OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 4 February 2016 commencing at 10.00 am and finishing at 2.40 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	District Councillor Martin Barrett (Deputy Chairman) Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods District Councillor Monica Lovatt District Councillor Susanna Pressel District Councillor Nigel Randall
Co-opted Members:	Moira Logie, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Belinda Dimmock-Smith and Julie Dean (Corporate Services); Director of Public Health

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 and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

1/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

There were no apologies for absence or substitutions.

2/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

3/16 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 19 November 2015 were approved and signed as a correct record subject to the following amendment:

- Minute 113/15 'Healthwatch Oxfordshire – Update' – page 7, paragraph 3, second sentence - to erase the word 'own' and to add 'home or care';

The Minutes of the meeting held on 11 December 2015 were approved and signed as a correct record subject to the following amendment:

- To erase Cllr Nigel Champken-Woods from the list of voting members present at the meeting;
- Minute 118/15 'Rebalancing the Health Social Care System in Oxfordshire; - page 11, paragraph 3, first bullet point - to erase the words 'Information about how many'

4/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to requests from two members of the public to address the meeting. Both had requested to speak at this item:

Joan Stewart, spoke on behalf of 'Keep our NHS Public', in regard to Agenda Item 8 'Closer to Home – Health & Care Strategy'. She expressed her concerns about the scale and pace of change associated with the devolution and integrated community care proposals. She added her view that there had not been much public engagement to date, nor stakeholder engagement on the new models of care in Oxfordshire, in the form of discussion or debate. She called for the following:

- Clarity of clinical evidence base
- Robust patient and public engagement
- Clarity of the financial evidence base

She asked the Committee to step up to the challenge and ask the clinicians and finance officers to demonstrate how they intended to engage with the patients and the public.

County Cllr James Mills addressed the meeting in relation to Agenda Item 14 'Toolkit' pointing out that in his view, the revisions made to the proposed toolkit had not gone far enough. He commented that the revisions made had still not addressed the issues of 'openness, transparency and looking after Oxfordshire residents.' He pointed out that the meeting between members of HOSC and OCCG representatives to consider the proposed decision by the OCCG to temporarily close the Wenrisc ward at Witney Community Hospital, was sufficiently substantial to require a full public consultation. He added that it was not quorate, in line with the proposed, newly revised 'Toolkit', as only two voting members of the Committee had taken the decision. Thus the meeting

had not been properly constituted. It was his view that there was a need for more transparency with stakeholders, as specified in scrutiny guidance. Moreover, the Francis Report had advocated that scrutiny should espouse an open and effective channel of communication. The meeting, as he had understood it, had been led by Health providers and had not been dealt with in a sufficiently independent manner by those HOSC members present.

5/16 FORWARD PLAN

(Agenda No. 5)

Members were asked to prioritise items from their Forward Plan (JHO5) for the next meeting and to consider whether they wanted to add any issues to be considered at future meetings. They **AGREED** the list following:

Items to be considered at the next meeting:

- Health Inequalities Commission and Health of Minority Groups
- Update on Commissioning of Public Health services for Children (aged 0-5 years)
- Oxford University Hospitals Foundation Trust (OUH) update on implementation of action plan (post inspection), plus achievement against targets
- Oxfordshire Clinical Commissioning Group (OCCG) - report on NHS Recruitment and Retention strategy
- Quality reports from South Central Ambulance Service (SCAS), OUH and Oxford Health (OH)
- Southern Health NHS Foundation Trust - monitoring report
- 'Rebalancing the System' update.

Items to be considered at future meetings:

- June meeting – a report on health at Bullingdon Prison and Campsfield Detention Centre

6/16 OUTCOME BASED CONTRACTING FOR ADULT MENTAL HEALTH SERVICES - AN UPDATE

(Agenda No. 6)

Ian Bottomley, Head of Mental Health Services, OCCG presented a report on progress made on implementation of the outcomes based contract (OBC) as signed by the OCCG on 1 October 2015. The report (JHO6) clarified the scope of the contract, explained the contracting mechanism and identified the next steps.

A member of the Committee asked about experience so far in relation to the new contracts. Ian Bottomley explained that OCCG had deliberately opted for a 5 + 2 year contract, as some changes would take time in order to align people to assist in helping patients into work and education. Some of the measures were new and were being developed as the contract developed. Some providers were already moving

ahead, for example with the purchase of more intensive support accommodation. The full impact of year 1 would be seen at the end of year.

