Skolar and from Mrs Anne Wilkinson.

2/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

3/10 MINUTES
(Agenda No. 3)

The Minutes of the last meeting held on 19 November 2009 were approved and signed.

4/10 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

There were no speakers or petitioners.

5/10 OXFORDSHIRE LINK GROUP
(Agenda No. 5)

The Committee had before them a report (JHO5(a)) which had been prepared by a LINk Drug Recovery Project (DRP) group. Also before them was a written update on the LINKs latest activities (JHO5(b)). A member of the DRP project group, together with Adrian Chant, Locality Manager for the Oxfordshire LINk, were available to answer any questions from the Committee.

Members thanked Richard Lohman and Adrian Chant for attending the meeting.

The Committee **AGREED** to

(a) thank the LINk for the update on their activities and for their very detailed DRP report; and
(b) in view of concerns that there might be a major service change requiring full consultation, to defer full consideration of the report until the next meeting of this Committee on 11 March 2010; and to request the PCT and Jo Melling, Director of the Drug and Alcohol Action Team, to prepare a report on the changes made to the service.

6/10 PUBLIC HEALTH
(Agenda No. 6)

Dr McWilliam introduced his deputy, Dr Shakiba Habibula to the meeting. He reported three areas of interest which had arisen since his last report:

- The Demographic Challenge – Some good work had been done by the Health & Well Being Partnership. Moreover a multi agency, Healthy Ageing Strategy would be produced by March this year which would give some guidance on how to prevent a problem if it should arise;
- A new Bowel Screening Service was due to start the following week at the Horton General Hospital. Eventually the service would roll out to the whole of the county and would have positive outcomes; and
- A new community breast feeding service had been started which aimed at getting more children breast fed within the more deprived communities.

There were no new major areas of concern which had arisen since the last meeting. However, he did raise the following, together with a request for vigilance on the part of the Committee:

- Unease with regard to funding for Public Health, both within this county and nationally, as part of the aim to reduce overall NHS management budgets by 30%;

- The major opposition draft political manifesto on Health issues aimed to turn the Department of Health into a Department of Public Health nationally. While that would not be a problem, it would be important to ensure that prevention continued to be moved further up the agenda.

There followed a discussion on the above issues, together with a question and answer session with regard to the following:

- The proposal by Surrey PCT to no longer treat people with morbid obesity;
- Proposal by Government for free care for older people in the future, together with the possibility of free domiciliary care;
- The 'poor' accommodation and staffing quota given to breast feeding clinics by the ORH in the John Radcliffe Hospital;
- The policing of the use of antiseptic gel at the John Radcliffe Hospital, despite MRSA rates falling within the count; and

The Director and Deputy Director of Public Health were thanked for their valuable input to the meeting.

It was **AGREED** that Councillor Couchman be invited to the next meeting on 11 March 2010 to give an update on measures taken within Oxfordshire, post scrutiny review, to address the demographic challenge relating to older people.

7/10 PAEDIATRIC TRAINING ACCREDITATION AT THE HORTON GENERAL HOSPITAL

(Agenda No. 7)

At the November meeting, the Committee had agreed the following:

'The OJHOSC urges that discussions should continue with the Oxford Deanery aimed at achieving training accreditation for middle grade paediatric posts at the Horton General Hospital (HGH). He report from the Deanery visit to the HGH on 13 November should be made public as soon as possible'. This referred to the Deanery visit, led by Mr Tony Jefferis, Acting Postgraduate Dean, that evaluated the possibility of reinstating training accreditation for middle grade paediatricians.

The report had now been published and a copy was attached to the Agenda at JHO7. The outcome of the visit had been that, due to insufficient workload, accreditation could not be given for training middle grade paediatricians.

Mr Jefferis had been invited, and had agreed, to attend this meeting in order to explain the reasons for that decision.

Mr Jefferis was invited by the Chairman to give a brief presentation of his report. Julia Cartwright, Chair, Community Partnership Forum and Andrew Stevens, ORH, were also invited up to the table with a view to forming a Panel, together with Mr Jefferis, to respond to questions from the Committee.

Members asked a number of questions, a selection of which are included below:

Q How can the service be kept open?
R (Mr Jefferis) There needs to be a radical rethink in the way in which the service is delivered. The world has changed since the European Working Directive was introduced in August 2009. Nobody wants their children to have a lesser service but nationally we are having to adapt to a shrinking, not an expanding service. Training can be offered at the HGH during the working day but it is what is happening at night which is the problem. We would be able to pick up the little problems which occur, but we would not be in a position to solve them all.

