

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 17 September 2009 commencing at 10.00 am and finishing at 12.30 pm

Present:

Voting Members: Councillor Dr Peter Skolar – in the Chair

Councillor Tim Hallchurch MBE
Councillor Jenny Hannaby
Councillor Sarah Hutchinson
Councillor Ray Jelf
Councillor Don Seale
Councillor Lawrie Stratford
Councillor Susanna Pressel
District Councillor Richard Langridge (Deputy Chairman)
District Councillor Rose Stratford

Co-opted Members: Ann Tomline
Dr Harry Dickinson
Mrs A. Wilkinson

Officers:

Whole of meeting J. Dean and R. Edwards

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.

47/09 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for Absence were received from Councillor Dr Christopher Hood and Councillor Jane Hanna.

48/09 MINUTES

(Agenda No. 3)

The Minutes of the last meeting held on 16 July 2009 were approved and signed.

With regard to Minute 42/09 – Parkinson's Disease Services – Roger Edwards reported that the PCT had responded in relation to recommendations (a), (c), (d) and (e). The Chairman and Deputy Chairman undertook to decide what action to take, once responses had been received from all parties.

49/09 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 5)

Members of the Committee questioned Adrian Chant, Locality Manager, Oxfordshire LINK, Mary Judge and Anita Higham, members of the Steering Group with regard to the update which had been circulated.

They were thanked for their report and for responding to the questions.

50/09 NOMINATION OF DELEGATES

(Agenda No. 6)

The informal South Central Joint Health Overview & Scrutiny Group

The South Central Joint Health Overview & Scrutiny Group comprised all of the HOSCs within the South Central region. In previous years, the Oxfordshire HOSC had sent two delegates (together with a substitute) to these meetings. The Committee were asked to provide nominations to represent this Committee.

It was **AGREED** that the Chairman and Deputy Chairman would represent this Committee at these meetings. In the event that one or neither could attend, then a substitute, or substitutes would be sought from the Committee's membership.

Informal meetings with senior managers from various NHS Trusts.

A number of informal meetings had taken place during the year, and in previous years, with senior managers from the Primary Care Trust and the other Trusts. The purpose of these meetings was to keep abreast of emerging issues. The Chairman attends each of the meetings as a matter of course, however, it was necessary to nominate a further member to attend with him.

It was **AGREED** that the Deputy Chairman would accompany the Chairman to these meetings. However, should there be an issue of interest to another member of the Committee, then that person would also be invited to attend.

51/09 PUBLIC HEALTH

(Agenda No. 7)

Dr Jonathan McWilliam, Director of Public Health, reported the following:

- His third Annual Report, reporting on 2008/09, which had contained recommendations for 2009/10, had been approved by the County Council on 8 September. The report aimed to continue the focus very firmly on the five main long term threats to public health, which were:
 1. Breaking the cycle of deprivation.
 2. An aging population – the 'demographic time bomb'.
 3. Mental health and wellbeing: avoiding a Cinderella service.
 4. The rising tide of obesity.
 5. Fighting killer infections.

There had been an emphasis throughout the report on two critically important areas:

1. The impact of the credit crunch and the recession.
 2. The importance of carers;
- Pandemic Flu – Preparations were being made for the second wave of pandemic flu. Its intensity could not be predicted. A major focus for the preparations was on ensuring good primary and secondary services and enough intensive care beds, the numbers for which could be expanded, if needed. Vulnerable groups would now be immunised at the appropriate time;
 - The Health & Well-Being Partnership Board were currently focussing on arriving at a shared plan on how services for older people might be commissioned jointly.

The Committee questioned Dr McWilliam on a number of issues with regard to the above.

52/09 TRANSFORMING COMMUNITY SERVICES (Agenda No. 8)

The Transforming Community Services Policy had been launched by the Department of Health in January 2009 in order to strengthen PCT capabilities in delivering community services. It aimed to enable transformational change and support the provision of high quality care which was responsive to local patients and communities. Along with all other PCTs, NHS Oxfordshire had been charged with transforming the commissioning of services in line with World Class Commissioning criteria and assuring that organisational arrangements were fit for purpose. This comprised a wholesale review of community services and high level market analysis, together with a PCT Board decision on the most appropriate options for future organisational form for its provider.

