OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Friday, 11 December 2015 commencing at 10.30 am and finishing at 1.40 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair District Councillor Martin Barrett (Deputy Chairman) Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods District Councillor Monica Lovatt District Councillor Nigel Randall Dr Keith Ruddle Mrs Anne Wilkinson
Co-opted Members:	Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Belinda Dimmock-Smith and Julie Dean (Corporate Services)
Part of meeting	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.

115/15 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Moira Logie and Cllr Susanna Pressel.

116/15 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

117/15 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 3)

Clive Hill – Chipping Norton Action Group (CNAG) addressed the meeting in relation to Agenda Item 3 'Rebalancing the Health Social Care System in Oxfordshire')

Mr Hill emphasised that he was not in any way criticising non-NHS nursing care but it was the view of the CNAG that if patients' needs were to be better diagnosed, then nursing care would be better carried out at Chipping Norton Hospital by NHS nurses, who would be better placed to supervise. He added that, from statistics put together by a local resident in Chipping Norton, it had become apparent that NHS nursing performance was significantly better than that of non NHS care. It would then follow that the NHS staffing and manager provision would be best qualified to reduce delayed transfers of care. In light of these statistics he requested that Chipping Norton Hospital retain its NHS nursing staff and managers until the countywide review of community hospitals had been completed. Furthermore, it was the view of the CNAG that Oxford Health had the scope to do the job at Chipping Norton Hospital and, if fairly costed, he believed that this would prove a better alternative. He pointed out that the hospital was ideally situated for this given its proximity to the GP Health Centre and the pharmacy which were on the same site.

Councillor James Mills addressed the meeting in relation to Agenda Item 3 – 'Rebalancing the Health Social Care System in Oxfordshire.'

Cllr James Mills, Councillor for West Oxfordshire District Council and member for West Witney and Bampton, addressed the meeting in his capacity as a County Councillor. He commented that he was broadly in support of the information contained in the paper. He also commended a video on the Oxford University website as very useful in helping to promote understanding. He was keen to understand what made Delayed Transfers of Care (DToC) so urgent particularly as the issues were so long-standing in Oxfordshire. He stressed the importance of communication to the public in order to gain a greater understanding of the issues involved and he asked that information be provided to the public from the service providers at the earliest opportunity. He added that he had expected that the revised 'HOSC Substantial Change' Toolkit would be presented to the last scheduled meeting of the Committee for consideration, which had not happened.

The Chairman responded to Cllr Mills by stating that an explanation had been added to the Chairman's report to the last meeting, which stated that officers were currently looking at best practice from Councils across the country and that the revised toolkit would be presented at the next scheduled meeting on 4 February 2016.

118/15 REBALANCING THE HEALTH SOCIAL CARE SYSTEM IN OXFORDSHIRE
(Agenda No. 4)

The Chairman welcomed the following representatives from the following organisations to the meeting:

- Paul Brennan, Oxford University Hospitals Foundation Trust (OUHFT)

- Stuart Bell MBE, Oxford Health Foundation Trust (OH)
- Diane Hedges and Barbara Batty, Oxfordshire Clinical Commissioning Group (OCCG)
- John Jackson, Oxfordshire County Council) & Oxfordshire Clinical Commissioning Group

The Committee was seeking more information about the proposal that the JR Hospital and others would contract 150 Intermediate Care beds for a 6 – 8 week period and then continue until equilibrium had been attained, to reduce Delayed Transfers of Care (DToC). This was against a background of Oxfordshire's health and social care system having the highest numbers of delayed transfers of care (DToC) in the country. At any one time around 150 patients, whose medical care was complete, had remained in hospital waiting to be discharged. A large number of patients needed some form of ongoing health and social care or rehabilitation in their own homes or nursing home care. Over the past few years a number of plans to reduce the number of DToCs had been developed, but these had not significantly reduced numbers. Whilst there had been improvements to many of the processes which caused the delays, the organisations involved believed that a radical plan was needed to change patient were discharge. The OCCG had offered to provide up to £2m in this financial year to enable patients to be discharged. This funding was a one-off injection of funding. Any ongoing financial implications of this plan would be addressed in the negotiation of contracts for 2016/17. The Committee had requested details on the location of beds, staff and key performance measures to allow for the successful monitoring of this pilot scheme.