Mr Bottomley was asked what impact the recent County Council cuts contained in the County Council's budget would have on the contract. He responded that there would be none, as it had been agreed prior to the recent cuts. However, there could be some implications around services for the homeless, with a significant cross over with services for people with a mental health illness. In his view there was already a reasonably good care pathway, so that help and support could be given by mental health support workers further along the line.

Mr Bottomley was asked what the impact on waiting lists for first entry into the service would be. He explained this was being monitored and the Trust had continued to meet all targets, and there was no waiting list. A national initiative requiring a two week wait for patients experiencing the first onset of psychosis had been put into place, so those patients were coming into the front door very quickly. He added that where there were instances of patients being 'behind the front door' these were being addressed. Mr Bottomley, explained that services provided 'at the front door' comprised two service contracts, 'Assessment 'and 'Treatment Specification', which provided four sessions with every patient. The provider would sit with the patient and work out what was needed. This might mean care planning and support, access to work or psychiatric care, all or part thereof. The target also ensured psychological support for the patient, if needed, as soon as possible, as well as access to housing, physical support etc.

Mr Bottomley was asked if the threshold would gradually rise over time if other organisations found it necessary to alter their thresholds due to cuts. He explained that the OCCG had built part of the contract around national measures for mental health. Over many years the 'Care Plus' component had stratified patients into those suffering from varying conditions categorised as mild to severe. It was not possible to move from one patient cluster to the other without being in breach of contract.

Mr Bottomley explained that accommodation provision had been organised prior to the new contract being set up. Floating Support had also been included within the new contract in the same form as before.

In response to a question about the robustness of the discharge planning process (in light of the recent fatal stabbing incident in Abingdon), Mr Bottomley stated that the aim was for people to live independently, but only with the appropriate risk planning in place. This would be flagged up with the appropriate organisations.

With regard to the monitoring of safe and effective care, a member asked how the OCCG picked up a service delivery problem within its measurement of outcomes and what would it focus on to ensure an improved service? Mr Bottomley responded that individual incidents would continue to be investigated, and Trusts would be expected to report on how they were addressing issues arising from incidents. If necessary, associated risks would rise if the provider was not able to deliver. When measuring patients with care plans, Mr Bottomley explained that a plan was not measured per se, but certain indicators were examined to see how well patients were doing in the

patients' own experience, He pointed out, therefore, that outcome planning was measured, as well as delivery.

Ian Bottomley was asked, in light of the recent incidents in Abingdon and in Didcot, who monitored the incidents where risk assessments had gone wrong. and how was the information collected? He explained that in cases such as these, contract monitoring took place following a review. Dr McWilliam clarified that contracts were let to credible providers who were qualified to do the job. There were internal quality controls on the provider for the daily treatment of the patient. If something was to go wrong, the provider would submit a report to the commissioner, who would do a quality check on it and draw their own conclusions. Issues would then be raised with the provider.

A member asked if there was a more robust way of ensuring that the provider reported back following an incident, and of ensuring that lessons had been learned. Mr Bottomley responded that the OCCG had never had any concerns about the reporting of incidents. An issue which the OCCG was currently addressing in relation to care providers was that the driver for outcomes was sometimes at the expense of good quality care. Dr McWilliam pointed out that generally speaking, there were many routes from which poor quality service became apparent, via inspection reports, patient groups, local members, scrutiny committees etc. Commissioners would also be talking to patient groups.

The Chairman thanked Mr Bottomley for his attendance.

7/16 REBALANCING THE SYSTEM

(Agenda No. 7)

Following discussion at the special meeting of this Committee on 11 December 2015, Paul Brennan, Oxford University Hospitals NHS Foundation Trust (OUH) gave a powerpoint presentation updating the Committee on the pilot project to rebalance Health and Social Care. He stressed that the project was not at end until 31 March 2016, and to date, there were no plans to make it permanent. John Jackson, Director of Adult Social Services was also at the table speaking on behalf of the whole system.

