Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 15 November 2012 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Rose Stratford

Councillors:	Jenny Hannaby Jim Couchman	Anthony Gearing Gillian Sanders	Keith Strangwood Lawrie Stratford
District Councillors:	Martin Barrett Christopher Hood	Susanna Pressel Alison Thomson	
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes:

Date of next meeting: *17 January 2013*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk

Committee Officer - *Claire Phillips, Tel: (01865) 323967*
claire.phillips@oxfordshire.gov.uk

Peter G. Clark

Peter G. Clark
County Solicitor

November 2012

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 8)

To approve the minutes (**JHO3**) of the meeting held on 27 September 2012 and to note for information any matters arising from them.

4. Speaking to or Petitioning the Committee

5. Public Health (Pages 9 - 12)

10.15

The Director of Public Health, Jonathan McWilliam will provide the committee with his regular report on matters of relevance and interest to the committee.

Angela Baker, Consultant in Public Health, NHS Oxfordshire will present an update **(JHO5)** on work to address Tuberculosis in Oxfordshire.

6. Temporary suspension of births at the Cotswold Maternity Unit, Chipping Norton (Pages 13 - 16)

10.35

Andrew Stevens, Director of Planning and Information and Jane Hervé, Head of Midwifery from the Oxford University Hospital Trust will report (JHO6) to the committee on the Trust's decision to suspend the intrapartum (births) service at the Cotswold Maternity Unit, Chipping Norton for a period of 3 months to enable the Trust to complete a review of the unit.

7. Primary Care in Oxfordshire (Pages 17 - 36)

11.05

This item enables the committee to look in detail at how the commissioning and delivery of primary care is changing. A background report **(JHO7a)** prepared by the current primary care commissioners at the Primary Care Trust sets out the background and key changes of the four areas of primary care; medical, dental, ophthalmic and pharmacy

Representatives from the Primary Care Trust, Clinical Commissioning Group, Commissioning Board (Local Area Team) and Local Medical Committee (GP representatives) will be attending the meeting.

The second paper **(JHO7b)** provides members with background and an update on the contract performance of the Banbury Health Centre (GP-led Health Centre).

Also included is an update report **(JHO7c)** outlines Oxfordshire PCT's position on the provision of annual health checks to people with learning disability and reports progress so far this year.

8. Clinical Commissioning Update (Pages 37 - 42)

12.35

A representative of the Clinical Commissioning Group will attend the meeting to provide the committee with an update **(JHO8)** on the progress towards the authorisation of the clinical commissioning group.

9. Oxfordshire LINk Group – Information Share (Pages 43 - 46)

12.50

Adrian Chant from LINk will attend to provide an update on the work of Oxfordshire LINk **(JHO 9a)** to include an update on the review of maternity services which HOSC members are involved in alongside LINk.

Also attached is the report on the LINk 'Enter and View' visit to the Howard House Drug & Alcohol Detoxification service **(JHO 9b).**

10. Chairman's Report

13.10

The Chairman will give a verbal update on meetings attended since the last formal meeting of the Health Scrutiny Committee in September.

11. Close of meeting

13.15

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

This page is intentionally left blank

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 27 September 2012 commencing at 10.00 am and finishing at 1.25 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Rose Stratford (Deputy Chairman)
	Councillor Jenny Hannaby
	Councillor Jim Couchman
	Councillor Gill Sanders
	Councillor Keith Strangwood
	Councillor Lawrie Stratford
	District Councillor Martin Barrett
	Councillor Susanna Pressel
	District Councillor Alison Thomson
Co-opted Members:	Dr Harry Dickinson
	Dr Keith Ruddle
By Invitation:	
Officers:	
Whole of meeting	Claire Phillips
Part of meeting	Dr Jonathan McWilliam
	Angela Baker
Agenda Item	**Officer Attending**
7	Dame Fiona Caldicott, Sir Jonathan Michael, and Andrew Stevens
8	Dr Stephen Richards, and Alan Webb
9	Sue Butterworth, Adrian Chant, Lisa Gregory

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/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

54/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Dr Christopher Hood, Councillor Anthony Gearing and Mrs Anne Wilkinson

55/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

- Councillors Rose Stratford and Lawrie Stratford declared an interest as members of the Bicester Hospital League of Friends.
- Councillor Jenny Hannaby declared an interest as a member of the Wantage Hospital League of Friends
- Councillor Alison Thomson declared an interest as a member of the Faringdon Health and Social Care Group.
- Councillor Dr Peter Skolar declared an interest due to involvement in the development Townlands Hospital in Henley.

