OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 15 September 2011 commencing at 10.00 am and finishing at 12.45 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Dr Christopher Hood (Deputy Chairman) Councillor C.H. Shouler Councillor Keith Strangwood Councillor Lawrie Stratford Councillor Val Smith Councillor Jenny Hannaby District Councillor Hilary Hibbert-Biles District Councillor Rose Stratford Oxford City Councillor Susanna Pressel
Co-opted Members:	Dr Harry Dickinson Mrs Ann Tomline
Other Members in Attendance:	
By Invitation:	
Officers:	
Whole of meeting	Roger Edwards; Dr Jonathan McWilliam; Dr Shakiba Habibula
Part of meeting	As shown in the agenda
Agenda Item	**Officer Attending**

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.

49/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Don Seale and Mrs Anne Wilkinson.

50/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillors Rose Stratford and Lawrie Stratford declared an interest as Chairman and member of the Bicester Hospital League of Friends.

51/11 MINUTES

(Agenda No. 3)

The minutes of the meeting held on July 7th were agreed and signed following the addition of the name of Councillor Val Smith to those in attendance.

52/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There were no requests to speak or petitions to present.

53/11 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health, Dr Jonathan McWilliam, updated the Committee on the latest developments with the restructuring of the NHS in Oxfordshire.
Strategic Health Authorities are to be "clustered" with South Central going into a new South of England cluster that will stretch from Kent to Cornwall and up to north Oxfordshire. It is still planned that SHAs would be abolished at end of March 2013.
Oxfordshire PCT staff not in Public Health will be divided between the PCT cluster and the Oxfordshire Clinical Commissioning Group (CCG).
Dr Mary Keenan, Lead GP for the North locality and county lead for planned care, has been appointed to the position of Deputy Leader for the Oxfordshire CCG.
On being transferred to the local authority, Public Health will take on responsibility for sexual health and drugs and alcohol action. There is to be a national model for the public health of 0 – 4 year olds but how this would be dealt with locally remains unclear.
There is continued uncertainty around how much funding will be provided to local authorities when Public Health transfers from the PCT. A national data collection exercise is ongoing to identify how much Public Health costs now and it is likely that, from that, a formula would then be created to allocate funding.
The aim is that shadow budgets would be in place by the end of the calendar year to be followed by HR guidance.
The powers of Health and Wellbeing Boards (HWB) are to be strengthened so that the HWBs have a role in signing off CCG structures and would receive an annual report on the CCG.
The HWB would produce an annual plan based around the agreed Joint Strategic Needs Assessment and the CCG would have to provide an explanation if they were to stray away from the plan.

The Deputy Director, Dr Shakiba Habibula, presented a series of health profiles to the Committee. The profiles provide a picture of health in the individual district council areas of Oxfordshire. Dr Habibula reported that Oxfordshire is a healthy county. The City and Cherwell district lag behind the other districts in some areas but in general health indicators are good in all areas. Red indicators were highlighted and Dr

Habibula explained why they were red and what is being done to improve performance.

Members thanked Dr Habibula for the presentation.

54/11 SOUTH CENTRAL AMBULANCE SERVICE - UPDATE ON PERFORMANCE
(Agenda No. 6)

The Chief Executive of the South Central Ambulance Service (SCAS), Mr Will Hancock, reported on response times and new national service indicators.

- Overall 999 and Urgent demand continues to trend upwards
- Overall Red Call performance has held well and shows improvement over the last year – remaining above the national Standard for the PCT area.
- Good improvement in the Red 8 minute performance can clearly been seen in each of the individual districts
- In early July 2011 the new Emergency Control room computer system (CAD) was introduced into Bicester. This is the final phase across SCAS and now means that all three control rooms operate on the same CAD, allowing true integration and resilience across the whole of SCAS.
- Early September saw the switching on of a single virtual telephony platform across all three control rooms, providing even greater resilience and patient safety.
- The CAD installation was wholly successful and performance during the critical 3 months post implementation (during which time staff will become fully efficient) has been significantly above planned levels.
- The expectation is that the improvements (seen particularly across West Oxfordshire and South Oxfordshire during the first part of this year) will be recovered quickly in the second half of this financial year.