Paul Brennan made a presentation giving the detail which had been requested by the Committee at its last meeting. A copy of the presentation was included on the Addenda for the meeting. Information requested included:

- Information about how many nursing home beds status
- Detail on the Patient Transfer Programme
- The purpose and function of the Liaison Hub
- The role of the staff in the Liaison Hub
- The Ward Release Programme
- General Staffing Information
- Key Indicators in use to support the programme
- Potential Outcomes of the Programme

Paul Brennan gave an update from the Liaison Hub established on 7 December, stating that if the programme is successful, the number of patients delayed would fall from the current figure of 167 to approximately 30. By 31 March there was an expectation that there would be no patients delayed. He stressed that some of that number would still be in beds, but in nursing home beds. He reported that, to date, according to the tracking programme which had been put in place for each patient and the Ward Release Programme, 29 had already been transferred by 9 December and a further 18 people had gone home with support. 21 patients were being transferred on the day of the meeting. It was envisaged that 150 would be moved

before Christmas. The main transfer was to commence on 14 December and complete by 18 December.

A member asked who was championing workforce issues to ensure that staff involved were valued. She asked if there was any reliance on agency staff and, if so, what was the financial impact. Mr Brennan responded that staff were working on a flexible basis to support the hubs. The OUHFT were working closely with Oxford Health, the Clinical Commissioning Group and the County Council on this and the staff involved had been given appropriate support and training. Staff came from Social Care, Home Care Support and the Hospital Support Teams and there was no agency care staff. All patient transfers were made with family support. He added that an additional positive benefit of the process was that more staff were emerging with a better understanding of the patient transfer process.

Mr Brennan was asked what support was being given to staff in care homes. He responded that the hub operators would make daily contact with care home staff – and, in turn, staff from the homes would come to the hubs to assist the staff who were in the process of tracking patients.

A member of the Committee was reassured that the numbers of people who had passed away and those that no longer needed care were two separate categories. Mr Brennan stressed that the former group constituted those that were very frail with ongoing illnesses. He added that a move to a more homely environment could be a better pathway of care, but it had to be in a setting appropriate for that patient. He pointed out that many of those who remained for a long time in an acute hospital bed and who did not require specialist palliative care, would much rather end their days in a different environment. In response to a question asking whether patients in DToC situations were necessarily all elderly, Mr Brennan stated that not all were and there were occasions when younger patients no longer needed to be cared for in an acute environment and, following a thorough assessment ,would be transferred to the most appropriate care for their needs.

A member asked about the impact on patients and staff when DToC patients were placed in, say, the orthopaedic ward at the Horton Hospital. Mr Brennan stated that the issues had been discussed with medical/nursing colleagues and they had declared themselves comfortable with these arrangements. He added that some patients might be placed in a side ward, if appropriate, and there would be special training to staff to hand so that they are able to support the transferees.

Mr Brennan was asked how many patients had been able to go to care homes near to their home and how many, needing long-term care, would be able to stay in their placement, rather than having the disruption of being moved again. He responded that all 29 of the people already placed in homes were happy with the location of the move. The Committee, though understanding that all would not wish to stay where placed, asked that continuous attention be given to this issue at all times.

A Committee member commented that there would need to be a big increase in home support if a patient was to be transferred to a home environment and asked if the risks raised by John Jackson were too high. John Jackson explained that in an initiative in 2012/13, only 2% of patients went home. However last year, OCC

received winter pressures monies which enabled more input from social workers, therapists etc and the outcome was that 44% went home. This year the target was 66% to go home. He believed the role of the hub to monitor outcomes for patients was of paramount importance in order to hit the target and meet the needs of patients. This would allow appropriate resources to follow. Those that were going home to no acute medical care would receive short, sharp intensive support in order to help them to re-learn how to do things again.

A Committee member asked what would be the wider impact on the market for beds 'becoming available'? Also, how permanent was the £2m funding from the OCCG? Cllr Mrs Judith Heathcoat, as the cabinet Member for Adult Social Care, came to the table expressing her concern that the market was becoming flooded with only a limited number of beds. John Jackson referred to the background OCCG paper that had been circulated which expressed concern that they were struggling to purchase traditional community hospital beds at value for money. He agreed that it was a big issue to support a cap on a system which was already heavily strained, but there were also benefits. For example, an expanded Emergency Assessment Unit would benefit those patients who were in a ward long term and who were at risk of a deterioration of their health. This would enable more resources to be given to that patient, in the form of, for example, reablement treatment, which could avoid any deterioration and assist them in promoting a quality of life. He added that the nature of this work was fundamentally different to that which had gone before. The Chairman commented that the Committee would expect to be told of any ongoing concerns about the risk element to the plan.

