# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Thursday, 4 April 2019 commencing at 10.00 am and finishing at 3.17 pm

**Present:**

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| **Voting Members:** | Councillor Arash Fatemian – in the Chair |
| | District Councillor Neil Owen (Deputy Chairman)<br>Councillor Mark Cherry<br>Councillor Mike Fox-Davies<br>Councillor Laura Price<br>Councillor Alison Rooke<br>District Councillor Susanna Presselw<br>Councillor Nick Carter (In place of Councillor Dr Simon Clarke)<br>Councillor Jeannette Matelot (In place of Councillor Hilary Hibbert-Biles) |
| **Co-opted Members:** | Dr Alan Cohen, Dr Keith Ruddle and Barbara Shaw |
| **Officers:** | |
| Whole of meeting: | J. Dean and S. Shepherd (Resources); |
| **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.*

## 13/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Nick Carter attended for Councillor Dr Simon Clark, Councillor Jeannette Matelot for Councillor Hilary Hibbert-Biles and apologies were received from Councillor Nigel Champken-Woods and Councillor Monica Lovatt.

The Chairman took this opportunity to welcome the Committee's new co-opted member, Barbara Shaw to her first meeting.

## 14/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Dr Alan Cohen declared a personal interest in relation to the Agenda as a whole on account of him being a trustee of Oxfordshire Mind and Councillor Mike Fox-Davies declared a non-pecuniary interest in Agenda Item 7 on account of his previous work in private health care provision and his employment as a senior member of the In Health Team.

## 15/19 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 7 February 2019 were approved and signed as a correct record (JHO3).

## 16/19 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

William Walton presented a petition to the Committee on behalf of the organiser of the petition, Alan Davidson of '38 Degrees', in relation to Agenda Item 7 'Regional PET-CT Scanning Service – Provision' stating the following

'Stop the privatisation of cancer scanning at Oxford's Churchill Hospital. Please intervene in this decision and stop private companies from running this cancer scanning service'.

Signed by 9,712 residents of Oxfordshire

Mr Walton told the Committee that he had been a former patient at the Churchill Hospital. He was discharged two years ago but was participating in a long-term trial which required a number of scans. He stated that many people in Oxfordshire were concerned about this possible privatisation of a health service, which would serve to fragment a very good working system which was rooted in collaboration with other NHS services. He added that the public was outraged at the lack of real communication and evidence and the injury being done to a centre of excellence.

Julie Dean reported the following requests to speak at this meeting – all relating to Agenda Item 7. All addresses were to be made at Agenda Item 7 prior to Committee consideration of the Item:

- Suzy Drohan (on behalf of Anelise Dodds, MP)
- Liz Peretz (on behalf of Didcot Town Councillor Cathy Augustine)
- Oxford City Councillor Louise Upton
- Jackie Beaumont – member of the public
- Jean Simmons – a member of the public
- Mr John Lowe – retired clinician
- Rebecca Rue – a member of the public
- Rob Lawrence – a member of the public
- Barry Neville – a member of the public

- Oliver Ormorod – clinician
- Anita Higham – member of the Council of Governors, OUH

## 17/19 FORWARD PLAN

(Agenda No. 5)

The Chairman reported that he had met with the Chairman of Performance Scrutiny Committee, Councillor Liz Brighouse OBE, to discuss how to delineate the range of issues around mental health service in relation to each Committee's functions, in order to avoid any duplication. It had been decided that Cllr Brighouse would write to the Chairman of this Committee two weeks prior to a HOSC meeting listing those issues which it was thought suited the role and function of this Committee better. These would then be included in the Committee's Forward Plan for consideration at its next meeting.

Following consideration, the Committee **AGREED** the following:

(a) with regard to the November 2019 meeting – Mental Health item – the Committee asked that the report would clearly state the particular mental health contracts this item related to;

(b) to add a report on the Local Health Needs Assessment Framework in OX12 and the Wantage Hospital Task & Finish Group to the Agenda for the next meeting in June 2019; and

(c) with regard to the Health Inequalities Commission's update in six months' time – to present a strategic plan indicating where the remaining recommendations would be reported and managed.

## 18/19 CLINICAL COMMISSIONING GROUP (CCG) - KEY AND CURRENT ISSUES

(Agenda No. 6)

The Committee had before them a report (JHO6) on the key issues for the OCCG, together with the current and upcoming areas of work. These included:

- The NHS Long Term Plan
- Gynaecological Services – Outpatients
- Oxfordshire Vasectomy Service
- South Oxford Health Centre
- Judicial Review Appeal

Louise Patten, Chief Executive Officer, OCCG attended the meeting, together with Dr Ingrid Granne, Clinical Lead for Gynaecology, OUH.