Chipping Norton First Aid Unit Update

The First Aid Unit (Chipping Norton Hospital) pilot is coming to an end. This pilot has seen an Emergency Care Practitioner based at the new Hospital every week day evening and during a long day on both Saturdays and Sundays.
Its use has been pleasing, with the vast majority of patients who presented themselves being managed locally.
9 Patient experience surveys have so far been returned, with overwhelming support for the service.

Other Developments
Since April this year 11 new indicators have been introduced covering the three quality domains of safety, experience and clinical effectiveness. They are:

Service Experience Indicator – Patient satisfaction surveys – how ambulance trusts find out what people think of the service they offer and how they are acting on that information to improve patient care.

Outcome from acute ST-elevation myocardial infarction (STEMI) indicator - STEMI is a type of heart attack. For many conditions recovery will be more likely and quicker following early treatment. Measuring patient outcomes in this way will allow services to place performance in context and stimulate discussion on how to continually improve.

Outcome from cardiac arrest: return of spontaneous circulation indicator – This indicator will measure how many patients who are in cardiac arrest (i.e. no pulse and not breathing) but following resuscitation have a pulse/ heartbeat on arrival at hospital.

Outcome from cardiac arrest to discharge indicator – This measures the effectiveness of the whole system in managing those patients who are in cardiac arrest. That is the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.

Outcome following stroke for ambulance patients' indicator –This indicator will require ambulance services to measure the time it takes from the 999 call to arrive at a specialist stroke centre.

Proportion of calls closed with telephone advice or managed without transport to A&E indicator – Ambulance crews are often able to treat patients without the need to take them to an A&E department. Also, alternatives to A&E may be more appropriate for the patient. This indicator should reflect how the whole urgent care system is operating, rather than simply the ambulance service or A&E, because it would reflect the availability and provision of appropriate alternative urgent care destinations and treatment of patients in the home.

Re-contact rate following discharge of care indicator – To ensure that ambulance trusts are providing safe and effective care first time; every time, this indicator will measure how many callers or patients call the ambulance service back with 24 hours of the initial call being made.

Call abandonment rate –This indicator will measure how often people who phone 999 are not able to get through.

Time to answer calls – This indicator will measure how quickly 999 calls received by the ambulance service get answered.

Time to treatment by an ambulance-dispatched health professional – This will measure how long it takes for an ambulance-trained healthcare professional to arrive at the patient 9note; not necessarily an ambulance).

Category A, 8-minute response time –This indicator measures the speed of ambulance responses to the scene of potentially life-threatening incidents.

A discussion then took place in which the following points were made:

It is pleasing to see the new emphasis on clinical indicators and indicators that cover the whole patient experience. Work is going on between SCAS and clinical colleagues to improve services particularly by ensuring that patients get to the right place at the right time.

It is good to see improved times and the development of the first responder programme.

There should be more ambulance coverage in rural areas to ensure that all patients have an equal chance of recovery regardless of where they live. There should be more joining up with the Out of Hours service.

Some members questioned whether it was reasonable to expect the same service in rural areas as in urban settings.

More data on “just missed times” (i.e. more than 8 minutes) would be useful.
The number of calls taking more than 30 minutes has been reduced and rural performance has improved with 75% of calls in West Oxfordshire taking 7 minutes or less.
Ambulance demand has doubled in the last 10 years.
It is hoped that the new non-emergency 111 service, which SCAS is bidding to run, will improve the Out of Hours situation as all calls will be brought together to one call centre.

Members thanked the Chief Executive and his colleagues for attending the meeting.
The Chief Executive agreed to provide "meaningful information" on the new performance indicators as soon as it becomes available, probably early next year. He also agreed to let members have information relating to the actual length of time for calls that exceed 8 minutes. Also, the Committee will be kept informed of the outcome of discussions with the PCT about the Chipping Norton FAU pilot (since the meeting the life of the FAU has been extended to the end of January 2012).