Paul Brennan reported the key issues of concern to date. These were:

- Movements in the workforce as a consequence of the changes were overall in line with projections at this point. However, the numbers of patients needing to be discharged to the reablement service were behind target, due to a reluctance of staff wishing to be transferred;
- Delayed Transfers of Care (DTOC) performance figures were good during the first few weeks of the project, when the numbers delayed dropped from 150 to 90 – but over the Christmas period the numbers had risen as expected;
- Section 5 discharge orders were issued over 7 days per week. However, during friday – monday bank holidays there had been no teams able to discharge patients. This problem was continuing;
- A key challenge was that the number of patients with no home placements was currently at 37. 27 were waiting to go home with domiciliary care and 8

with reablement through the supported hospital discharge service. The total numbers of DTOC was 121 to date;

- Performance from when this initiative was started was at 85%, and at one point had risen to 90%. As a consequence of delays, this had decreased to 75%.

The Committee asked what actions were to be taken to alleviate this setback. Mr Brennan responded that the Team had agreed a series of additional measures to bring it back in line. The biggest single issue was the number of patients needing reablement services provided by Oxford Health (OH). The Team had agreed a programme for all staff to work in the OUH, including part-time and bank staff. A staff incentive had been offered in a bid to achieve an additional 1,600 hours per week in February and March. This measure had had a virtual 100% response rate. Current caps on NHS agency staff had been released in order to remove blocks in the flow of the system.

A member asked how OCCG focused on individual patient experience, having heard anecdotal stories of patients being moved a number of times; of families upset; and patients being taken to nursing homes with little attention being given to reablement. Mr Brennan responded that any feedback was being monitored, and an evaluation would be undertaken in order that patient stories could be compiled. No formal complaints had been received from any patients or relatives, to date. A formal evaluation was also to be undertaken.

In response to a Committee member's comment that District Councils were failing to adapt sufficient homes for people to be discharged to, John Jackson stated that these delays few and far between.

Mr Brennan was asked how many out of county delayed transfers there were. He responded that the figures reported were for Oxfordshire patients only, but at any time there were approximately 20.

When asked if patients were being transferred to locations closest to their homes, Mr Brennan answered that there were 70 homes in different geographical localities and staff did try to match homes to where patients lived.

In response to a question about whether there were sufficient home care staff to ensure people were looked after in the proper way when sent home, John Jackson explained that this was being monitored closely. He added that home care hours purchasing had risen in December/January by 10%. However, demand had continued to grow, particularly for home care and there was concern around getting more resources from the Health sector to support it.

In answer to a question about how many patients had been readmitted to hospital, Mr Brennan responded that the figure was at 14. Some of these were still in hospital and some had been discharged to their own home. A report would be made at the end of the project.

A member asked what was the impact of more GPs leaving the profession. John Jackson responded that the whole question of recruitment was a real priority, to be

identified by the Transformation Board. He added, in response to concern expressed that the doctors' trade union had voted to withdraw their services to care homes, that this was untrue and doctors were not withdrawing their services.

In response to a question about how many acute beds were now closed, John Jackson stated that, from November 2015 to date, the number had reduced by 96 and 20 had been reopened as an extension to the emergency admission unit. He added that this figure was very close to the original proposal to close 70 beds.

Mr Brennan was asked about the current financial position of the programme. He stated that at the outset it had been made clear that although £2m had been made available from the OCCG for this project to the end of March 2016. The current position as at the end of January was £250k below budget. He added that this may well pick up in the second phase of the programme and expressed his confidence that it would come in within budget at the end of March.

Mr Brennan and Mr Jackson were thanked for their attendance.

8/16 CLOSER TO HOME - HEALTH & CARE STRATEGY

(Agenda No. 8)

Dr Joe McManners and Rosie Rowe, OCCG and John Jackson, OCC attended the meeting to give a powerpoint presentation on the Closer to Home – Health & Care Strategy (JHO8). The presentation covered the need for implementation, the Model itself and its development, what the changes would mean for 2016/17, its implementation and finally the planned engagement and consultation on the proposals.

A member asked how and when would the public be informed about the changes. Rosie Rowe stated that engagement with the public had begun and a broad model already presented. However, work with the locality forums on the details was planned to take place over the next two months, which would then lead to more formal proposals. Consultation on these would take place in the Spring/Summer of this year.

A member asked if it would be possible for all consultations for this proposed Strategy, the Transformation Strategy, Intermediate Care in the county, Rebalancing of Health & Social Care could all be run together. John Jackson stated that there was a need to set out specific issues which needed to be addressed now, within the context of the emerging Closer to Home Strategy.

John Jackson was asked when the Committee would see a draft of the consultation document. He confirmed that this would be substantial changes and there would be a lengthy consultation. When the proposed Strategy was brought to the Committee, it would effectively be when the consultation would begin. He added that there would be opportunities to ensure issues were flagged up and included within the consultation. He would also set out a scenario of how it would affect each locality.