Louise Patten introduced the report, highlighting the following:

- The NHS Long Term Plan – she advised that the Kings Fund had given a good summary of the Plan itself. Group practices, rather than individual GP practices would be working together, via Primary Care Networks, which would ensure a more equitable distribution of services. Mental Health and

digital services would be more of a focus also, via digital technology. In relation to Mental Health services, she explained that the changes would relate to the delivery of services in more of an integrated way across the system so that people would only be assessed once, and an efficient pathway of care would be in place;

- Gynaecological Services - it had been agreed to look to refer patients to alternative providers for a period of 3 months, as a means of tackling the waiting times at the OUH. Dr Granne informed the Committee that the numbers of patients waiting over 18 weeks had now been halved and capacity extended. OUH was also developing a business case to employ additional consultants to ensure that targets were hit. She reported 2,200 patients were awaiting their first appointment. She added that there had also been changes in the operative capacity and theatres could now meet the number of operation requirements. The theatres were also being refurbished in order to cope with the flow. With regard to GP referrals for the location of gynaecological services, it was the GP who made the decision, together with the patient. Quicker appointments depended upon whether the patient was happy to travel to Berkshire or Buckinghamshire. A report giving information on where patients went for their treatment would be submitted to the Committee in due course. In response to a concern from a member of the Committee, she gave her assurance that theatre capacity would also be increased in the north of the county. In addition to this, outpatients would be re-designated to the Horton Hospital;

- South Oxford Health Centre - Louise Patten reported that a mini-procurement exercise was to be undertaken to seek a local resolution. Furthermore, the OCCG was planning for a worse - case scenario in order not to waste any time.

Prior to questions from the Committee on the above issues, Louise Patten was asked when the Physiotherapy services were due to return to Wantage Hospital. Louise Patten responded that the planned date was within the following six weeks, adding that the provider had to agree that the venue was at their own risk. She assured the Committee that OCCG wanted this service to return to Wantage.

Louise Patten was also asked for information with regard to the Health & Wellbeing Board's (HWB) Stakeholder Group Workshop on voluntary sector involvement. She advised that a report was due to be submitted to the next meeting of the HWB.

Questions from members of the Committee, and responses received on the above issues were as follows:

- NHS Long Term Plan – Louise Patten was asked if there would be additional monies available for mental health services, with a maximum amount for children and young people. She explained that Oxford Health was not the main provider for mental health services as it was the voluntary sector, GPs and their staff who also provided services to ensure a smooth pathway. In response to a comment that NHS long term planning was not aligned with the local authorities in terms of time-scale, Louise Patten

stated that OCCG was working with planning colleagues to determine what growth would look like, after which a look at the required health services would be undertaken. She agreed that unlike local government, the NHS's trajectory was only 3 – 5 years ahead, and there was no accuracy after that, adding that OCCG had learned that it needed to work with its County Council and District Council colleagues to reach a level of accuracy. This had the utmost importance for the future as health partners aimed to plan for the buildings they would require which could be as flexible in their use as possible. A member also commented that developers' were building retirement and care homes because they were not required to pay CIL/106 fees. Louise Patten agreed that this was a challenge as care homes attracted people from outside of the county. She added, however, that OCCG was monitoring this and responding accordingly;

- Vasectomy Services – A member enquired about the timescales in relation possible changes in Vasectomy Services. Louise Patten stated that this was the first test of the temperature to undertake initial scoping of public opinion, adding that the next few weeks would decide whether to take further steps. The Chairman stated that this procedure to take the temperature before deciding on how to proceed was a welcome step as far as HOSC was concerned. Louise Patten, in response to a further question from a member, Louise Patten gave her reassurance that OCCG was also taking into consideration the knock - on effects to other services, should funding be re-directed.

  Louise Patten was asked what the pattern was across the Thames Valley for these services and was a lack of consistency a problem? She explained that OCCG looked for value for money for the Oxfordshire pound. A Thames Valley Priorities Committee was the body who would look at an issue and was clinically advised on whether this was, or would become, an area of low clinical value. Furthermore, across the area, Berkshire West no longer provided this service, but Buckinghamshire had continued it. OCCG also checked for local responses on whether it was valued locally or not before proceeding. A member asked why undertake this procedure when there were far bigger priorities elsewhere? Louise Patten explained that nationally it was classed as a low priority treatment – which meant that it had to be reviewed together with the spend. Opportunity cost also had to be considered and weighed up to decide whether to take this forward. She added, in response to a comment from a member, that the OCCG could be relatively accurate with its forecasting and that this particular problem was caused as a result of a surge in demand which was not consistent with overall trends in patient flow.

  Louise Patten was thanked for the update and she and Professor Granne were thanked for their attendance.

  The Committee **AGREED** to receive the report.