A member of the Committee asked if there were arrangements for rebooking the beds after the 8 week period and also was proximity to people's homes taken into account when booking beds? Mr Brennan responded that beds were booked for an 8 week period and 75 beds were to be kept 'in reserve' until the end of March 2016. Proximity to homes was taken into account.

Cllr Mrs Heathcoat commented that one of the risks was that beds would have to be purchased at the right price, otherwise there would be further pressures on the Adult Social Care budget. Diane Hedges, in response to this, referred the Committee to the background paper which had been circulated (in the Addenda) which explained that if there were excess bed days, there would be an excess daily charge. She added that a further area in which patients could be helped and supported was that, providing there was the right rebalancing of reablement, any money saved could be re-invested into the community. The Chairman stated how important this project was, and crucial that the public get the message that hospital might not be the most appropriate place to be at the end of their lives.

A member echoed the concern about the unknown impact of implementing the national living wage, particularly on the community hospitals. John Jackson strongly agreed stating that he had sent an email to all three Health Chief Executives reflecting discussions which had taken place in the OCC Cabinet on this issue. He stressed that OCC was not in a position to provide additional funding as a consequence of this plan. Any costs had to be met so that resources were available for Health and Social Care in 2016. The Committee **AGREED** that it was important to

carefully track the impact of the plan on other community packages, together with any risk to the OCCG budget.

Diane Hedges commented that there could be too much focus on the risks, wheras the real prize was reaching equilibrium and doing the right thing for the patients in their move from hospital and ensuring the right kind of support for them out of hospital. She added there had been positive developments from this work, such as asking the voluntary sector to work more closely together to provide a consistent response. She emphasised organisations were now working creatively to provide solutions in working together more effectively. Organisations were trying to understand the specific needs of the individual in terms of therapeutic support, domiciliary care requirements etc and directing them to the right care.

A member asked how certain were organisations that the new plan addressed all the previous causes of delay. Diane Hedges referred members to page 34 of the background report for the major causes of delay.

A member expressed concern that patients requiring residential nursing care would not be going to the most appropriate setting. John Jackson responded that the numbers of people going into nursing care was limited, and if they needed that care they would receive it. He added that most of the DToC plan involved patients who wanted to go into residential community hospitals.

John Jackson was asked what systems were in place for complaints. He explained that there was a team of people monitoring the quality of care in community hospitals. They would be talking to residents, staff and families and would be liaising closely with the OCCG Quality Team, GPs and the Care Quality Commission (CQC). A traffic light system was also in operation and if necessary, detailed checks would be conducted. A member asked if spot checks were made. John Jackson stated that Social Care had no right of entry, unlike the CQC who were able to look at records, medicines, staff etc. He stressed therefore, that if relatives had any concerns, they must let Social Care know, who would then notify the CQC. He was also asked how much of a discussion they have with Healthwatch Oxfordshire (HWO) about complaints. He responded that engagement happened with many parties and HWO was an important part of it.

In response to a request that the OCCG would fund a project looking into the mortality rates of the over 85's in various settings, Diane Hedges undertook to circulate the outcomes of the research on completion

A Committee member asked what input the community hospitals were putting into the plan and also what staff Oxford Health was putting in. Stuart Bell explained that, of the 150 beds, 30 were community hospital beds. With regard to staff he said that a very significant part of the whole Oxford Health service was working to progress the Plan. This would comprise part of the Health Visitors team, the whole of the Hospital at Home Team and the whole of the Oxfordshire Reablement Services Team. The Nursing Home Support Team would be working with the Hub. He emphasised that Oxford Health were keen to operate as a 'whole system' alongside the other organisations.

A member asked if the Liaison Hub, and the financing of it, was intended to be a permanent fixture. David Smith referred members to the next item on the Agenda, saying that the OCCG had committed finances for the remainder of this financial year, but subsequently more work would be required from the component agencies working as a whole system to think about how to effect a shift of resources from the acute sector to other forms of care. David Smith continued that the current system, where each organisation was a separate statutory body, carried risk, making it very important to work out what was best for patients and to ensure that no single organisation would be carrying the bulk of it. If this was to be a long-term process then money would have to be pooled.

A member asked if 18 more patients recently able to go home on the DToC project, was it the result of better assessment. Diane Hedges commented that an improved, less fragmented, multi-agency process helped to focus on the patient's needs more appropriately and thus lessened the need for any delay.

All the representatives were thanked for their attendance.