55/11 RIDGEWAY PARTNERSHIP MERGER/ACQUISITION

(Agenda No. 7)

The Chief Executive of the Ridgeway Trust, Mr John Morgan, together with the Lead Commissioner and SHA lead for the merger process took the Committee through the present situation of the Ridgeway Trust and what is happening to secure its future.
Due to the more challenging financial environment the Trust would be unable to meet Monitor’s financial criteria to achieve Foundation Trust status. Hence they are going through the merger and acquisition process in order to join up with another organisation to achieve sufficient volume to satisfy Monitor.
A lot of interest has been shown in merging and a short list of six bidders has been put together. This will be whittled down to one preferred bidder by January. The successful bidder would then have to provide a business case to satisfy Monitor, the Co-operation and Competition Panel (CCP) and the Secretary of State. The Ridgeway Trust would then be dissolved and absorbed into a new Trust. The exercise is being driven by one overall aim – to find a secure home for services.
Stakeholders, including staff, service users and commissioners, have been involved at all stages of the process and their involvement will continue.

In response to members’ questions the following points were made:

There is no choice about seeking Foundation Trust status; it is a requirement by the Government. The benefits are mainly around greater public engagement in the running of the Trust; the ability to borrow money and a little more independence from the Department of Health e.g. around staff terms and conditions.
The Co-operation and Competition Panel will examine whether there would be any loss of competition and/or choice due to a merger.
It is essential to get on with the process so that service users can be secure and know what is to happen.

The Chairman thanked the presenters, stated that the Committee would note the report, wished them well for the future and congratulated them on the stakeholder engagement.

56/11 RECONFIGURATION OF THE GYNAECOLOGY SERVICE AT THE HORTON HOSPITAL

(Agenda No. 8)

The Gynaecology Service at the Horton General Hospital (HGH) delivers elective and emergency care to the local population north of Oxfordshire and the surrounding counties. The Oxford Radcliffe Hospitals Trust recently announced a number of changes to the service.

This is a complex issue that relates not just to change in gynaecology services but also to the much wider issues of reducing activity in acute hospitals, cutting down on numbers of beds, developing day services and/or outpatients for procedures that previously would have required hospital admissions and providing services closer to home.

The Trust has stated that the aim is to create a dedicated gynaecological Day Surgery and Diagnostic Suite that will ensure the following:

- Fewer women living in Banbury and surrounding areas having to travel to the John Radcliffe Hospital due to the expanded and improved volume of services provided locally at the Horton General Hospital
- The creation of new outpatient clinics, including tertiary level services.
- Performing less invasive laparoscopic surgery.
- Avoiding or minimising the need for admission to hospital unless clinically necessary.
- Improving the quality of care for women needing treatment

Service structure

- Inpatient and day case surgery will continue to be performed at the Horton General Hospital.
- New diagnostic services will be set up at the Horton General Hospital, including outpatient hysteroscopy clinics, mirroring those running at the John Radcliffe Hospital. This represents an expansion of the existing services provided at the Horton General Hospital and will avoid the need for women to travel to the Women's Centre in Oxford as is currently the case for such procedures, minimises in-patient stay and reduces waiting time for surgery.
- Clinics such as the hysteroscopy clinic will enable procedures to be performed on an outpatient basis as opposed to having to go to theatres and in some instances, avoid the need for an anaesthetic.
- New urodynamic clinics will be set up at the Horton General Hospital. These will match those running at the John Radcliffe Hospital and will benefit women living in Banbury and the surrounding areas, who also currently have to travel to Oxford for this diagnostic service.
- Specialised tertiary clinics such as Reproductive Medicine will commence on the

Horton site, strengthening the relationship between the Horton and the University and enabling local access to highly specialised skills.

- Late terminations of pregnancy due to foetal abnormality will be performed under the care of maternity services at the Horton General or John Radcliffe Hospitals in line with agreed clinical pathways.
- There will be no reduction in the budgeted number of medical staff or changes to their working hours. It is anticipated that the creation of new services will help to recruit medical staff into long-term vacancies, thereby minimising the need for agency staff and improving the continuity and quality of medical support.