Dr McManners asked if the Committee wanted engagement with the public to be 'joined up' in one local area about everything – or would it want it to be repeated in

each locality? The Chairman responded on behalf of the Committee to say that the latter would the most sensible.

A member asked if the future role of the Health & Wellbeing Centres could be considered as part of the Strategy, to include how the existing premises and staff skills could be integrated into working measures. Dr McManners confirmed that the OCCG was looking at local bases for all services, including those of the children's centres, and was considering whether a pooled budget could assist in supporting these services. John Jackson added that there was a need to see these within the context of devolution. He explained that NHS England was requiring all healthcare systems to provide Sustainability and Transformation Programmes by the end of June this year. He added that this was well timed as work was already underway to introduce integrated locality working.

The Chairman, on behalf of the Committee, thanked Dr McManners, Rosie Rowe and John Jackson for attending.

9/16 OXFORD HEALTH FT CQC COMPREHENSIVE INSPECTION OUTCOME

(Agenda No. 9)

Ros Alsted, Director of Nursing, Oxford Health, presented the results of the recent Care Quality Commission (CQC) Comprehensive Inspection Outcome (JHO9).

A committee member asked what was the outcome of the inspection of community hospitals in the county the last time they were inspected? Ros Alsted responded that they had never been inspected by the CQC.

Ros Alsted was asked how the pressures of a significant reduction in beds in Community Hospitals impacted on the report, in particular in respect of Witney Hospital. She responded that the inspection took place at the end of September and at that point Witney Hospital had two wards in operation. There had been no evidence that care outcomes being delivered to patients had reduced.

Ros Alsted was asked if there was anything in the capital budget for improvements to the fabric of some of the Warneford Hospital's buildings. She stated that there was a small recurring capital budget for £5m which could be used to do a small amount of builder's work, adding that a significant amount of maintenance work was undertaken using this budget. Moreover Trusts were expected to raise their own capital, either via efficiency savings or via loans. She highlighted the new mental health campus in Buckinghamshire, costing £43m, as a major investment in estates, but added that it was usually difficult to raise that amount of investment.

A member asked if discharge planning was sufficiently robust in light of recent fatal incidents in Abingdon and Didcot involving ex patients. Ros Alsted explained that these were rare instances, but when they did occur, rigorous internal and external independent reviews were undertaken by the Trust and by NHS England to discuss the findings and to determine if there were any unforeseen issues. Very structured support was also given in these circumstances. A member asked if the Trust learned

from the reviews, to which Ros Alsted directed the Committee's attention to page 43 of the Agenda papers which cited some good learning which had occurred.

Dr McWilliam noted the 'outstanding' CQC result for Children and Young People's Services. The Chairman also congratulated OH commenting that she had met with the CQC during that week and they had stated that OH were providing Oxfordshire with a very good service which was consistent, robust and well-co-ordinated.

Ros Alsted was thanked for her report and for her attendance.

10/16 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 10)

The Chairman welcomed Carol Moore and Eddie Duller OBE of Healthwatch Oxfordshire (HWO). Prior to consideration of the HWO report (JHO10) the Committee asked that its thanks and best wishes be sent to Rachel Coney, the former Chief Executive of HWO, following her departure to a new post.

In response to a number of questions about the capacity of HWO to look at major issues such as the impact on carers/users of the closure of the Health & Wellbeing Centres, Carol Moore stated that it would be difficult to replicate past work on projects such as this, in light of the coming 30% budgetary cut. She added that HWO would be planning to work differently, possibly with colleagues in the voluntary sector.

The Committee asked Eddie Duller about plans to reorganise, given the funding cut to their budget. He reported that HWO had begun an internal reorganisation, to be completed by the end of the financial year 2016. Initial plans had been made on the possibility of raising other means of support which could mean that HWO's impact may not be cut by a third. However, the most expensive events, for example Hearsay! may have to be reconsidered. He added that HWO would ensure that patients were put first as it was required to do.

A member of the Committee asked if HWO was satisfied that carers knew how to find information on support services. Carol Moore explained that feedback given by carers themselves indicated that it was difficult to find the information online, and the online tool did not encourage them to reflect their needs. Work was ongoing to look at this problem.