56/12 MINUTES

(Agenda No. 3)

The minutes of the meeting on 24 May were agreed and signed subject to a minor correction.

Members requested an update on the integration of Oxford Health, Social Care and GPs at a future meeting.

57/12 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

None

58/12 DIRECTOR OF PUBLIC HEALTH UPDATE

(Agenda No. 5)

Jonathan McWilliam, Director of Public Health and Angela Baker, Consultant in Public Health, Prevention & Protection presented to the committee on,

- NHS transition
- Teenage Pregnancy
- Health profiles

NHS transition

Jonathan McWilliam reported that Public Health is making preparations for its move into local government in April 2013. Approximately twenty staff will move across. He also outlined the Commissioning Board arrangements for the Southern Region led by Andrea Young and the Local Area Team – Thames Valley (Matthew Tait) which will cover ten Clinical Commissioning Groups.

Teenage Pregnancy

Angela Baker clarified that teenage conception rates are calculated based on the total number of conceptions under the age of 18 by the 15-17 year old population. This is a nationally defined indicator and is unable to distinguish between wanted and unwanted pregnancies.

Members noted that performance is better than in the past with approximately 60 conceptions per quarter. Didcot has lower than average rates but is being watched as the rate has risen recently. The sex education programme is being redesigned to bring together county council and public health work and there are good relations with most schools. It was noted that we will need to work with academies and the service is offered to independent as well as state schools.

Health profiles
Angela Baker took the committee through the indicators showing red in the health profiles. The following points were noted,

- Whilst incidences of malignant melanoma are high there are relatively few deaths which shows that we are successfully identifying cases.
- Given the general affluence of the county healthy living indicators are not very good. However it was acknowledged that these indicators tend to relate to self reported surveys which whilst statistically robust are not comprehensive.
- Schools will no longer be required to report on the three hours exercise target.

59/12 HEALTH AND WELL-BEING STRATEGY
(Agenda No. 6)

Jonathan McWilliam explained that Oxfordshire's is the first health and well-being strategy with objectives and targets.

It was agreed that performance information on these targets should come to the HOSC as well as the Health and Well-being board in future.

The committee felt that the strategy focuses on public health and the integration of health and social care which whilst important does not include priorities for providers.

Keith Ruddle suggested that the current strategy is not sufficient to monitor the NHS on issues of dignity and patient care which will be very important for the future.

60/12 OXFORD UNIVERSITY HOSPITALS TRUST
(Agenda No. 7)

Dame Fiona Caldicott, Chairman, Sir Jonathan Michael, Chief Executive and Andrew Stevens, Director of Planning and Information, Oxford University Hospitals NHS Trust presented the paper to the committee highlighting in particular the following changes in the past 12 to 18 months,

- The clinical management structure has been in place for over a year
- Integration with the Nuffield Orthopaedic Centre
- Improved links with the University of Oxford
- Implementation of the electronic patient record
- Biomedical research unit and integrated spinal pathways

The OUHT representatives went on to discuss their foundation trust (FT) application and noted that the trust has refreshed its values to put compassionate excellence at the core. The trust's priorities are to improve local accountability and be responsive to needs. Seventeen public meetings have been held during the consultation period along with engagement with the voluntary and community sector and media interest. It was noted that foundation status gives greater local accountability and ownership. As a FT any surplus generated will go back for reinvestment.

