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 .....