We were asked if we could look at the Portland Hospital model and this we did. However, we had some misgivings about it as it is run as a fully serving procedure. Infrequent, emergency occurrences are dealt with on a case by case basis.

Q Have you considered the implications for Maternity in relation to the distances for patient travel?
R (Mr Jefferis) We did consider it, but in the report we focused on the training aspect of it.

(Julia Cartwright) In the Portland model there is a 24/7 consultant delivered service in obstetrics and no middle grade tier. With regard to paediatrics in Banbury, we are continuing the dialogue with the Deanery. There is a need to be at the forefront with regard to training and a little creativity is needed on the part of the Deanery so that everybody can access the services.

Q How can a hospital improve if there is not the appropriate training available?
R (Andrew Stevens) There are a number of problems, one of the European Working Time Directive coupled with equality issues. A number of patients are seen at the HGH, but the way the rotas are, the junior doctors are not seeing enough patients to get the training recognised. An option put forward by the BHCP has been rather than focus on training, to explain how to get a clinically and financially stable model to sustain it.
Q What are the range of consultant –led models within the country as a whole?
R (Tony Jefferis) Most consultant-led models have not been sustainable and middle grade doctors have been brought in. Most of the models do not have 24 hour cover in their hospital. The Weston-Super-Mare model, for example, is a 16 hour service locally and then the team go to the Bristol Children's Hospital to provide the service there. Where the models work well there is strong clinical leadership. The rota is developed to best fit the service and the community. We are working with consultants at the Royal Free Hospital, London, to see how their consultant –led model works there, but it is a different sized hospital to the Horton. We want to be creative with our ideas too.

(Andrew Stevens) We are looking at a number of other hospitals with consultants and other graded staff working on a rota basis.

Q This is quite a critical report – there is no training for middle grade doctors, no appraisal structure, no study leave etc. What is your view on this?
R (Andrew Stevens) This is legitimate criticism. We have to be creative. It is currently a balancing act with regard to the clinical service at the Horton. To date we have supported and maintained the service at the Horton using a series of short term

locums, who, along with the consultants, have worked over and above their call of duty to keep the service going.

Q Is there any reason why the Weston Super Mare model would not work for Oxfordshire?
R (Andrew Stevens) This model is similar to the model originally proposed by the Trust, but which was turned down by the Independent Review Panel; ie an external, community based service, but with no in-patient facilities overnight.

Dr McWilliam commented that every part of the Oxfordshire population was in receipt of a high quality paediatric service, which enjoyed high investment and a significant amount of clinical 'willingness'. Given this, it was his view that there could be a model found to provide a service for both sites using middle grade doctors. Andrew Stevens agreed adding that it was the role of the PCT to decide what was the best service which could be provided for all children across the county. Currently they were looking at where paediatrics was going as a profession and also working with GPs to keep as many robust community based services to enable children to be treated at home. Research indicated that children recovered better. This role needed to be married up with the objectives of the BHCP.

Q Isn't there more to it than whether the PCT can pay or not? If there is clinical willingness – shouldn't that be explored?
R (Andrew Stevens) Yes. The clinicians want to do what is best for the children of Oxfordshire. There is a national move towards community based services and, in the light of this, we need to think about what is the most appropriate service we can afford to get the best clinical outcomes for children and their families.

Julia Cartwright pointed out that the Community Partnership Forum were an independent body who saw their role as bringing all the parties together and keeping the dialogue going. They encouraged 'thinking outside the box' and liaised on A nationa basis. She added that there were very different kinds of issues affecting the two strands of the profession(the acute and the community sector) in the future. For example, the clinicians needed to think about child protection issues in light of the two areas of deprivation in Banbury. The service was undergoing continuous change and there was a need to talk to the public, and to use the skills of the community services to ensure that Banbury was seen as a training of excellence.
Members of the Committee thanked Tony Jefferis, Andrew Stevens and Julia Cartwright for attending the meeting and for their valuable input.

It was **AGREED** to request Mr Edwards to write to the Deanery giving the views of the Committee as expressed in the meeting (a full note will be included in the Minutes); in particular recommending that more clinical willingness and creative thinking be applied to any deliberations on a possible solution.