The Committee encouraged HWO to keep following up on the recommendations their Discharge Project report. Carol Moore responded that most statutory organisations had responded within the required 28 day period, after which the correspondence had been published. She expressed the hope not to have to escalate anything to Healthwatch England, in recognition of the very good relationships established in Oxfordshire.

In response to a question about the publicity on flaws in the data analysis in the Discharge report and whether agreement with the OH and OCCG had been reached, Carol Moore stated that their comments were fair, but had been received too late, meaning that HWO were unable to change the report prior to publication.

A member commented on how powerful the Hearsay! 2015 event had been in attracting so many patients, carers and users to the event. As a result, so much valuable work had come out of it.

Carol Moore was asked about the turnout for the recent voluntary sector conference. She expressed the disappointment of HWO that 70 individuals and groups had registered, but only 30 had attended. Age Concern did not attend. Eddie Duller responded that it was an ideal opportunity, however, to hear the voice of the smaller voluntary groups.

The Chairman, on behalf of the Committee, wished HWO well and congratulated the organisation on their valuable input of views and opinions from users and providers. She also thanked Carol Moore and Eddie Duller for their attendance.

11/16 CHIPPING NORTON - IMPLEMENTATION UPDATE

(Agenda No. 11)

The Committee noted the consultation report of the Director of Adult Services (JHO11) in respect of the future provision of intermediate care in north Oxfordshire; and the decision by Cabinet to implement Model A – the Intermediate Care Unit continues and the full 14 bed service is provided by St John's Care Trust.

12/16 SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST (SCAS)

(Agenda No. 12)

Mark Ainsworth, Director of Operations and Richard McDonald, Locality Director for the Thames Valley Region attended the meeting to respond to questions on the latest progress report submitted by the Trust.

Members questioned Mr Ainsworth and Mr McDonald on the recent fines imposed in respect of response rates. Mark Ainsworth responded that within most NHS services there were penalty clauses. The Trust was working with the DoH to consider how £1m could be reinvested into the service to cover the fines and to address the reasons behind the penalty. He added that there was a possibility that the Trust would not incur the full extent of the penalty.

They were asked what impact the decisions made by the localities with regard to patient transport services would have on the finances of the Trust. Mark Ainsworth responded that the Trust had been successful in gaining all patient transport services across the whole of the Thames Valley region. However, it would have to take care in applying the criteria, or it would have to pay costs if it exceeded other providers. It would depend on whether activity levels increased or decreased.

In response to a question about whether outcomes involving delays since 2011 had been publicised at Board level (for example, delays getting patients to Stroke Centres), Mark Ainsworth stated that data had previously been published nationally and was in the public domain. He added that this was a target that all Trusts struggled with nationally and a significant amount of work was being undertaken with contact centres to identify which calls involved stroke to ensure classification as a red

response. National reports only required data on the Trust's performance – but from Monday next week the Trust was due to go live with Electronic Patients Records in Oxfordshire, to enable more data on patients to be seen more quickly.

A member of the Committee asked if data existed in relation to incidents where a crew had missed their targets, particularly where they were 30 miles away from hospital (page 179 of the Agenda papers). Mark Ainsworth explained that there are typically 40 – 50 red calls across the Trust per day, and each required an 8 minute response. The 8 minute response began on the close of the call. A sample of patients outcomes was taken by the control team/and clinicians, and risk scored according to the level of impact experienced. The intention was to look at the process followed, and if identified correctly, to talk to the patient about his/her experience. A member suggested that the question to be asked was what the impact was for the patient. Mr Ainsworth reported that the Trust did not receive data from the hospitals – any data was received after the patient had left hospital. Dr McWilliam explained that nobody would be able to ask such questions as it implied randomised enquiry which was deemed to be not ethical and unknowable.

A member asked if all calls were met with the same standards. Mark Ainsworth responded that a part of the work of the National Ambulance Response Programme was to look at other categories of calls to try to move them onto a clinical outcome basis.

Mr Ainsworth was asked in what category outside falls were classified as. He explained that they were a green 30, particularly if the patient had fallen outside and they had sustained injuries.

A member asked if the primary care based Out of Hours service was putting a strain on the service. Mark Ainsworth reported that this was being monitored closely and there was to be a national review on the issue. In his view this area was improving despite overnight primary care being limited and GPs not always being available to provide response times. This added to adverse response times for the Trust.