A paper was before the Committee (JHO8), which was presented by Catherine Mountford, Director of Strategy & Quality, Oxfordshire PCT and Geoff Rowbotham, Managing Director of Community Hospitals, Oxfordshire.

Mr Rowbotham commented that the internal processes were about separating out the Community Hospitals Oxfordshire (CHO) strand from within the PCT. This process of change had been part of their focus over the past six months. It was designed to ensure that, as an organisation they could respond in an innovative way to allow challenge to be made more openly. He added that this would work as long as they worked in partnership with other providers. CHO coordinated a plethora of services within the community, which was a key part of its success. In reality, CHO was a separate entity, although legally it belonged within the PCT. It had its own Board, its own financial accounts and its own sense of direction. He added that there was a recognised need to get back to basics with the provision of community based health care. Over the next 6/9 months CHO would be looking at key core services such as

district nursing to see how they might be driven forward, in partnership with key partners.

Members of the Committee asked a number of questions, some of which are included below:

Q Much of Oxfordshire is rural - will there be sufficient funding to allow district nurses to travel between patients? Where will you recruit from and has the Council got sufficient funding in place to enable it to happen?

R (GR) CHO has the funding and can decide which areas it wishes to spend on. Mr Rowbotham stated that he had had a number of meetings with district nurses to hear their views. He added that Oxfordshire had an ageing profile with regard to district nursing staff and this needed a response and a strategy. At the moment the district nurses saw themselves 'in limbo', but there were exciting opportunities for the service.

Q Will the services be in place at the right time? Are there sufficient resources in place? How will we find out whether patients are satisfied?

R (CM) From a community point of view we have worked with the patients, public, CHO, ORH etc. We have got to get a lot better at checking patient experience ourselves or via our providers to ensure that we act on what is not working. We have done a technical 'unbundling' of the tariff to ensure that part of the money goes to CHO to run the services.

GR added that it had been demonstrated by the beneficial changes made to Stroke services within the county that communication can be handled well. It is also a very good example of what can be done, quickly and effectively. The patients and public will quickly see significant benefits – there are good examples already emerging. With regard to feedback on our services, the commissioners are doing it and we also do our own surveys. We also meet with the public regularly in order to monitor what they are saying – as well as taking analytical data .

Q Are you asking people what they want? Are you, for example, linking with colleagues in the Oxfordshire LINK?

R (GR) We do ask and we do listen. As a result we are opening an interim community hospital in Oxford. In the meantime we are asking for representatives to input, discuss, and get actively involved in the decision making.

Q If the public say that 20 beds at Oxcomm are not sufficient, will you give them 28?

R (GR) If a case is made for 28 beds then we will respond. We need to manage the whole bed base across the whole of Oxfordshire. Wherever we can put local patients in a hospital local to them, we will, but we cannot always guarantee it. At the moment our work indicates that 20 beds at Oxcomm is a sufficient number. If this proves to be wrong we will have to respond to it.

(CM) We are asking what is important to the public in accordance with national guidance about where the PCT should be focussed. We continue to have open conversations with the public, asking what is important to them, how it should be done and how they ought to be delivered.

Q Will you be able to satisfy public expectation? It could be that you will not be able to afford everything?

R (GR) There is no spare money. Like Social Care we have a very challenging efficiency programme this year. We have the ability, now that we are a separate organisation, to respond to the community agenda and make our allocations appropriately. This is a very challenging period in that we have to help the public to understand that we have choices to make and get their backing for those choices. If we, for example, decide that we are going to drive more effective district nursing services, something else will have to give.

(CM) We recognise that, in order to make the best use of the £800m, it will be necessary to work together with the main providers and the public. For example, there is to be a seminar next week with partners, including the Chairman and officer of this Committee, to focus on this very issue.

Q How are these arrangements an improvement?

R (CM) There is now a contractual relationship in place. CHO have their own funding, and this cannot be taken away for other projects.