## 19/19 REGIONAL PET-CT SCANNING SERVICE - PROVISION

(Agenda No. 7)

Prior to consideration of this item the Committee was addressed and petitioned by the following members of the public:

Alan Davison presented a petition with 9,711 signatures on behalf of the '38 Degrees' campaign. He stated that he had been discharged as a patient at the Churchill Hospital two years ago and was currently taking part in a long-term trial which required a number of scans. He highlighted the outrage expressed by the signatories, who resented the giving of public money to private companies; the start or creeping privatisation and the perceived secrecy behind the procedure. He asked why fragment a very good working system which was routed in co-ordinated collaboration. He also expressed his own outrage at the lack of real communication and evidence and the injury being done to a centre of excellence.

Suzy Drohan read out a statement on behalf of Annelise Dodds MP, who informed the Committee that she had been contacted by an unprecedented number of members of the public, researchers and clinicians, all concerned about the new partnership. Some of these had spoken to her regarding their concerns about the threat of legal action made by NHS England against critics of the new arrangement, on the grounds of care quality. She hoped this Committee would reject these plans for two reasons. Firstly, that it was her view that InHealth lacked the requisite staff to operate the scanner and there was no clarity about how the partnership might develop over time. Secondly, it would create a two-tier system as people from Swindon and Milton Keynes would be required to come to Oxford for treatment from a perceived, poorer quality mobile scanner – and there would be pressure on the service.

**Action -** The Chairman requested a copy of the letter threatening legal action.

Liz Peretz addressed the meeting on behalf of Didcot Town Councillor Cathy Augustine. She stated that, as the contract had yet to be awarded, the process needed to be halted on the following grounds:

- In her view the process was flawed and the OUH bid had not been fairly considered. There was pressure on staff not to criticise;
- The consultation had been conducted online, and for one month only, which, in her view, was inadequate;
- A full consultation was required, together with an impact assessment on financial and medical grounds;
- The full details of the plan needed to be put in the public domain, for example for who was responsible for the upkeep of the equipment, who employed and trained the staff; and who was responsible for the data. Given this lack of detail the Committee could not say what level of engagement was appropriate

She stated that there was still time for the Committee to take the above forward, adding that the OUH was where the scanner belonged. She denounced the sub-

contracting of OUH and called on the Committee to stand firm, not engage and refer the matter to the Secretary of State for Health.

**Action** – The Chairman asked Senior Policy Officer, Sam Shepherd to circulate a list of the other contracts held by InHealth.

Councillor Louise Upton, Oxford City Councillor and Executive Board member for 'Healthy Oxford' stated that she was particularly concerned about NHSE's 'guarded ' comments within their report. She stated that she had not been placated by the recent report that the scanners would remain at the Churchill Hospital, asking if OUH would be receiving less money for services as a result. Her view was that it would be either a lesser service, or at greater cost.

She stated that she had been a patient of the Churchill twice in the last ten years and each time had received excellent, joined-up, world class care which had derived from a shared belief in common endeavour. She added that the scanner was paid for by the state and was not meant to be something for private profit. She asked the Committee to remember the fate of Carillion stating that privatisation could have serious consequences down the line.

Councillor Upton told the Committee that her career had been as a neuro scientist working at Oxford University, which was a leading centre for research globally. It was her view that not only were high resolution scanners crucial to, and a scarce resource for research purposes, but also an important means of extra diagnosis. She urged the Committee to use its influence to stop this 'insane' proposal.

Jackie Beaumont, speaking on behalf of the Oxfordshire Oesophageal and Stomach Association, told the Committee than she had been diagnosed with cancer 12 years ago and re-diagnosed 6 months later. Since then she had been clear of the disease, thanks to the head clinician at the Churchill and his staff. She had four main concerns. Firstly, with regard to quality of service, the OUH was a leading service in PET/CT scanning, which double reported on all scans and which also carried out the radiotherapy treatment. It was her view that InHealth was not able to supply this level of service and would also give a reduced quality of care. Secondly, in relation to safety, InHealth did not supply doctors who would give direct supervision. Thirdly, there would not necessarily be the same facilities for the patients, such as hoists and finally there would not be comparable training and research, which would cause a negative impact.

Jean Simmons speaking on behalf of the Renal Support Group, informed members of the Committee that her partner had been diagnosed with cancer in 2008 and had moved across a number of units within the OUH. Each time, the service he had received had been excellent. Since then her partner had led a cancer education group. She now worked in medical education. She asked if there was a possibility of reversing the decision to outsource the PET/CT scanner, because details of the contract were unclear. She also asked why NHSE had not consulted with staff and patients prior to making the decision to award InHealth preferred bidder status, as the patients could have helped to fight the outcomes via formal and informal links. She also expressed her concern about the possible closure of the current purpose-built centre, which also had training facilities, asking who would benefit from this? It was

certainly not the patients or the hospital itself. She felt that this was a case of 'follow the money'.