Other issues noted were,

- The Trust's focus on transforming local services and the ambition to put more services in community settings.
- The new Health Science Network which is expected to bring benefits for local people. This is partnership between the hospital, university, GPs and local authority focusing on dementia with benefits for the Thames valley.
- The trust is trying to engage with local communities more having learnt lessons in the past.
- In terms of performance the trust is performing well though with the following issues noted – A&E four hour wait has been experiencing some difficulties but the target is expected to be met; issues with the 18 week referral are being overcome and the intensive work is underway including with partners to address the poor performance of delayed transfers of care.

The session was then opened up to questions from the committee. In response to questions from members the Trust provided the following responses,

- The trust is committed to high quality general acute services as well as providing specialist services to Oxfordshire and beyond. The committee were concerned that the trust is focusing too much on providing high profile specialist services at the expense of general acute services. The trust gave their strong commitment to general services for the local community.
- The trust's viable financial position must be demonstrated to Monitor to achieve foundation trust status. The financial position is widely known and last year was 98% on target. This year the saving required is approximately £48M.
- The quality of the PFI buildings is excellent and the annual charge as a percentage of annual turnover is relatively small and can be managed. The aim is to move out of older buildings and reduce the footprint. There are no plans for new PFI projects.
- There is an action plan in place for delayed transfers however along with increased A&E admissions there is a resulting impact on planned work cancellations.
- The trust was not happy with it's performance against the Care Quality Commission's dignity and nutrition quality standards 18 months ago but has recently reviewed them and is now compliant.

- All efficiency proposals are reviewed at a senior level and to ensure that they do not have an impact on quality/safety go to a quality committee for approval.
- The trust agrees with the commissioner the likely levels of activity that will be delivered. The number of planned referrals was expected to go down and has done but the number of emergency admissions has not. This 'overperformance' is funded but not at full cost.
- The sustainability of maternity services if training posts cannot be filled was noted and that the trust is looking to see what the options are. The trust is working with the community partnership network in Banbury on this. Recruitment issues were noted and the age profile of staff making it hard to recruit new staff to an affluent area like Oxfordshire.
- There is a need to reconfigure services to be more integrated rather than institutional based ones. Experience in Banbury has shown how they need to engage only with patients, GPs and the public on proposals.
- It was welcomed that the trust is reversing the trend of the last decade by engaging more with the whole health economy in Oxfordshire rather than being isolationist.

The committee AGREED that it was happy to support the OUHT's foundation trust application but with reservations on the financial position and the prioritisation of general acute services for people in Oxfordshire.

61/12 CLINICAL COMMISSIONING PROGRESS
(Agenda No. 8)

Dr Stephen Richards, Chief Executive and Alan Webb, Interim Director of Partnerships & Development, Oxfordshire Clinical Commissioning Group reported to the committee on the recent CCCG authorisation process site visit.

Alan Webb explained that the visit had focused on a defined list of Key lines of Enquiry which by the end of the day over 90% were rated red. The feedback report was positive and the links to the Health and Well-being board were highlighted. The areas flagged red are expected to move to green in the coming weeks are were around the following issues,

- Financial plans and Quality Innovation Productivity Prevention (QIPP)
- CCG constitution
- Working collaboratively with other CCGs
- Leadership and management capacity

Oxfordshire CCG is moving ahead in the first wave of CCG authorisation in order to move into operational delivery as soon as possible.

It was noted that the 111 non-emergency service had had a 'soft' launch with the 'hard' launch expected in October. The soft launch has reduced the number of calls to out of hours significantly.

The priorities in the six localities will inform the CCG strategy which will also inform the health and well being strategy and be reflected in the joint strategic needs assessment thus ensuring the local granularity of needs.

The Oxfordshire CCG is ahead of development of the commissioning support unit which will cover 14 CCG areas in the central southern region. Until it is formed the CCG will continue to work with PCT colleagues to get intelligence.

It was noted that many practices are increasing their patient involvement and the CCG is encouraging this.

The CCG budget will be around £650M which is mainly tied up in contracts that will transfer. Plans for funding will go through the PCT cluster in the next six months.

It was noted that the any qualified provider programme this year is focusing on adult aspergers, audiology and podiatry which means that any qualified provider can bid to provide these services.

The committee thanked Alan Webb for his contribution to the HOSC over the years and wished him all the best for the future.