(GR) This would certainly show significant benefit to any organisational change. The question as to whether it would give a better basis for the provision of better services – this has not yet been proven.

Q How do you propose to link in with the providers of the Mental Health services, given that it is often not obvious that people have mental health problems?

R (CM) We have, as commissioners, strategic goals in this area for the next 5 years, significant parts of which will be jointly led by the PCT, the County Council and a Mental Health Strategy. The providers already work closely with the mental health services.. The PCT are doing a significant amount of work in developing community Mental Health services.

(GR) There are three areas where we will be working with the Mental Health Care Trust; Huntercombe Prison, the homeless centre and the PCAMS service.

(CM) There is significant input from the Community Psychiatric Nurses into the Intermediate Care Team in terms of the provision of support to people with mental health problems and to people with dementia.

Q (To GR) How do you see your style in the future in view of the CHO separation?

R One of the current debates has been about its future form. A paper is going next week to the PCT Board to discuss what form it can take and the next steps. It is crucial we involve the public in the debate.

Q How many district nurses will you need?

R (GR) 200 at the moment. We need to look at what the retirement rate is and what role we want them to perform in a new healthcare market which is community based.

Q What monitoring arrangements have you made to ensure that all the services will be joined up?

R (CM) There are no separate conversations - the providers are coming together to say that they will be able to deliver a particular service. The Partners

know how best they will be able to deliver a service – they want to engage with one service called ‘NHS’.

Q Now that you are set up as a separate organisation, are you anticipating any extra costs? Will you, for example, be setting up administration which might otherwise have been used for service provision?

R (GR) There are additional costs and we are aware of it. We have to demonstrate that we can provide a more efficient community health service and that the benefits outweigh the cost. CHO is very outcomes focussed, we do not see it as a cost, but as an investment.

Following a full discussion and question and answer session, the Committee thanked Catherine Mountford and Geoff Rowbotham for their attendance and for making themselves available for the question and answer session.

The Committee were pleased to learn that the NHS would respond to a case made for additional beds to be provided in Oxford, should it be deemed necessary in the future; and also that there was sufficient funding ring-fenced for CHO to carry the plans forward for Oxfordshire as a whole.

Members also stressed the importance of ongoing formal and informal consultation with this Committee, and other parties, at each phase of the project.

53/09 THE NEW OXFORD COMMUNITY HOSPITAL (Agenda No. 9)

The Oxford Community Hospital (Oxcomm) had existed on the Churchill Hospital site for a number of years, closing in May 2008 due to issues relating to facilities design, maintenance and control of infection. Alternative provision for community beds had been made at other community hospitals within Oxfordshire and at the Albany Care Home in Headington. In the autumn of 2008, the Oxfordshire PCT outlined to this Committee proposals for the re-provision of community services formerly provided by Oxcomm. In March 2009 Alan Webb, director of Commissioning, Oxfordshire PCT, made a commitment that 20 beds would be available for community rehabilitation by October of this year whilst a longer term proposal was being developed.

Community Health Oxfordshire (CHO) had been commissioned by the PCT to provide the service. It had now been confirmed that the service would be provided by CHO on the John Radcliffe (JR) site.

Carol Knott from CHO, Dr Peter von Eichstorff, a Practice Based Commissioning lead for the City and Dr James Price, a specialist in care for the elderly, ORH, working in several of Oxfordshire’s community hospitals, gave a presentation on a document which was before the Committee entitled ‘Community Health Oxfordshire, City Community Hospital, Communications Strategy (version 1)’ and, at the invitation of the Committee, formed a panel in order to respond to questions.

Dr Price commented that there had been very positive engagement with the various partners in relation to the model, adding that the PBS partners were very happy with the way services would be delivered for their patients.

Q Would patients residing outside of the City be able to use the facilities offered by the City Community Hospital?

R (CK) We would like to get patients as close to home as possible. There are very definite criteria for patients admitted to wards.