John Lowe, a former Clinical Leader, informed the Committee that his employment background in the 1990's had been as a specialist radiographer at hospitals in London. During his tenure he had often requested scans for his patients from OUH, because of its 'persistent high standards'. He then had become a member of the NHS operation and CT scanner team at OUH. The team had seen growth of 20% year on year, so much so that a further machine was required. A large amount of innovation work had taken place. Furthermore, he had worked with 'excellent' colleagues and together they had built up a responsive service. He expressed his concerns about the tender process and about the loss of money to OUH. He concluded by stating that, in his view, the decision to sub-contract had been a 'mistake' and that it 'needed to be in the capable hands of the NHS'.

Rebecca Rue told the Committee that she had been diagnosed with a stage 4 cancer and the diagnosis by OUH had helped to save her life. She expressed her anxiety about other services going along a similar route, which, in her view, would lead to a health care system similar to that of America. She was concerned that this 'excellent' service would be taken away from the next generation, due its privatisation. She urged the Committee to take every action it was able to keep the current service at the Churchill Hospital.

Rob Lawrence stated that he had been a lay member on several project committees as part of the OUH research programme to improve patient outcomes. He expressed his concerns regarding the process conducted by NHSE - and read out a letter he had sent to NHSE expressing these. In it, he stated that he wanted reasons from NHSE for the decisions made in relation to patient outcomes and value for money. He wanted answers to the questions of why this particular company had been chosen, to what extent had patient representatives been consulted about the decision and where was the information in relation to how the contract would be monitored? He added that there needed to be an established trust in the process, taxpayers needed assurance that this was in the patients' best interests and it needed to be publicly accountable.

Barry Neville told the Committee that he had been treated at the Churchill for a cancerous condition since June 2012 and was a resident of Wokingham. On hearing the news about the preferred bidder, he had feared that his ongoing treatment would be compromised and was relieved that the Churchill would continue to provide specialist services. However, more detail was needed. He made reference to the outcry from patient groups with regard to the proposal, emphasising that it was the patients who mattered the most in these circumstances. Mr Neville asked why was the InHealth proposal given preference to that of the OUH - and was there grounds for a re-think? He urged the Committee to give this its full scrutiny and to use its powers to the full.

Oliver Ormorod, Consultant Cardiologist, OUH, stated his concern regarding the decision taken by NHS England, both as a senior cardiologist and as a patient himself. He informed the Committee that within cardiology, much of the screening was undertaken outside of the discipline itself. Therefore, if another scanner was

needed, it was vital to know the details and to hold discussions about funding in a face-to-face manner via a multi-disciplinary meeting. He asked if the heart scanner, which was very specialised, would be lost altogether at the Churchill Hospital? He also voiced his concern about the lack of training and research in radiology, which would ensue if the contract was awarded to InHealth, referring to Professor Harris's letter. Mr Ormorod made reference to the loss of research which was internationally recognised and concluded by stating that he would be interested to hear how NHS England could justify this decision to make InHealth the preferred bidder.

Anita Higham OBE, Elected Public Governor, OUH – made the following points:

- It was her view that, if the contract was awarded to InHealth, a post-code lottery would be created and a private company would be paying a commercial premium to sub-contract the existing service back to the existing provider. She added that this could not be in the public or the patients' best and safest interests;
- It was her view that InHealth had no proven experience in training Cancer doctors, Radiologists, Radiographers or Nurses in Critical Care. She stated that this had to be one of the essential contractual requirements for the delivery of a PET Scanning service in a Tertiary Care Acute Hospital Trust with a global reputation for its teaching and training of clinicians and for its outstanding research;
- She felt that the Committee needed to be reassured that there had been very sound scrutiny of the processes, as a result of which NHS England's Specialist Procurement Officer had judged 'InHealth to be the preferred bidder for this contract. She added that NHS England had claimed that there had been public and patient consultation, but, to her knowledge, none had been knowingly undertaken in Oxfordshire;
- She understood that the highly qualified and experienced clinicians in the OUH's Nuclear Medicine department, were unwilling to work for a private company, the quality of whose work in this, and other clinical contracts, had, she alleged, been poor. She stated that they considered the potential risk to cancer patients' safety was too high and that the OUH could not run the risk of jeopardising its professional reputation, and that of its clinicians as providers of good and sound medical practice; and
- She concluded by urging the Committee to refer this matter to the Secretary of State.