62/12 OXFORDSHIRE LINK GROUP – INFORMATION SHARE
(Agenda No. 9)

Adrian Chant updated the committee on the status of the maternity project. Evidence gathering will be going on into October, the main themes coming out are around consistency of support and advice, mothers being left alone on wards, lack of follow up before discharge and poor communications between hospitals and GPs. The final report will be brought to HOSC at the January meeting.

Adrian Chant reported on the Omega group (chronic fatigue and ME) work which identified more cohesive community based services, training for GPs and greater emphasis on children as needed.

Sue Butterworth noted the forthcoming meeting of Patient Participation Groups meeting. Also noted that in the past year LINk has been more focused on project based work and working with the public than before. Hosting by ORCC has enabled better public engagement.

LINk is involved in a shared document on public engagement in Health and well-being boards.

Lisa Gregory gave an update on the procurement of Healthwatch which will start in November to appoint the provider in January. It will be up to Healthwatch to decide how they will recruit members.

63/12 CHAIRMAN'S REPORT
(Agenda No. 10)

The Chairman reported on recent meetings,

- Meeting with the CCG about the Pelvic Floor Service and gluten free foods prescribing.
- Liaison meeting with Outgoing Oxford Health Chief Executive, Julie Waldron. covered performance of community hospital beds
- HOSC members discussed the DoH consultation on Health Scrutiny. No outcomes of the consultation have been publicised yet.

64/12 CLOSE OF MEETING
(Agenda No. 11)

13.25

..... in the Chair

Date of signing .....

This page is intentionally left blank

Briefing for Health Overview and Scrutiny Committee
15 November 2012
Addressing Tuberculosis in Oxfordshire

Background

TB is caused by a bacterium that can infect almost any part of the body. The most common infection site is the lungs. When active lung disease is present, TB can be contagious and infected individuals should be identified and treated quickly. Treatment is effective but requires long term antibiotics and compliance is crucial for cure and to prevent the development of antibiotic resistance.

Homeless communities, those suffering from alcohol or drug-misuse, people who are immune-suppressed, and people from countries with high incidence of TB are more likely to have tuberculosis but cases occur in all social and ethnic groups.

HOSC requested that the Public Health team should provide an update on the current position and action underway.