(JP) No Oxfordshire community health services have an absolutely defined geographical area. We have to take into account the clinical needs of the patient and the facilities provided. If a bed is not available at the Oxford City Community Hospital then there will be alternative facilities at other community hospitals. We juggle with this every day, looking, not simply where the patient lives, but where their relatives live, where the appropriate facilities are and the needs of the patient.

Q Is the sensory garden on the same level? Would it be possible to have the number of beds available and how many of the patients got their first choice? What makes it a community hospital rather than merely a ward in the JR Hospital?

R (CK) The sensory Garden will be on level 4 – it is currently being developed.

With regard to the bed numbers, the Commissioners will provide a written answer to that. The Hospital offers up to 20 beds on a flexible basis. Physically there is a footprint of one ward at the moment. It would be difficult to push extra beds in but, if necessary, we would use escalation beds elsewhere. An additional improvement has been that we have separated the sexes.

(JP) Within the 20 bed arrangement for the City Hospital, there will be no escalation beds. However, the acute sector have well thought through plans for escalation bed availability for the whole of Oxfordshire. This sounds rather inflexible, but, for example, it would be more convenient for people living in the peripheries of the City, such as in the Botley and Littlemore areas to go to Abingdon Hospital. We work within the constraints of the system to find a solution. The refurbishment will deliver, within an acute medium, the best quality physical environment possible. He added that the staff approach would be very different in relation to the post acute, therapeutic area.

Q Once phase 2 is up and running, will you have the ability to increase the numbers of beds available if the situation is deemed to be not working?

R (CK) Yes – the JR flexes its space. Within the confines of the physical footprint, there are adjacencies which could be used if needed in phase 3 possibly.

(JP) We need phase 2 to be future proofed. Arrangements have been rather ad hoc in the past, we are looking to a more logical provision on an incremental basis.

Q Will there be a review after 12 months?

R (CK) Yes – there will be an ongoing review.

Q Will Oxfordshire PGs receive priority over beds for their patients? Who decides how this is going to work?

R (JP) The patients admitted will be divided into two groups – those acute patients who are receiving rehabilitative/palliative care and those patients residing in the community; operating between the doctor on the ward and the senior nurse. They will have the final say throughout all the community hospitals, liaising with the professionals who want to refer and admit patients.

Q Will there be special provision made for car parking at the JR Hospital?

R (CK) There has been no special provision made for parking.

Q Will the progress of discharged patients be monitored?

R (CK) Yes, their progress will be monitored by social care, medical and nursing staff.

Q Will this help the situation in relation to delayed discharges of care?

R (CK) This is being regulated. There is an emphasis on bringing the numbers down. It is believed that there is a downward trend.

Q Has any training been put in place for auxiliary staff for the care of vulnerable older people?

R (CK) This is very high on the agenda. Training is all competency based.

Q You seem very confident that 20 beds are sufficient for Oxford City. Do you plan to roll out this model of care to other community hospitals?

R (CK) We need to look at the whole picture in the light of improvements to length of stay etc. At the moment 20 beds is an appropriate number, but this will be reviewed. There has been investment in specialised stroke beds elsewhere and investment in the total number of beds has remained the same. We would be happy to review it, if necessary.

(JP) There will be times when Oxford residents will require 30 beds or 15 beds. We can give no guarantee that we will be able to offer a bed in Oxford to Oxford residents – sometimes patients will have to be treated outside of the Oxford boundaries. If it becomes necessary the commissioners and others will have to take a further look at the situation. There has been huge progress during the last few years in terms of improvements to the quality of patient care. This is ongoing and very positive.

Q What about provision for those areas outside of Oxford? You say that the overall number of beds will not change – have you taken in account the projected rise in population? Will there be an impact elsewhere?

R (JP) I have no doubt that Oxfordshire has sufficient hospital beds - whether they are in the right place is an important consideration as there are a number of patients in hospital beds who could actually be in their own home. The issue in the medium term is about the reshaping of the number of beds. An immediate problem is the delayed transfers of care. It is important that we do not duplicate what is available nearby. The JR has a specialist day care facility on level 4.