119/15 OXFORDSHIRE DEVOLUTION PROPOSAL UPDATE: HEALTH AND WELLBEING ASPECTS

(Agenda No. 5)

Oxfordshire was currently in discussion with the Government over a county-wide devolution proposal. This had been discussed in Oxfordshire County Council and other public meetings over the last few weeks. One strand of the proposal was specifically about health and wellbeing, and proposed the public benefits of working more closely across all Oxfordshire's health, social care and public health services, and linking these closely with community planning. This built on the close strategic work between the Clinical Commissioning Group (OCCG), the County Council (OCC), NHS England, the District Councils and Healthwatch Oxfordshire through the Health & Wellbeing Board over a number of years. It also built on increasingly close working relationships between Oxfordshire's major NHS Foundation Trusts.

This direction of travel had recently been supported and given impetus by the Chancellor in his Autumn Statement which proposed the integration of NHS and Adult Social Care services across England by 2020. Because of the nature of the discussion with Government, this topic was progressing rapidly. The views of this Committee were sought to help shape the proposals and take the work forward.

Dr Jonathan McWilliam gave a presentation which briefed the Committee on the current thinking behind the proposals made to Government. He emphasised that there had been no formal proposal made to Government, or local decision made on this subject. Dr McWilliam was accompanied by David Smith, Chief Executive, OCCG and Stuart Bell, Oxford Health NHS Foundation Trust (OH).

Dr McWilliam began by highlighting the problems with the current system which were:

- System was very complex, making it hard for the user to use and causing confusion for all. It also made it difficult to scrutinise;

- There were three decision – making systems, causing bureaucracy and duplication;
- Financial Plans were mis-aligned (NHS being over a single year, OCC being over 3 - 5 years);
- Value for money could be improved if there was a single plan;
- There were long-standing issues arising from its complexity, such as DToC.

Dr McWilliam made the following points on how integration and devolution could help:

- Although organisations had started to fix problems (integration of Health and OCC to the sum of £30m), devolution would help to finish the job by bringing together CCG, OCC, Health Trusts and NHS England services, eg Pharmacy, dentistry and specialised services;
- 3 - 5 year financial plans could be aligned;
- local political and clinical leaders would be able to make decisions in one place – thus bringing local democratic aspects to the fore and making one accountable body;
- Services would be easier to use and more easily accessed at a single point, and they would be commissioned in a unified way, via integrated commissioning. Delays would be reduced and duplication would be erased;
- Devolution would improve the health and wellbeing and prosperity for the 670,000 residents of Oxfordshire. By 2020 there would be a decrease in mortality from, for example, heart disease and a reduction in health inequalities.

Dr McWilliam stated that talks had been held, or were to be held, with all District Councils, the Local Enterprise Partnership, Oxford University, the Oxfordshire Health Science Network, the Oxfordshire Safeguarding Boards, the Oxfordshire GP Federations and Age UK. He and colleagues had held conversations and briefings with Healthwatch Oxfordshire who wanted to maintain their independence at this point.

David Smith then explained the process and timescale for the proposals, subject to legislation and full delegation of primary care commissioning for the county from NHS England:

Devolution would mean:

- Co-location of local commissioners for OCCG/Adult Social Care/Public Health;
- A pooled budget for Adult Social Care/Public Health/some Education care services/ OCCG with staff working closely together under a single accountable officer;
- Reporting to a strengthened Health & Wellbeing Board, with scrutiny by HOSC and Performance Scrutiny. All accountable officers were engaged in discussions regarding this;
- Major providers working more closely together. David Smith emphasised that the proposals were not just about co-commissioning, it was about getting the system to work as a whole to improve services and health outcomes for the people of Oxfordshire;

- Bringing together governance/strategy/plans/quality measures.

David Smith reported that, subject to consultation, and subject to OCC and OCCG Governing Body approval, phase 1 of the proposals would mean from 1 April 2016, the OCCG and OCC commissioning would be co-located. Phase 2 would implement a combined budget for Health and OCC (£1.3b).

Stuart Bell stated that Oxford Health supported the proposals as providers, wanting the best possible value for the people of Oxfordshire and improved health outcomes. He welcomed the possible removal of barriers to help focus on what was necessary. He explained that it was the function of the Transformation Board to look at how the Oxfordshire Health & Wellbeing Board could be enhanced to support the new proposals and it was his view that all the right people were on that Board to deliver them, it being a joint endeavour. He added that the most crucial long-term issue for joint discussion was that of the sufficiency of, and the best possible use of staff for the best possible outcomes. He added also that in his view the academic, life science, housing and domiciliary care linkages were also critical to the success of the proposals.