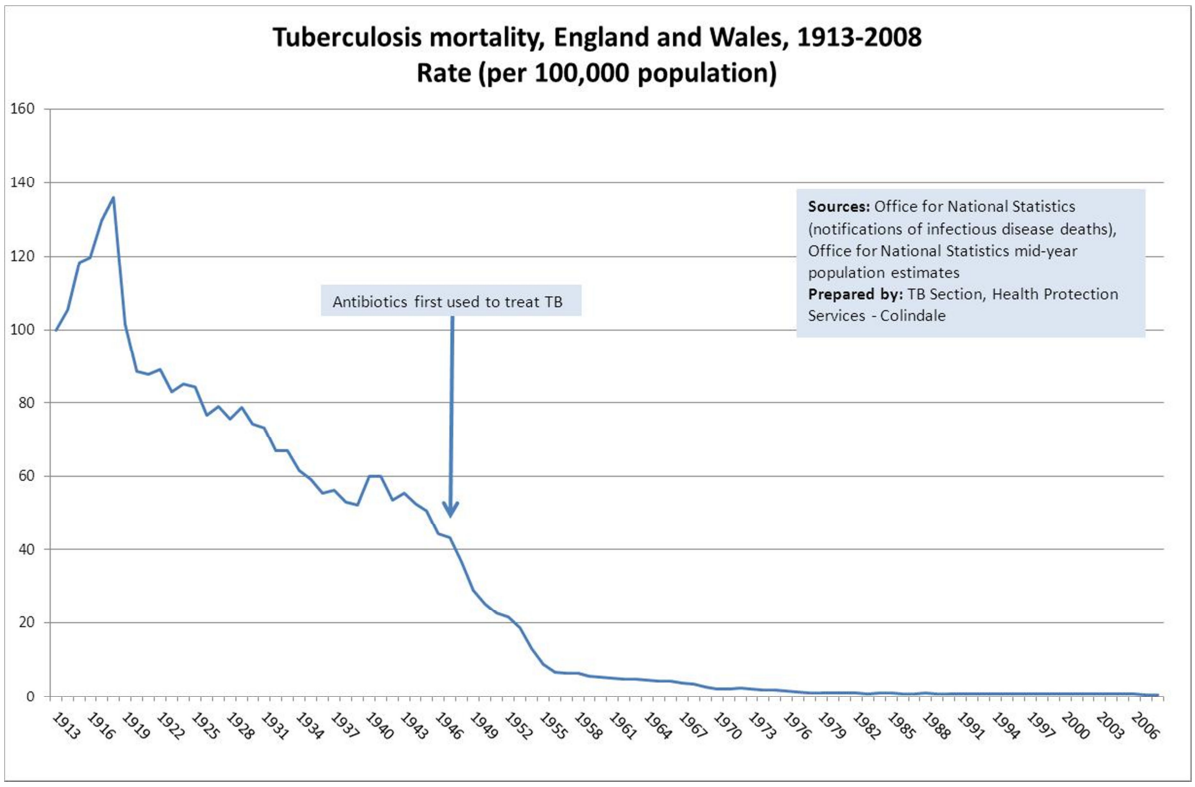
Current Position

We benchmark well against national and regional trends. There were 69 cases of TB reported in Oxfordshire in 2011 compared to 59 in 2010. The rate of TB in Oxfordshire remains lower than the Thames Valley average with Oxford City having a higher incidence than elsewhere in the county. The increase in number of cases could be either due to better case finding and contact tracing, increased transmission of the disease, or increased numbers of infected individuals moving to the city. There is no evidence for increased local transmission of the disease over the past year.

Year	Number of Cases	Oxfordshire Rate per 100,000	National Rate per 100,000
2007	76	12	14.6
2008	56	8.8	12.85
2009	55	8.6	12.8
2010	59	9.2	13.9
2011	69*	10.7*	14.7

* = provisional figures which may be adjusted.

Even before the advent of antibiotics, better housing and nutrition has meant that TB prevalence was already dropping significantly.



Treatments helped to speed up this and although we have never completely eradicated TB, progress has been made. Overtime, the bacterium has changed and the TB bug of today is more virulent and has become resistant to some antibiotics. New treatments have been developed and the disease is no longer in the total population but has become a disease of specific populations, meaning that identification and screening needs to become targeted at those most at risk.

The main interventions to control tuberculosis are immunisation of those at risk, early diagnosis and effective and complete treatments. This means that we offer

- Targeted immunisation for those who are from “at risk” populations
- A requirement to prove vaccination status prior to entry and specific checks at points of entry
- Increasing awareness of signs and symptoms of the disease
- Early diagnosis and effective treatments which are completed
- Effective contact tracing of those who have been exposed to people with a confirmed diagnosis

Oxfordshire is doing well with regard to treatment. In 2010, 72% of pulmonary cases were confirmed by laboratory culture (the HPA target is 70%), and 98% of cases completed treatment (the target set by the Chief Medical Officer is 85%).

Reducing TB locally

Screening amongst the homeless population

Given the increased incidence of TB in those who are homeless a mobile x-ray screening was undertaken in this group in Oxford this year. This was led by Public Health with input and support from the local government, NHS and voluntary services. No TB was found on

screening a large proportion of Oxford's homeless population. This offers some reassurance that cases among this population are being diagnosed promptly by local healthcare services.

Pharmacy Campaign to raise awareness of TB Signs and Symptoms
During August, 102 local pharmacies took part in a campaign to raise awareness of the signs and symptoms of Tuberculosis. This included displaying posters, distributing leaflets and credit cards which highlighted what to be aware of. Pharmacies had over 30 conversations with people who were concerned about TB and signposting people into local services. Five pharmacies have requested a permanent stock of TB materials to display.

Conference to raise awareness of TB amongst Language Schools.
15 Language schools attended a conference which highlighted the need to be vigilant against TB and in particular raised awareness of their responsibilities to ensure students attend for screening. The day included information about TB, requirements pre and post arrival and accessing healthcare for visitors. We have also made links with and are intending to work with Oxford City Council, who run a network for Language schools every March.