Inpatient beds

- Advancements in surgical techniques mean that many procedures, which previously necessitated an inpatient admission, can be performed as a day case or outpatient procedure. This has reduced the overall need for inpatient admissions and therefore the number of beds required for the service.
- Gynaecology patients requiring admission will have access to 6 beds on an inpatient ward. These beds can be 'flexed' up or down dependent on clinical need, in line with current practice adopted by all specialities across the Oxford Radcliffe Hospitals.
- It would not be possible for these beds to be ring fenced to the detriment of emergency admissions as this could compromise clinical safety at the Horton General Hospital. As is currently the case, this is managed on the basis of clinical risk, patient need and overall demand for particular specialties. This may mean that emergency cases are on occasions managed between the John Radcliffe Hospital and Horton General Hospital. This is normal practice currently and does not reflect a change in service provision.
- The inpatient beds identified at the Horton General Hospital have three side rooms which have en-suite facilities. This is the same number as on G Ward. Every endeavour will be made to accommodate patients undergoing sensitive procedures i.e. miscarriage into a side room as is current practice across Women's Services.

Women's Day Surgery and Diagnostic Suite

- The Women's Day Surgery and Diagnostic Suite will initially be open between 7:30am and 8:00pm.
- There will be 9 day case trolleys and 3 treatment rooms on the unit.
- Patients who require admission to an inpatient bed following day surgery will have their admission organised by the Duty Operational Manager for the Horton General Hospital as is current practice.
- It is not anticipated that patients will travel during rush hour times, as per current practice, and therefore patient travel times will be kept to a minimum. If a patient chooses to have their procedure performed at the Horton General Hospital and their travel time is over 1 hour this will be considered by the listing surgeon when assessing an individual suitability for day surgery.
- The Horton General Hospital currently performs day surgical procedures for patients as far afield as Swindon who choose to attend the Horton General Hospital.

Emergency Gynaecology patients and clinic

- The Urgent Gynaecology Clinic will be open between 8:30am and 4:00pm, with the last booked appointment at 2:00pm. This is in line with the hours of service of the clinic at the John Radcliffe Hospital.
- Emergency patients admitted outside of the scheduled opening hours will be seen and assessed in the Emergency Department following discussion between the GP and the Registrar/Consultant. This is in line with the current emergency patient pathway.
- If patients are discharged and require a follow up, an appointment can be made in the Urgent Gynaecology Clinic for the following day.
- Any patient requiring admission to hospital following assessment by the gynaecology medical team will be admitted into an inpatient bed, in line with current practice.
- Hyperemesis (extreme morning sickness) patients requiring admission will be admitted to either a gynaecology inpatient bed or the maternity unit in line with clinical policy, as is current practice.

Outpatient diagnostic clinics

- Urodynamic (how the bladder and urethra perform their job of storing and releasing urine) and Menstrual Disorder clinics will be run from the Women's Day Surgery and Diagnostic Suite at the Horton General Hospital. This will expand on the range of service offered at the Horton General Hospital. Patients currently requiring urodynamic assessment have to travel to the John Radcliffe Hospital to have this specialist service performed.
- The new hysteroscopy (the inspection of the uterine cavity by endoscopy) clinic will allow patients to be assessed and treated in an outpatient setting, improving patient experience and matching the service offered at the John Radcliffe Hospital. Patients are currently undergoing this procedure in theatre.
- By treating patients in an outpatient setting as opposed to theatre, patients will benefit and it is anticipated this will assist in reducing surgical waiting times for other gynaecology patients.

Staff and local residents question whether it is all good news. They have raised a number of doubts and queries around the loss of beds throughout the hospital and whether the proposals take sufficient account of knock-on effects elsewhere.

In order for the HOSC to be seen to be acting openly and fairly in this matter the Chairman proposed that a toolkit meeting should take place to ascertain whether there should be full public consultation. It was proposed and agreed that a group of members of the HOSC should be delegated to meet ORH managers and clinicians, staff representatives, members of the Community Partnership Forum from Banbury and the LINk in order to come to a conclusion. No changes would take place at the Horton until after the meeting.