8/10 STROKE - COMMISSIONED CARE PATHWAY FOR OXFORDSHIRE
(Agenda No. 8)

Members of the Committee welcomed Sylvie Thorn, Mary Barrett and Suzanne Jones, Oxfordshire PCT; and Dr James Kennedy, Consultant in Stroke Medicine, Oxfordshire Radcliffe Hospitals NHS Trust to the meeting. They gave a presentation

to the Committee and afterwards responded to questions. There follows a selection of those that were asked and the responses received:

Q To have a stroke is a very frightening experience, what kind of information is available to patients and their families and friends afterwards?
R (Sylvie Thorn) We have tried to address this by setting up a one year pilot scheme whereby a Stroke Co-ordinator is based at the ORH Stroke Unit. That person will work with the patients, on a face to face basis, who have been admitted. The Co-ordinator will give them the advice and information they require and signpost them to other services, if needed. S/he will also contact patients at home and signpost them back into services if this is so required.

Q Will services such as physiotherapy and speech therapy be available for patients in their home?
R (Suzanne Jones) The PCT has put in some investment into this service. They have concentrated on the acute side first, then it will be the turn of the rehabilitation side.

Q Will everybody be called in for some kind of screening for stroke?
R (James Kennedy) We are not investing in it – there are no risk factors for stroke. Dr McWilliam and his deputy reported that currently there is in situ one clinic in Oxford City and two in Banbury who are offering the service for one year for targeted patients. We invited GP practices in the area to identify screened patients from the 43 – 47 age group, who might be offered intervention or treatment. The programme plan is to eventually expand across Oxfordshire.

Q At what stage does the County Council's Adult Services take over? How does funding work out with the PCT?
R (Suzanne Jones) In respect of the first question, the decision is made on a clinical basis. When somebody has a long term care need, any decision is made by the people looking after that person. In respect of the funding, at the moment it is carried out via a handover from Health to Social Care. The Stroke Association have a return to work programme on the voluntary side.

Sylvia Thorn commented that funding goes through the normal process integrating the additional services that have been developed since the Strategy started. We use the grant to try to develop services. At the end of the pilot scheme.

James Kennedy further commented that the Strategy is the paradigm of necessity for Health and Social Care to work together. Formerly the intensive acute model could not be matched with social Care. Now we are trying to run with Social Care in at the beginning of the process in order to manage people's expectations and in order to smooth out the pathway and make it seamless. Our job is to get the maximum recovery possible.

The Committee **AGREED** to note the progress report and also to note that Health and Social Care may be required to take action to maintain coordination once pump priming monies are put in place, as it was possible that funding might not be included within the next service review.

Dr McWilliam commented that it was good to now have prevention in at the start of a patient's pathway. He asked James Kennedy if the funding for the prevention programme in the right place. Dr Kennedy responded in the past, funding had focussed only on acute care, but this was now changing. The SHA and the Clinical Stroke Network were taking the preventative aspect very seriously and they would be performance managing the PCT and the section managers, He added that the United Kingdom had a very bad record for unhealthy life styles.

Q Unfortunately there does not appear, so far, to be 'joined up' thinking in terms of life style and awareness training. Many people do not see their GPs very often and therefore are under the 'radar'. Is there sufficient publicity for it?
R (Dr Kennedy) Yes. People have a clear idea of what a heart attack entails, but it is a different picture for stroke. The Stroke Association will only achieve persistent media coverage of issues such as the signs appertaining to mini strokes, in television 'soaps'. The Stroke Association are given a total of 130 minutes of public awareness media time. It has chosen to select opportunities to highlight the prevention agenda, such as targeting the television programme 'Top Gear ' for screening its message, which attracts a targeted audience of middle aged males.

Dr McWilliam pointed out that Public Health were also carrying out outreach. For example, information had been given out and Health Checks performed at two football matches in a bid to get people, particularly middle aged men, into screening earlier.

Q Do you do work with the younger generation?
R (Dr McWilliam) Yes prevention is part of the promotion of a healthy lifestyle, ie. Healthy eating, weight control and exercise.

Q How are you addressing the challenge to get the Oxfordshire public more involved?
R (Dr McWilliam) We are starting a Stroke Community Forum, the first meeting of which is on 17 February. It will include a number of stroke survivors and their carers and will highlight and discuss a number of communication problems. A web site is also being set up where members of the public can pose questions to be answered if they are not able to come along to the Forum.

(Dr Kennedy) This is indeed a major challenge and the targets will have huge outcomes and be of enduring benefit. Stroke has had its moment in the sun with these new initiatives. This Committee could assist in this by keeping up the pressure on Health and Social Care to maintain the co-ordination between them once the pump priming money is put in place. The danger might be that it may not feature in the next service review.