When asked about the 15 minute turn around period from handover of the patient at hospital to the ambulance being ready to leave, Mark Ainsworth stated that this time scale could be variable depending on which hospital the ambulance was at. It was generally looked at on a ward basis. Some hospitals were showing improvements. For example, the John Radcliffe Hospital had dramatically improved the queuing situation by moving their triage to the front of the Accident & Emergency doors. The Horton Hospital was very good and had a 90% achievement rate. The Committee asked to know where and how improvements were being registered.

It was the view of the Committee that there was a need to look at restructuring the 111 service, which was putting a stress on an already very challenged ambulance service, who were one of the largest providers of 111. They **AGREED** that 999 and 111 response rates be brought closer together and to review the part that primary care brings to these services.

A Member asked what happened if the IT service failed. Richard McDonald explained that there were two contract services, one in Bicester and one in Otterbourne,

working virtually and independently. This provided a resilience. In addition to this, the IT linked with other providers, giving a default to landlines.

The Committee congratulated the Trust on the hard work undertaken on workforce recruitment, making it now well staffed. Members also congratulated the Trust on the service given over the Christmas period and the good response from the CQC in relation to the 111 service.

A member asked how the Trust was tackling rural response rates in the west of the county. This was being monitored by the Committee. Mark Ainsworth explained that this was being undertaken by increased numbers of staff on the road in both ambulance and response cars. The Trust was also working with the Oxfordshire Fire Service, by placing co-responders in Abingdon and Didcot and by increasing the number of community first responders. The RAF was also providing a response service. The Trust was also managing demand into the call centres by increasing the numbers of clinicians to sieve calls. Currently, in Oxfordshire there were two clinicians short. The Trust was looking at efficiency in the call cycle times by sorting out the most appropriate calls and the most appropriate car response times and time saving vehicles. The ambulances had stand-by points which gaves a better response to an area. For example, in Witney, cars were based 24/7 on one of the industrial sites with a view to attending all of the Witney and Carterton area within the 8 minute response time.

Councillor Martin Barratt, the Committee's Deputy Chairman, who had been asked by the Committee to look into the data submitted by the Trust, asked a number of questions and received the following responses:

- Why were response times at variance with statistics from the OCCG? – the OCCG present their figures grouped in calendar months;
- In the past the Committee had received data in tabula form for each District, making it much easier to read. Would it be possible to have tabular information for each district, this making comparisons much easier? Mr McDonald agreed to supply the information in this form;
- In the past, the Committee had information on the overall success rates for red calls. This information does not tell us how often a red 8 and 19 response fails? – Mr McDonald agreed that in the future he would try to split out and show the whole number of patients the response vehicles can get to within 19 minutes;
- It is useful to see turn - around times and the allocations to each hospital site. It makes it easier to see the trends – Mr McDonald commented that this could only be done on A & E sites;

Mr McDonald was asked if he could provide turnaround times for the Thame area (Stoke Mandeville Hospital). Mr McDonald stated that the information submitted would include all for local patients, not just Oxfordshire patients.

Mr Ainsworth and Mr McDonald were asked for a plan of improvements to be made that would, in particular, indicate those for the west of the County. A request was also made, as part of the Trust's work to build a whole team of responders; if all parish councils in the county could receive defibrillators? Or should they only be given to first responders? They stated that first responders would deal with calls as first on the scene. Training would be given.

Mr McDonald confirmed that if there was a call to the west of the Faringdon area, it would be put through simultaneously to the South West Ambulance Service. He also confirmed that he was not aware of any response time statistics from April 2014 being revised.

Mr Ainsworth and Mr McDonald were thanked for their attendance.

13/16 THE DISTRICT COUNCIL CONTRIBUTION TO HEALTH & WELLBEING IN OXFORDSHIRE

(Agenda No. 13)

The Committee received a presentation given by Val Johnson, Partnership Officer, Oxford City (JHO13). She was accompanied by District Cllr Anna Badcock, Vice-Chairman, Health Improvement Board and Dr Jonathan McWilliam, Director of Public Health, OCC.

Val Johnson referred to a report commissioned by the Association of District Councils by the Kings Fund, to look at what district councils could provide, particularly at this time of devolution. This report recommended that both the district councils and the Association of District Councils should be much clearer about the impact and measuring impact of added value. It also recommended that District Councils should be actively involved in Health & Wellbeing Boards. She added that in Oxfordshire was lucky in that two district council representatives played a significant role in contribution to discussions, as Chairman and Vice-Chairman of the Health Improvement Board. Cllr Badcock gave her wholehearted support, stating that most of the work of district councils was around public health, a significant part of the work of the Health & Wellbeing Board.