The following representatives from NHS England attended to present their report (JHO8):

- Fraser Woodward, Head of Communications and Engagement
- Nicola McCulloch, Head of Cancer Programme of Care, Specialised Commissioning NHS England
- Dr Wai Lup Wong, Clinical Lead for PET-CT, NHS England; Consultant Cancer Radiologist, East and North Hertfordshire NHS Trust and Honorary Senior Lecturer, University College, London
- Dr Vaughan Lewis, South East Regional Medical Director, NHS England

Oxford University Hospitals Foundation Trust attendees:

- Dr Bruno Holthof – Chief Executive
- Nick Maynard – Consultant, Trust-wide Cancer Lead

InHealth attendees:

- Richard Bradford – Chief Executive
- Ralph Toop – Head pf PET-CT

Dr Wong addressed the paper submitted by NHS England (NHSE) (JHO8). He listed the benefits associated with the plans for the long term as follows:

- Prompt access for patients to diagnostic procedures – 28 days
- A faster, more personalised treatment
- The patient empowered with enabled support via digital technology
- Harnessed benefits of collaboration for research – InHealth (IH) was committed to supporting changes in academia and industry; and
- IH, along with OUH, would ensure PET/CT scanners delivered world class cancer treatment, led by the Churchill Hospital.

Nicola Mcullough made the following points:

- Phase 1 would see the service expanded, at a reduced price;
- It was anticipated that there would be a high level of diagnostic demand, a rise of 10% per annum, which would double the need to secure long-term provision to meet it;
- All of the above was a part of the regulatory consultation which had taken place. Engagement had been for 30 days in 2016, via a county-wide procedure. The original proposal and engagement report was on the NHSE website, together with the responses received. Significant changes to the proposal had been made as a result of the responses. A questionnaire on patient access had also been undertaken, together with 3 patient workshops;
- The NHSE goal was to produce a high quality, accessible service for patients;
- The procurement process had been robust;
- NHSE had also seen an opportunity to expand the partnership and relationship with OUH, thus giving 3 partners working together towards a goal;
- Excellent services would be provided on the Churchill site.

Nicola McCullough accepted, and apologised that events had overtaken them which had resulted in a failure on the part of NHSE to consult with this Committee.

Dr Lewis stated that the proposal had been set out as a part of the national engagement process, prior to regional engagement. He added that NHSE had the original proposal, together with the accompanying statistics, and was happy to discuss these with this Committee in order to widen public engagement.

Dr Holthof, in presenting his paper to the Committee (JHO8) thanked the members of staff and particularly the patients who had addressed this meeting; and also those who had made written representations to the Committee. He also thanked the local MP's for their support for the Centre of Excellence at the Churchill Hospital. He described this time as 'challenging', especially for the staff involved. He added that from OUH's point of view it would always take quality and safety as the most important of principles for the service provided to patients.

Mr Nick Maynard advised that OUH would share its clinical concerns regarding the above principles should the contract be awarded to IH. He added that there had also been very real concern about the original provision in the bid to put a scanner on a site other than that of the Churchill. Mr Maynard also added that IH had moved forward during recent discussions, submitting proposals to address quality and safety concerns – and it was important for the Committee to dive into details of this work. Furthermore, a question to be asked was what would happen to staff, working arrangements and data? He clarified that, in principle, the current proposal was that OUH would run the services and keep ownership of the equipment, with no operational involvement from IH on how to run the scanner.

He joined with Dr Holthof in thanking the staff and patients for their support in expressing concerns which centred on quality, research and training. Mr Maynard emphasised the excellence of the current PET/CT operation, which had proved to be one of the biggest improvements in cancer care, run by Kevin Bradley and Kevin Gleeson at the forefront. He emphasised his view that if this service was lost, patients would receive an inferior and less safe service, and there would be a similar impact on research and training. Mr Maynard added that further research had been conducted into his own area of speciality, which was cancer of the oesophagus, and OUH had refined treatments for this throughout the world. The service received patients from far afield. Moreover, there were frequent, fundamental changes to treatments based on the PET/CT scans which often changed patient pathways from palliative to curative. He stated that Oxford patients received a high quality service throughout the year.

Mr Maynard explained that meetings of the Cancer Multi-Disciplinary Team (MDT) took place each week which centred on cancer diagnoses, strategies etc. PET/CT radiologists also attended each meeting, which was deemed as being of essential value. He added that this input would be lost if the bid was won. In conclusion, he stated that the population of Oxford and the Thames Valley were lucky to have such world class services based in Oxfordshire and urged the Committee not to allow the loss of this service.

Dr Holthof, responding to a question from the Chairman about references to a letter published by the Guardian newspaper regarding legal action, stated that there was a procedure to follow with regard to this and that OUH and NHSE were currently exchanging letters on the process of procurement. He added that the Trust had received no visibility of the part IH had submitted to NHSE.

The Chairman invited IH representatives to comment. They declined but agreed to answer any questions from members of the Committee. He extended his thanks to them for this and for their attendance at the meeting.