Identifying children in need of BCG vaccination
When babies are born, they are assessed to see whether they require a BCG vaccination. This works well for children who have always lived in Oxfordshire. Some children move into the area, different areas have different approaches, this means that some children can be missed. To ensure that these children are vaccinated, all children at school entry (age 5) and school transfer (age 11) are sent a questionnaire to assess their TB risk and BCG status. In the school year 2011, 7935 questionnaires were sent out, 6034 where completed. This equates to a return rate of 76%. 7 children aged 5 and 187 children aged 11 were identified as needing further assessment. 87 of these children were then vaccinated.

Work with OCCG
TB services transfer to Oxfordshire Clinical Commissioning Group in April 2013. Work has started to prepare for this transfer. TB has been identified within the new structures and legacy documents are being prepared so that all services continue to be delivered to the high standard that we have achieved.

We will continue to monitor TB rates in Oxfordshire, through the DPH annual report and take a proactive stance to raising awareness.

Angela Baker
Consultant in Public Health, NHS Oxfordshire
October 2012

This page is intentionally left blank

Oxford University Hospitals NHS
NHS Trust

HOSC meeting

15 November 2012

Title	**Temporary suspension of births at the Cotswold Maternity Unit, Chipping Norton**

Status	A paper for noting by members of HOSC outlining the current situation with the Cotswold Maternity Unit (CMU) and the proposed way forward.
History	Not applicable.

Board Lead(s)	Sir Jonathan Michael, Chief Executive			
Key purpose		Assurance		

Summary

1	The OUHT has decided to suspend the intrapartum service at the Cotswold Maternity Unit, Chipping Norton for a period of 3 months to enable the Trust to complete a review of the unit. During this time mechanisms will be put in place to properly support the staff and pregnant women in the local area. It is planned to complete the review within 3 months i.e. end of January 2013.
2	During the time of the review when the unit will not be open for women in labour other services will continue. Women will be able to attend the unit for antenatal care, postnatal care, breast feeding support and neonatal hearing tests.

Temporary suspension of births at the Cotswold Maternity Unit, Chipping Norton

1. A number of issues have been raised in relation to the Cotswold Maternity Unit which requires further exploration. These concerns have been identified through internal monitoring processes, the staff and via the Maternity Services Liaison Committee. The issues mainly relate to working practices within the unit but do not relate to one single incident.

2. As part of the monitoring of the maternity service it appears that there is a higher than expected transfer rate of women in labour from the unit to a Consultant led unit, either the Horton Hospital or the John Radcliffe Hospital. It should be stressed that this does not necessarily indicate there is a problem, but the transfer rate in conjunction with a fall in the numbers of women choosing to give birth in the unit may indicate an underlying problem.

   The statistics detailed below outline the activity in the CMU over the last four years and the falling birth rate in this financial year.

2.1 Number of births

Year	Births	Transfers
2009/10	159	22 (11.8%)
2010/11	92	17 (11.4%)
2011/12	117	35 (18%)

2.2 Births and transfers - 2012

Month	Women expressing an interest to birth in the unit	Births	Transfers
April	22	5	7
May	19	3	4
June	15	6	2
July	17	6	3
August	19	9	5
September	27	1	4
Total	119	32	26 (47%)

3. The Trust has a duty to monitor trends and investigate outliers and as part of this process it is necessary to review practice in areas where concerns are identified. It is important in this instance that the review involves staff, the local population and other key stakeholders to ensure the future of the unit is secure and safe for women and their families.

4. The rationale for suspending the intrapartum service is to enable the Trust to properly support the staff and mothers during this review. It will be a difficult time for all

concerned and we are keen not to add extra pressure on the staff in the unit which may impact on the outcomes for women and their babies.