The Committee thanked Sylvie Thorn, Mary Barrett, Suzanne Jones and James Kennedy for responding to questions and for taking part in the discussion. It was **AGREED** to note the progress report and also to note that Health and Social Care may be required to take action to maintain co-ordination once the pump priming monies are put in place, as it was possible that funding might not be included within the next service review.

9/10 CENTRE FOR PUBLIC SCRUTINY - SCRUTINY DEVELOPMENT AREA BID - ACCESS TO PRIMARY PHYSICAL HEALTH CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS LIVING IN RURAL AREAS

(Agenda No. 9)

The Centre for Public Scrutiny (CfPS) had announced in November 2009 a two year programme aimed at raising the profile of overview & scrutiny as a tool to promote community well-being and help councils and their partners to address health inequalities within their local communities. As part of this the CfPS sought applications from scrutiny committees seeking to become what are to be called 'Scrutiny Development Areas (SDA's)'. SDA's would share learning with other scrutiny committees via 'action learning meetings' throughout 2010 and a national conference would be held in 2011.

The chosen scrutiny committees would undertake a project during 2010 that would be used to form part of a national resource kit aimed at developing the role of overview and scrutiny in tackling health inequalities. They would be expected to use 'innovative approaches to undertaking scrutiny reviews' and to work in partnership with one or more district council scrutiny groups as well as other partners such as community groups and NHS colleagues. There would be only four of these across the country and each would receive a small amount of funding (up to £5,000) to help with the project.

The OJHOSC put in a bid to become an SDA, based around a project to review access to primary physical health care for people with mental health problems who find it more difficult to gain access to primary health services. This is compounded for people living in rural areas where access generally is more difficult. The project would seek to identify the evidence most relevant to developing future policy and action and attempt to describe how the evidence could be used to develop practical improvements that would reduce these health inequalities. Unfortunately the bid had been rejected by the CfPS and, as a consequence, members were asked to consider how to proceed with this piece of work.

Following a brief debate, it was **AGREED t**o to proceed with the project, on the terms expressed above, despite the bid having been unsuccessful and to convene a working group comprising Councillor Rose Stratford, Councillor Jenny Hannaby, Councillor Richard Langridge and Dr Harry Dickinson.

10/10 JOINT OXFORDSHIRE, HAMPSHIRE AND BUCKINGHAMSHIRE REVIEW OF THE PERFORMANCE OF THE SOUTH CENTRAL AMBULANCE TRUST (SCAS) IN RURAL AREAS

(Agenda No. 10)

This joint review had been instigated by this Committee following meetings with managers from SCAS. Members had been concerned that the performance of the Trust was much worse in rural localities than in urban areas. This situation had corresponded to that in other counties in the SCAS region and it had been considered that it would be beneficial to undertake a joint project. Two select committee style sessions had taken place with a number of witnesses which had

included some members of the public, the Cabinet Member for Health from West Oxfordshire District Council, ambulance crew members, commissioners, first and co-responders, SCS managers and the Trust Board Chairman.

It had been anticipated that a report would be available for public distribution prior to the meeting. Mr Edwards reported that unfortunately this had not proved possible. It was currently with stakeholders for factual checking. He added that there had already been a significant amount of public interest in it.

It was **AGREED** to note the report and to look forward to its consideration at a future meeting.

11/10 JOINT OJHOSC/CHILDREN'S SERVICES SCRUTINY COMMITTEE TEENAGE PREGNANCY WORKING GROUP

(Agenda No. 11)

The joint OJHOSC/Children's Services Scrutiny Committee Working Group had been set up some months ago to examine progress on developing an improved strategy for reducing levels of teenage conception across Oxfordshire. The Working Group had reviewed a joint County Council/PCT self assessment of progress and produced a number of recommendations for inclusion in the new strategy. These recommendations had all been accepted, as could be seen in the attached letter (JHO11).

It was noted that the strategy would be presented to the Children's Trust Board in January. The Working Group planned to review progress nine months after the implementation of the strategy.

12/10 CHAIRMAN'S REPORT

(Agenda No. 12)

In the Chairman's absence, Dr Dickinson reported on an informal meeting with the Chief Executive and other senior managers of the Oxfordshire & Buckinghamshire Mental Health Foundation Trust. The meeting was with regard to the reconfiguration of Mental Health day services provided by the voluntary sector. It had been decided to apply the 'tool kit' to determine whether the changes should be subject to full public consultation.

The report was noted.

13/10 INFORMATION SHARE

(Agenda No. 13)

There were no information items shared.

..... in the Chair

Date of signing .....