The meeting would take place on October 4th at the John Radcliffe Hospital and the outcome would be made public and reported to HOSC members.

57/11 SAFE AND SUSTAINABLE REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND

(Agenda No. 9)

The Chairman reported that Safe and Sustainable have published the results of the initial consultation on the proposals for Children's Congenital Heart Services in England. While the generally preferred choice was option B, that which contains Southampton and the one supported by the HOSC, the Joint Committee of PCTs (JCPCT) has still to meet to come to their decision. Therefore it is important that support for the option should be reiterated.

Caroline Langridge, representing the Young Hearts charity, reported on two positive developments. Firstly that a recently published letter from the Safe and Sustainable secretariat to Sir Neil McKay, the Chair of the JCPCT, had stated the following:

In October 2011, when the JCPCT next meets, the secretariat will advise the JCPCT that there is no available evidence that could reasonably suggest that a retrieval team from London or Bristol could reach the Isle of Wight in compliance with the time limits stipulated by the PICS standards [Paediatric Intensive Care Society standards for the care of critically ill children], even if the Isle of Wight is considered to be a 'remote area' and measured by the higher time threshold of 4 hours.

The secretariat will further advise the JCPCT to take these conclusions about retrievals from the Isle of Wight into account when considering the outcome of public consultation as part of the committee's deliberations to agree an eventual configuration option, and in any necessary re-scoring of options. paper had stressed that the necessary 4 hour retrieval time to get a child to hospital in an emergency could only be guaranteed if Southampton was to be the receiving hospital.

Secondly Sir Neil McKay had "expressed an interest" in hearing more about the network idea being led by Southampton and Oxford.

Following publication of the consultation report, HOSCs were being given an opportunity to add to their earlier submissions – the closing date for these further statements being October 5th. The Committee agreed that this opportunity should be taken and that Roger Edwards should respond to Safe and Sustainable on behalf of the HOSC. The submission should stress that the best outcomes for quality and safe clinical outcomes could only be achieved by the adoption of Option B.

The Chairman thanked Caroline Langridge for her contribution and the Committee unanimously thanked Young Hearts for their hard work and the hugely important contribution that they had made to the campaign to protect vital services for children in and around Oxfordshire.

58/11 CHIPPING NORTON HOSPITAL - UPDATE ON POSITION FOLLOWING THE LETTER TO SECRETARY OF STATE

(Agenda No. 10)

The Chairman explained that Chipping Norton Hospital has been on the HOSC agenda on a number of occasions over the years. Previously it had been agreed by the PCT that, with regard to the employment of nursing staff at the hospital:

i. To enable staff at the Hospital to decide which choice was better for them as individuals, they would be given the option of whether to remain as NHS employees and be seconded to the Orders of St John (OSJ) for a period of three years or to transfer under TUPE to the OSJ
ii. The PCT would not indicate a preference with regard to the above options
iii. In the event that an NHS employed staff member was to leave during the three year period, their replacement would be placed on NHS terms and conditions for the remainder of the three years.

At the end of the three years a review would take place.

The transfer of existing staff has happened in accordance with the first two statements above and all nurses employed in the hospital chose to be employed by the NHS. However the PCT decided that new staff employed during the three year period following the opening of the new hospital would be employed by the OSJ.

At their July meeting HOSC members had agreed to bring this matter to the notice of the Secretary of State for Health and seek his advice on whether or not the Independent Reconfiguration Panel could be invited to review the position.

Following the Chairman's opening remarks the Director of Communications for the PCT, Ronan O'Connor, reported that the PCT was proposing to bring forward the review of the new Chipping Norton Hospital from three years to two and that any staff employed during that time would be employed as NHS staff.

Before discussing the PCT's latest position the Chairman reported that there had been no reply yet from the Secretary of State to the latter sent on behalf of the HOSC in July.

Councillor Biles stated that, in her opinion, the HOSC should wait for the Secretary of State to reply before agreeing anything with the PCT. She considered that it would be reasonable for a review to commence three months before the three years were up.

The Chairman asked members to consider whether what the PCT was suggesting was reasonable.