5. Review

There is no evidence of poor clinical practice or adverse outcomes for women and their babies. The unit has received 2 complaints in the last 12 months neither of which have been related to clinical outcomes. However in light of concerns raised by staff (including alleged difficulties with some relationships), the evidence of increased transfer rates and a reduction in the numbers of births, the Trust has decided to suspend the intrapartum service for a period of 3 months. This is to enable the Trust to complete a review of the unit and during this time properly support the staff and pregnant women in the local area. The Trust acknowledges that it will be a difficult time for all concerned and will put in place extra support measures for staff and service users.

The review will take place between 22 October 2012 and a report will be considered at Trust Board in February 2013.

6. **Conclusion**

The OUHT is being proactive in reviewing the maternity service provided in the CMU following the identification of a number of concerns. The intention is to reopen the unit once any recommendations highlighted through the review have been implemented.

Stakeholder engagement is key and will be an important element of the review.

Key points

- A full review of the Cotswold Maternity Unit – to be completed within 3 months i.e. end of January 2013
- Temporary closure of the unit to women in labour during the time of the review
- Meetings to be arranged with staff and community midwives linking with the unit, the local community and GP's
- Involvement of the PCT
- Involve the Chair of the Maternity Services Liaison Committee
- Investigate and understand external influences

7. Wantage Midwifery Led Unit

The Trust is pleased to announce that following completion of the building work and successful recruitment to vacant posts that the unit at Wantage Community Hospital will be reopening for births on the 26 November 2012.

Jane Hervé, Head of Midwifery

25 October 2012

NHS
Buckinghamshire and Oxfordshire Cluster

Paper for the HOSC Meeting on 15 November 2012
Update on Primary Care Commissioning

1. Purpose

This paper will update the HOSC on aspects of primary care commissioning providing highlights from each of the 4 independent contractor areas in NHS Buckinghamshire & Oxfordshire. The paper outlines that the future destination for primary care commissioning sits with the NHS Commissioning Board (NHSCB) through the Thames Valley Local Area Team (LAT) covering Buckinghamshire, Berkshire and Oxfordshire.

2. Introduction

The Cluster Primary Care commissioning and contracting team working across the NHS Buckinghamshire & Oxfordshire is responsible for a total of 694 contracts covering medical, dental, ophthalmic and community pharmacy services. The current total expenditure by the Cluster across all primary care contracts is £222m.

	Number of contracts
Medical	141
Dental	196
Ophthalmic	154
Pharmacy	203

The team has successfully adapted to working across the cluster area with several posts already covering projects for both PCTs on an interim basis until future roles are defined as part of the formal transfer to the NHS Commissioning Board (NHSCB) Local Area Team (LAT) on 1st April 2013.

The team is part of a wide network of primary care commissioners linking both nationally and via the NHS South Central Primary Care Leads Group. Through these networks primary care commissioners have been involved in the co-production of the NHSCB's plans on how it will commission services through a single operating model in the recently published *'Securing excellence in commissioning primary care' (June 2012).*

The team is involved in the national transition work to ensure a smooth transfer of commissioned services to the NHSCB by 31st March 2012. All contracts are being checked and prepared for transfer during this process to ensure that there is continuity of care and the reduction of any areas of risk during and post transition.

The team continues to focus on ensuring the delivery of contractual requirements, business continuity and preparation for contract transfer during this period of transition.

3. Community Pharmacy

NHS Buckinghamshire & Oxfordshire currently has 203 pharmacies.

The PCT cluster has reviewed the outcomes of the Community Pharmacy Assurance Framework that was undertaken in 2011/12. This framework ensures that pharmacies are complying with the requirements of their NHS contracts. Pharmacies were required to complete a self-assessment questionnaire and from this 8 pharmacies were selected for a full contract review visit. Following a 3 year rolling program of visits the PCT took the decision to visit only new pharmacies and those where concerns have been raised.