Councillor Larry Sanders, a local City councillor, raised the following points:

- The bed numbers for Oxcomm started at 30 for half of the City, now it is 20 for the whole. He was not convinced that it met need – but he was pleased that this number could be revisited speedily, if necessary;
- NHS Oxfordshire should not be planning on an inadequate resource;
- Most community hospitals have very effective and useful Friends organisations. He hoped that real work would be put into creating one. This would be a significant step forward for users;

- He asked if the planners had consulted with Adult Social Care. CK responded that they had not in relation to phase 1, due to the tight time frame. However, they had consulted with 50+ groups in relation to phase 2 and had been very comprehensive in identifying all groups;
- He asked how guaranteed was it that the money was in place for all 4 phases? CK responded that there had been a commitment that money was currently available but this had to be taken within the context of changes to health care needs locally. GR commented that he was confident that the money would be there and if it wasn't, it would be found.

The Committee thanked Carol Knott, Dr James Price and Dr Peter von Eichstorff for attending the meeting and for responding to their questions. They expressed their satisfaction with the plans to date and were pleased to receive clear assurances about the funding of the project. However, they reiterated the need for ongoing formal and informal consultation with the Committee, users, voluntary organisations etc and the importance of maintaining a degree of flexibility over bed numbers.

54/09 FORWARD WORK PROGRAMME (Agenda No. 10)

The Committee were asked to consider items that it might wish to see included within the Work Programme during the ensuing twelve months. The Committee was advised that, depending upon the items chosen, decisions would be required on whether work would be undertaken by the whole Committee or by working groups. Members were reminded that these items would be in addition to issues that would have to be considered in response to plans and proposals from the local NHS.

It was **AGREED** that the following items would form the Committee's work programme for the coming year: each issue to be examined in 'select committee' style format:

- NHS Trusts employing older workers (for example, up to 70 years of age) with flexibility around hours and duties;
- Mental Health – to review strategic progress on common mental health issues;
- Partnership working to improve people's health and prevent illness (it was anticipated that this would include health inequalities);
- Alcohol misuse; and
- Access to NHS Dentistry.

Members of the Committee undertook to contact Roger Edwards by Friday 25 September giving their preferences with regard to a priority for the above items and the outcomes would be reported to the next meeting.

55/09 CHAIRMAN'S REPORT (Agenda No. 11)

The Committee noted the following:

- Further information on Parkinson's Disease services (see Matters Arising above);

- An informal meeting had taken place with the Board Chair and the Director of Planning & Information, ORH;
- An informal meeting had taken place with the Chief Executive and Medical Director, Oxfordshire PCT;
- Joint work had taken place with the Buckinghamshire HOSC in relation to concerns about the provision of care of patients at Thame Community Hospital. With regard to this it was **AGREED** that Councillor Nick Carter, local member for Thame, would represent the Committee on this matter; and that he would provide a report back; and
- The 19 November meeting of this Committee would have as its main item, proposals for the future of services at the Horton Hospital, Banbury. This followed from the detailed work that had been ongoing since the Secretary of State for Health rejected the proposals for change as proposed by the ORH. In view of the importance of this matter for people living in Banbury and its surrounding area, it had been agreed that the meeting should take place at Cherwell District Council, Bodicote House, Banbury, starting at 10am (pre-meet at 9.00am).

56/09 TEENAGE PREGNANCY
(Agenda No. 12)

An update was given on progress made by the working group.

57/09 INFORMATION SHARE
(Agenda No. 13)

- (a) The Committee were informed that Joint HOSC Committee had been set up to review the work of the South Central Ambulance Service (SCAS) with particular reference to their performance in rural areas. The review would take place in late November/early December. The Committee would comprise members of the Oxfordshire, Buckinghamshire, Hampshire and West Berkshire HOSCs, and would include non councillor members; and
- (b) Councillor Don Seale, Chairman of the County Council's Adult Services Scrutiny Committee, informed members of the work being undertaken by his Committee, in conjunction with John Jackson, Director for Social & Community Services, to provide a response to the Green Paper entitled 'Care & Support: Shaping the Future of Care Together'.

The meeting closed at 12:30 pm.

..... in the Chair
Date of signing 2009