A Committee member agreed that the district councils' contribution to health & wellbeing was impressive, but patchy. She gave an example of the homelessness pathway, where little work had been undertaken outside of the City. She asked what could be done to ensure that every agency was contributing what it could for its residents. Val Johnson stated that District Councils worked together to recognise the needs within Oxfordshire and to ensure the evidence base for it. District Councils recognised the importance of working together to get the most from limited resources that were available, not merely inviting other agencies to do the work. Moreover, the housing teams worked hard to prevent homelessness in the first place. Much of the contribution work was unseen.

A view expressed by some members of the Committee was that district councils needed to acknowledge the need to keep the multi-agency pathway alive. A

possibility could be that the district councils could look collectively funding housing associations for adaptations to prevent falls in the home, for example.

Dr McWilliam reported that housing and homelessness care was under the remit of the Health Improvement Board and currently there was a strong strand of work being undertaken on bringing key partners together. He added that this one issue should not detract from the wide range of work the district councils were engaged in.

The Committee took a view that, in the future, if the topic of obesity featured in the Committee's forward plan, it would be helpful to consider the role of district councils in relation to this. This could include a breakdown of what services are provided and commissioned and stating funding provision.

Cllr Badcock commented that it would be easier to look at the budget breakdown of the Council's themselves in relation to food safety, environmental health etc, which prevented people coming through the NHS system.

A Committee member commented on the need to understand the prospect of devolution and where it was expected that the district councils would contribute, asking, for example, if there was a responsibility for the district councils to respond after the closure of the Health & Wellbeing Centres. Cllr Badcock responded that it was too early to say, as the Kings Fund report had only just been published. It was a very new area.

Val Johnson and Cllr Anna Badcock were thanked for the presentation and for their attendance.

14/16 TOOLKIT

(Agenda No. 14)

The Committee had before them the revised version of the Toolkit for approval (JHO14).

Members of the Committee, on considering Cllr Mills' comments and the proposed Toolkit document commented that:

- Hannah Iqbal had undertaken significant best practice research into how substantial change is assessed in other areas. She had also considered Cllr Mills' comments and it was this process of extensive research that had caused the delay in the final proposed document coming to Committee. The Chairman had also engaged with the healthcare organisations and various providers in order to promote the Toolkit framework;

- The point of the Toolkit was not to enact public consultation with local members and other stakeholders at this stage, that would come later. It was to give some guidance or a steer to the healthcare organisations, through an early dialogue not performed in the public domain, to consider whether public consultation would be required and therefore whether the HOSC needed to know about it formally. There were no constitutional aspects to it and it did not

constitute even an informal meeting. However, with Cllr Mills comments in mind, it was agreed that there be a quorum at these discussions, as required at meetings of HOSC, and that a written note of the discussion be submitted to the next meeting of the Committee;

..... • The onus was on the healthcare organisations to seek the Committee's opinion, not the other way round. If the Committee had concerns about whether a proposal should be the subject of a public consultation, and it had not been the subject of early dialogue, then it would insist that it be submitted to the next HOSC meeting to be considered in the public domain. It was important also to note that members of HOSC attending a toolkit meeting were not required to give a steer. It could be decided to take it to the next meeting of HOSC. It should be noted that a healthcare organisation could, if particular rules and regulations (as stated in the Act) were satisfied around emergency procedure, evoke immediate action on a proposal without public consultation.

The Committee agreed, subject to the following two amendments to the Toolkit document, to approve the Toolkit for future use:

- Paragraph 1, second bullet point down, last sentence should take out the word 'sensitivity' to read (change in bold italics) – 'No substitutes will be permitted given the ***knowledge base required*** of issues to be discussed.'
- B. Assessment criteria – last one – addition of the words 'risks and' so that it reads (change in bold italics): 'Risk: What mitigations are in place to reduce any potential ***risks and*** negative impacts of the proposed change?'

15/16 CHAIRMAN'S REPORT

(Agenda No. 15)

The Chairman gave an oral update of meetings she had attended since the last meeting.

16/16 DATES OF FUTURE MEETINGS 2016/17 (FOR INFORMATION)

(Agenda No. 16)

The Committee noted the dates of future meetings:

21 April 2016
30 June 2016
15 September 2016
17 November 2016
2 February 2017

..... in the Chair

Date of signing