Questions, comments and responses received from members of the Committee were as follows:

The NHSE representatives were asked why the consultation had not been cascaded through to the Committee, it being a key stakeholder. Nicola McCulloch responded that no decision had yet been made in relation to the original consultation on what would be provided at a local or regional level. The Chairman stated that the original consultation was not sufficient and the engagement process had not taken place. NHSE would have needed to work through the Committee's toolkit to determine whether this was a substantial change of service; and to notify the Committee that this had taken place.

A member of the Committee added that the report to the Committee did not focus on the impact of the proposals for the residents of Oxfordshire and their concerns. There had been no engagement activity, not even a consultation. She asked how this procurement process would improve services for Oxfordshire residents. Nicola McCullough responded that the original consultation had been for regional services, across the whole footprint, not just for local services. She added that the service to Oxfordshire residents would remain the same and they would experience no change. Dr Vaughn Lewis stated that a significant amount of work was still to be done to refine the proposal; which would then result in the publishing of more detail on the partnership arrangements. This may result in further consultation. Nicola McCullough added that some of this detail was already being sought and would be ready by April/May this year. However, she was unable to discuss it in detail. She also confirmed that NHSE would consider consultation on this.

A member of the Committee asked that if there was to be no change of provision for the people of Oxfordshire, why was a further level required? She added that the Committee still did not know certain details such as who owned the data and who would perform the upkeep of the equipment? Nicola McCullough responded that she understood the Committee's concern with regard to an additional layer, but it was important to have a single, unified team working on this integration. She added that this contract was more about integration than adding an additional layer. It was not intended to create anxiety. With regard to the data and equipment and other details, this would be funded via NHSE and addressed in the contract structure when agreed.

Dr Wong was asked for his view on partnership working. He informed the Committee that he had worked in clinical radiology for 30 years in PET/CT scanning and was seconded for 1 day a week to NHSE to bring a broader perspective to the discussions. He continued that, from a clinical perspective, IH's work on patient safety in relation to PET/CT scanners had been very highly recognised by the Care Quality Commission (CQC) and ARSAL and had been awarded a high level of registration, in particular around PET/CT. Its work ensured a highest level of safety and quality. Dr Wong added the following points:

- PET audits in Phase 1 had shown a very low level (less than 1%) of serious /moderate errors;

- He was a Professor of Radiology and Chair of the Governance Board of AMC delivery. Performance Indicators supported this way of improving standards;
- The introduction of new software and the use of radiology was, as yet, unproven as regards the clinical benefit - knowledge was unsettled. A European medical journal article by Sally Barrington had cast doubt on its benefits.

Mr Nick Maynard stated the following:

- He spoke of his concern that there would not be a doctor present on the site of the scans should medical problems be revealed. Doctors were often called upon when needed;
- There was a lack of concrete evidence suggesting that the new equipment was less than worthwhile. Double reporting at scans was an important practice. Moreover, the length of radiographers' scanning process all contributed to a significantly higher quality of service;
- With regard to Multi-Disciplinary Teams (MDT's) - all cancer consultants were spoken to and it was seen as an essential part of the consultation process;
- The Lymphoma and Oesophageal Cancer Unit had led the world and developed processes in the use of a PET/CT. This had been published widely and the Radiology service had achieved more success in defining the process. The world had followed this lead;

NHSE, at a Member's request, gave confirmation that there was no working relationship in the daytime work of employers from NHSE and IH.

A member of the Committee who had seen the 47 responses received in relation to the Engagement report, asked how IH's bid had been evaluated, as compared to that of OUH. Nicola McCullough explained that the evaluation had been based on 9 separate questions which had been set up. It had been set at relative advantage of the IH and OUH bid under procurement regulations, in relation to patient access and price. On services, the scoring of both had been very similar, but IH had been better. In response to a question asking why quality of service was not present in the first bid, she responded that it was felt that the question of access across the whole geographical area gave patients best quality. This did not mean that the evaluation procedure was not robust. She added that this was a standard approach to the procurement process and the evaluation of procurement. An opportunity was seen to explore a partnership relationship with OUH – three partnerships working towards a goal. This would provide excellent services on the Churchill site. However, she did accept that events had overtaken them and gave her apology for the lack of local consultation. She was asked by a member of the Committee if consideration had been given to the loss of income to OUH, to which she responded that it had not, but the procedure included a financial assessment. Evaluation was made against the published criteria.

A member asked how the Committee could be confident that all would be involved in a future consultation, that it would be open and transparent; and that all would have the opportunity to could share their views. Fraser Woodward stated that a

collaborative solution was wanted by NHSE and he confirmed that there would be an open and transparent consultation.

Mr Maynard stated that IH would not have doctors on site to deal with any medical problems that patients had. He added also that the marginal gains mentioned by NHSE were also included in, and considered essential, in many of the OUH scans.