In response to a question from the Committee asking if they foresaw any problems in the differences in financial policies across both organisations, David Smith stated that the proposals would give a better chance of easing the financial pressures across the system. That the recent pilot measures to assist with DToC were a good example of this. He added that the heavier pressures on Local Government, in terms of financial constraint, caused a bigger divide, but they were trying to live with the realities of this in their quest for better value. He added that it would not solve all issues, and the ongoing work the Local Government Association were doing on this topic had resulted in the emergence of some issues. However, there was some evidence, albeit in Europe, that intermediate care was giving better value than traditional hospital care. It was too early to give concrete examples in the UK as yet.

A member commented that NHS bodies had been able to post budget deficits in the past, but OCC had had to balance its books: she thought social care should be strengthened by integration into the proposed system, rather than be made vulnerable by it. David Smith responded that the OCCG was statutorily the same as the Council in that one of his duties as the appropriate officer was that he could not breach his statutory duty to break even. Thus, though financial regimes differed, the dynamics each organisation were the same. Pooling budgets would give more of a certainty for the OCCG of 3 – 5 years funding to better align with OCC'S 3 – 5 year's medium to long term plan. Dr McWilliam stated that the detailed rules and safeguards etc would follow, should agreement be given to the proposals. Stuart Bell explained that Oxford Health did have powers to borrow by virtue of its status as a Foundation Trust, but the Trust had chosen not to exercise it. In the current year the Trust had submitted a plan to monitor for a deficit. The Trust was running at 13% more efficient than the UK average, yet it was still expected to make large savings. He added that the aim of the proposal was to put the staff in the right place, and on staff working everywhere to keep patients well. The proposals would give organisations the ability to set the framework locally.

A member asked if the proposals would require legislative change. Dr McWilliam responded that it was not known at this stage and work would be ongoing with the Health & Wellbeing Board, the OCC Scrutiny Committees and the OCCG Governing Body to address this.

As a result of a query from a member of the Committee, it was confirmed that Oxford Brookes University would be consulted on the proposals.

A member asked the proposals were looking at the benefits of integrating Oxford Health, Social Care and private providers, as well as OUHT joining up with OCCG (GPs). Stuart Bell commented that that was why the relationship in the Transformation Board was so important. He expected that resources would shift over time across Oxfordshire's care, voluntary and community organisations, as had been demonstrated in Oxfordshire Mental Healthcare partnerships. He believed that it was right to focus on developing 'integration' rather than just merging institutions. Dr McWilliam added that the proposals sought to balance both NHS and Local Government input in order to get the best of both worlds. John Jackson commented on the importance of professionals working together in a better way, via co-location of community workers with social workers, for example.

A member asked how much of the proposals could be developed without devolution. David Smith responded that it was probable that a large part of it could be achieved via S.75 provision. However, that would exclude a large part of specialised care and pharmacy, not currently commissioned by the OCCG. He explained that service provision had become fragmented as some services were run by the OCCG and some by NHS England. He added that if NHS England did decide to devolve the current joint budget in favour of the OCCG alone, this would put the OCCG in a stronger position to iron out the spend on services more fairly. He added if devolution failed to go ahead, then the OCCG would press to be represented on bodies such as the Growth Board to ensure their early awareness and involvement in planning for housing development etc and the opportunity to align plans. The Chairman welcomed this, highlighting the Committee's interest in this issue and its intention, as part of its Forward Plan, to investigate how the district councils were engaging with the OCCG and NHS England when planning for housing development, with a view to raising any concerns with the appropriate bodies.

The Committee thanked Dr McWilliam, David Smith and Stuart Bell for the presentation and for the frank input of their views; and looked forward to the consultation if agreement was reached to go ahead with the proposals.

With regard to the issue of consultation, the Committee then asked John Jackson to remain at the table to answer questions on the current public consultation on the future provision of Intermediate Care in the north of the county.

Cllr Martin Barratt reported that West Oxfordshire District Council (WODC) had passed a formal motion questioning the consultation process. John Jackson responded that the comments made by WODC would form part of the responses to the consultation which would be considered by the County Council's Cabinet on 26 January 2016. He added that all OCC's public consultations had to be compliant with

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OCC's consultation requirements and were subject to clearance by the County's Monitoring Officer.

The Committee **AGREED** that it would raise any concerns with Cabinet with regard to the final process and recommendations, if it was found to be necessary.

.... in the Chair

Date of signing