Councillor Pressel stated that she would agree with the compromise suggested by the PCT but would insist that no change should take place until the review was completed.

Mr O'Connor stated that local GPs considered the two year offer to be a reasonable compromise. He further said that the PCT would consider Councillor Pressel's point.

Councillor Stratford suggested that Mr O'Connor should take the HOSC's views back to the PCT, gat an answer and come back to the HOSC in November by when, it is to be hoped, the Secretary of State might have got around to replying.

The Committee supported Councillor Stratford's proposal and Mr O'Connor agreed to come back in November.

Councillor Shouler proposed that HOSC members should visit Chipping Norton Hospital to see how such a modern facility operates. Mr O'Connor agreed to arrange a visit.

59/11 FUTURE WORK PROGRAMME

(Agenda No. 11)

Two possible items were considered for the work programme; Drug and Alcohol Addiction Services and GP services for prison inmates.

Members agreed to set up a working group to consider the former item but not to purse the latter.

Councillors Smith and Hannaby and Dr Dickinson agreed to participate in the working group.

Councillor Hannaby proposed and the Committee agreed to add maternity services as an item for a future HOSC meeting.

Councillor Pressel wished to see regular updates on waiting times at the Oxford Radcliffe Trust hospitals. It was pointed out that this information is available regularly via the Trust's website.

60/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 12)

Mr Adrian Chant, the LINk Locality Manager for Oxfordshire, reported that the transition to HealthWatch is moving forward. The LINk Steering Group is to hold a stakeholder event on 28th November. Mr Chant will provide members with further information.

The LINk is to undertake a review of continence services and will meet parents an carers in early October. The Adult Services Scrutiny Committee will consider the LINk report.

The LINK would wish to liaise with the Committee on the maternity review when the time comes.

The latest LINk update had been circulated to HOSC members and the next Steering Group will be held in October. The outcome of the meeting will be included in the next update.

61/11 CHAIRMAN'S REPORT

(Agenda No. 13)

The Chairman reported that informal meetings had taken place with the Chief Executive and Directors of the ORH and the Chairman and Chief Executive of the PCT.

He also reported on a meeting that had taken place with PCT commissioners in connection with ambulance patient transport. This is the service that transports patients to hospital for outpatients appointments (i.e. not the emergency service). The commissioners reported that, in order to reduce costs, they were to begin enforcing criteria that had been in place for some time but which had been interpreted loosely. This had led to a situation where patients who were able to get to the hospital under their own steam had been using the service. In future only those patients whose medical needs require it would be able to use the service. They had consulted widely on this matter and would ensure that the changes would be well publicised before they were implemented. On that basis, and bearing in mind that no patient with a genuine need would lose the service, the Chairman had agreed that no formal consultation would be required. The Committee endorsed this action.

The Chairman had attended a meeting with colleagues from Buckinghamshire and the PCT to discuss the matter of "Any Qualified Provider". This is a Government initiative intended to increase patient choice. Any provider of NHS services will need to be qualified and registered to deliver a range of specified services within a community setting. They will have to meet certain standards for the quality of the care they offer. This will not be based on price - a single price for services will be paid to all qualified providers of that service.

Nationally eight community and mental health services have been selected and each area has to identify three of these for change to be in place by September 2012. Other services which are of higher local priority may be chosen, if there is a clear case based on the views of service users and potential gains in quality and access.

The eight services are:

1. Musculoskeletal services for back and neck pain
2. Adult hearing services in the community
3. Continence services (adults and children)
4. Direct access diagnostic tests
5. Podiatry services
6. Wheelchair services (children)
7. Leg ulcer and wound healing
8. Primary care psychological therapies for adults

Locally the following services have been identified by the PCT as priorities:

1. Adult hearing services in the community
2. Direct Access diagnostics
3. Podiatry

The PCT states that these services have been chosen because they believe that there is real potential to improve local access, the care pathways are relatively simple, and the current contract commitments mean that change can be achieved within the timescales set by the government.

The Government had instructed PCTs that they should undertake local engagement over the proposals (but not consultation). The Committee agreed that they would accept the action being taken by the PCT.

..... in the Chair

Date of signing .....