A Member asked Richard Bradford (IH) how the Directors of IH viewed the statement made by Mr Maynard that 'patients would suffer if the contract went to IH.' He responded that, in relation to quality of service, patient perspective was the most important factor to IH, who had two million patients. He added that friend and family evaluations were published and IH orientated itself around patient satisfaction; and its relationship with 120 trusts across the country bore this out. He wished to make it clear that IH saw itself as working with OUH in a way that added in terms of geography and access for patients outside of Oxford. The scanning speed would also be increased, which in turn would give growth in the numbers of patients seen by 10%. These amounted to improvements to the current scene as regards accessibility and availability, improvements which satisfied the criteria by which they were being judged by the Committee. Nicola McCullough added that, in terms of training, research and peer review factors, IH had produced quality outcomes which the Committee was welcome to monitor. The Head of PET-CT, Ralph Toop (IH) commented, in response to Mr Maynard's statement, that he could only speak for his experience of the success of IH over 20 years and stated that he was proud of what IH provided.

In response to a question from a member, Dr Wong stated that, according to expert opinion, the PET scanner situated in the mobile unit was exactly the same as the static one used at the Churchill. He accepted the Members' point however that patients would need to return to the scanner in which they were first scanned for follow-up and consistency purposes.

Mr Maynard informed the Committee that the length of the scan time at the Churchill differed from that of the mobile scanner in that the patient's trolley had to be transferred between the two and superimposed over, thus making the quality of the scan significantly inferior to that of the static scanner. He explained also that, at the Churchill, the patient went through the scanner for the initial CT scan and then through the same scanner for the PET scan, which took a little longer than that of the mobile scanner. He commented also that there was no consensus on the variation of scanning time making a real difference.

In response to a comment that no consultation had been run on these proposals and the NHSE'S guidance of 12 weeks consultation had not been followed, Nicola McCullough explained that initially there had been public engagement to help them to design the project. Once this was known, then it would be decided whether a public consultation would follow. If, in the event that a public consultation was required, then NHSE would come along to the Committee with proposals for a 6 week period of public engagement. She added that NHSE was committed to a full consultation and it had acted entirely in keeping with this. A member responded that it should have consulted with the public at the first stage. Nicola McCullough responded that the outcome was not known at that stage, other than the structure of the procurement

and patient access in the evaluation process. Once the scale of the change was realised and the type of involvement required, then public involvement would be very robust. She reiterated that the public consultation would be undertaken, if required at the local level. She stated that she was confident that the evaluation process had been met, in that it had been very specific. However, the initial engagement process had only been informal.

Dr Wong was asked if the initial process had included access to multi-disciplinary teams. Dr Wong responded that this was about improving relationships with clinicians etc. He added that a model and relationships of an integrated team had been set out for Oxfordshire, together with the wider Thames Valley. He pointed out his lack of understanding of why some of his patients had to travel so far from their homes to Oxford for scanning, asking why they could not be done more locally. He added also that the model that would be taken forward would include the scanning for rare tumours. Dr Wong emphasised that there would be no change in treatment for the residents of Oxfordshire. Nicola McCullough added that they were at the Committee that day to set out the process that NHSE had agreed to work through. There would be a full local consultation where full clarity would be provided, adding that it was difficult at this stage to provide that.

Dr Wong and Nicola McCullough gave the following assurances in response to questions from the Committee. In relation to the:

- possible loss of finance to OUH, due to the privatisation of the scanner? - this would be undertaken via the usual contractual procedures with the standard guards;
- loss of the worldwide reputation of OUH for research practices? – this was not part of the normal NHS contracts for clinical activity. Research activity was funded entirely separate from this and was a matter for the Trust itself; and
- a public consultation had not taken place to date. Both bidders had been informed that NHSE needed to undergo meaningful public involvement exercises.

On the conclusion of the discussion the Committee **AGREED** (unanimously on a motion by Councillor Arash Fatemian, seconded by Councillor Alison Rooke) to inform NHSE that the Committee intended to:

(a) refer this matter to the Secretary of State for Health on the following grounds;

(1) this Committee has not been consulted in accordance with its standard procedures prior to this contract going out to bidder status and the Committee is not satisfied with the reasons given for this; and
(2) for this reason, the proposal is not in the best interests of the patients.

The Chairman then instructed NHSE to halt all further work on this contract until the Secretary of State had given it his detailed consideration.

## 20/19 DENTAL SERVICES AND DENTAL HEALTH IN OXFORDSHIRE
(Agenda No. 8)

It was **AGREED** that this item be deferred to a future meeting.

## 21/19 UPDATE ON TRANSITION OF LEARNING DISABILITY SERVICES: BENEFITS FOR PATIENTS
(Agenda No. 9)

It was **AGREED** that this item be deferred to a future meeting.

**MEETING ADJOURNED FOR LUNCH: 1.30 PM**
**RECONVENED: 2.00 PM**

## 22/19 UPDATE ON RECOMMENDATIONS FROM THE HEALTH INEQUALITIES COMMISSION
(Agenda No. 10)

Jackie Wilderspin (Oxfordshire County Council) and Dr Kiren Collison, Oxfordshire Clinical Commissioning Group) attended to present the review of progress made (**JHO10**) in relation to the Health & Wellbeing Board's Health Inequalities Commission report.

In response to questions the Committee was advised:

- Data collection was still a concern but it was improving. In particular the equity audit was difficult when there is no record of ethnicity in 10% of cases. However, 90% was still a significant improvement. The new GP registration recorded ethnicity and hospital statistics were also improving.
- Work was underway on a prevention document and the impact of poverty and resource reallocation would be part of that work.
- Districts were involved in the Implementation Group and there was an awareness of geographical inequalities. It was suggested by a member that the Committee should look at the Prevention Framework at a future meeting. In relation to scrutiny of the 5 principles it was thought that this could be part of the scrutiny of the Health & Wellbeing Board in June.
- The Implementation Group was focussed on health and health outcomes and were not considering wider implications of Growth. The Committee was advised that it could be part of a wider discussion and that the Oxfordshire Strategic Partnership still met. The Chairman suggested it could be a matter for the new Director of Public Health to take forward and that it could come back as an action to a future meeting.
- Responding to questions as to what the specific health needs of the BME communities were the Committee was advised that there were inequalities. By understanding the nature of the disadvantage it was possible to address them. For example there was some increased prevalence of some diseases in various communities such as diabetes or sickle cell anaemia.

The Chairman noted that the new Director of Public Health would be in post shortly and he proposed and it was **AGREED** that the matter be looked at again in 6 months with a Strategic Plan to consider the way forward.

## 23/19 OUH - PROGRESS AGAINST QUALITY PRIORITIES 2018-19

(Agenda No. 11)

Dr Clare Dollery (Oxford University Hospitals Foundation Trust) attended to present the annual report on key progress against OUH stated priorities.

The Committee commented:

- On the cardiac arrest reduction target for 2018/19 that had not been achieved. The Committee was advised that it followed on 10% reductions in both of the previous 2 years. Over time more and more of the most well patients had received ambulatory care meaning that only the most ill patients were treated as in patients.
- That the layout and presentation of the information could be improved by being clear about the objectives, what was achieved and what was to be done where targets were not achieved.
- That it was important to be looking at the right metrics and that they were clear.
- That there was little detail about HART. A member suggested the need for a radical rethink and that there were geographical challenges to be met. It was queried what involvement there had been with the County Council. Dr Dollery commented that OUH was committed to working together and that there was a better relationship following the CQC System Wide Review.
- That measures to address the numbers of stranded patients did not seem to be working. It was noted that although the number had reduced significantly it was still high.
- On the usefulness of the current process and whether it could better link to the Health & Wellbeing Board priorities. Dr Dollery explained how it worked alongside the constitutional targets and the work being done to ensure that risk was considered alongside operational matters.

Dr Dollery responded to questions:

- Members queried why the survival rate for 2019-20 did not show a split between men and women. Dr Dollery stated that she was unable to advise on the gender split but would take the query back.
- There had been 16 never events this year which was a source of real concern. This was reflected in the current priorities.
- Dr Dollery explained the process for setting priorities. She added that something not being a current priority did not mean that work would stop.

Dr Dollery was thanked for her presentation and attendance.

## 24/19 HEALTHWATCH OXFORDSHIRE (HWO)

(Agenda No. 12)

Rosalind Pearce, Chief Executive Officer of Healthwatch Oxfordshire (HWO) to report on views gathered by HWO and its latest activities. (**JHO12**).

Ms Pearce undertook to provide to the clerk for circulation to members a presentation that had been made to Health & Wellbeing Board (HWB) relating to the first Stakeholder Group meeting asked for by HWB. This was the start of the process of better engagement with the voluntary sector.

Ms Pearce responded to questions:

- In response to a question concerning the PET scanner service being retained at the Churchill being described by HWO as good news Ms Pearce explained the context of the remarks and the information it was based on. On the face of it was good news in terms of location. They had to focus on patients and outcomes.
- Referring to the first of the six monthly meetings held on 28 February Ms Pearce indicated that there had been 6 or 7 members of the Health & Wellbeing Board present. Feedback would be a regular item on HWO reports to this Committee.

## 25/19 CHAIRMAN'S REPORT

(Agenda No. 13)

In addition to the submitted report the Committee noted a verbal update from Councillor Fox-Davies, Chairman of the Task and Finish Group on Local Health Needs Assessment in the Wantage Locality

It was AGREED to receive the Chairman's report.

..... in the Chair

Date of signing .....