The main themes of the contract review were as follows:

- Pharmacy leaflets – a number of pharmacies were required to update their leaflets to meet current DH guidelines and to include up to date PCT and PALS contact details.
- Child protection training – some pharmacies were required to confirm that all staff had received training.
- Signposting directory – some pharmacies were required to confirm they had the latest directory available for staff to use with patients.
- Hazardous waste bins – a small number of pharmacies did not have the required hazardous waste bin in the Pharmacy
- Record keeping for promoting healthy lifestyles and support for self-care – a small number of pharmacies were not keeping records as required for advice offered.
- Standard Operating Procedures (SOPs)– a small number of pharmacies were required to confirm that all staff had read and signed the SOPs.
- Medicines Use Reviews – 2 pharmacies were found to not have a compliant consultation area.
- Some pharmacies did not have an adequate locum folder

All pharmacies were required to confirm that they could be compliant with their contractual requirements where there was any shortfall by the end of March 2012.

In October 2011 the national New Medicines Service (NMS) was introduced. This service offers advice, information and support to patients on new medications at three stages, initial stage when starting the medication, day 7 follow up and at day 14-21 a further follow up is scheduled with the patient. This services supports compliance with medication regime. In the first six months of the NMS over 3,200 patients across Buckinghamshire & Oxfordshire have been recruited to this service.

Also in October 2011 changes were made to the Medicines Use Review service (MURs), so that each pharmacy is now required to ensure 50% of the MURs they undertake fall into one of the following areas:-

- Respiratory

- High risk medicine
- Post discharge

These are known as Targeted MURs.

From October 2011 - March 2012 over 19000 patients across Buckinghamshire & Oxfordshire have benefited from a MUR, this includes targeted MURs.

Some further clinical governance requirements changes have been made nationally to the contract for 2012/13. These are summarised as follows:

- The pharmacy is required to acknowledge which services are funded by the NHS
- The pharmacy is required to take action on its patient survey results and publish them.
- All patient safety incidents will be required to be reported to the National Patient Safety Agency (NPSA).
- Pharmacies are required to have a whistle – blowing policy in place.
- Patient Safety notices and alerts issued on behalf of the Medicines and Healthcare products Agency (MHRA) should be acted upon within required timescales and actions recorded.
- Requirement to keep staff and patients safe from health care acquired infections by putting in place appropriate infection control measures proportionate to activities undertaken in the pharmacy.
- Pharmacies are required to have a clear distinction between public areas and non-public areas of the pharmacy.

Compliance with these new requirements will be through the Community Pharmacy Assurance Framework for 2012/13 and monitored by the Cluster Primary Care Team.

Applications for new pharmacies are managed across the Cluster through the Pharmacy Applications Group. All processes must be compliant with the updated NHS Pharmaceutical Regulations (2012).

4. General Ophthalmic Services (GOS)

NHS Buckinghamshire & Oxfordshire currently has 93 Mandatory Services contracts and 61 Additional Services (domiciliary) contracts. All issues relating to GOS are managed for the Cluster by the Primary Care Team currently based in Oxford.

In order to ensure the probity of GOS claims by contractors Thames Valley PCTs have a post payment verification (PPV) visiting programme. This is carried out by Thames Valley Primary Care Agency (TVPCA) on behalf of PCTs and includes all contract holders. The PPV team carry out initial monitoring on GOS claims made where a number of criteria are compared

with the average to establish any outliers. In line with national guidelines it is planned that all contractors are reviewed at least once in a three-year period, with more frequent review where the risk has been assessed as, or evidenced as, high with respect to claiming patterns.

All new contractors receive a visit from the Optometry Contracts Manager and Optometric Advisor to ensure their awareness of the national Contract Compliance Framework used for monitoring all contracts. This framework ensures that all processes, policies and requirements of the GOS contract are being fulfilled. In addition to this the Optometric Advisor will review equipment used and record keeping.

Joint working across NHS Buckinghamshire & Oxfordshire and NHS Berkshire is already in place to develop common policies to underpin commissioning and contract management processes and to facilitate efficiencies within TVPCA.

The PCT has carried out targeted contract visits to concentrate on new practices and to follow up on PPV visits where appropriate.

NHS Buckinghamshire & Oxfordshire commission a local enhanced service for Intra-ocular pressures (IOP LES) from local ophthalmic opticians. This scheme is supported by the Clinical Commissioning Groups (CCGs) and allows opticians to re-measure intra ocular pressure. This means that the number of false positives being referred to secondary care is reduced. Currently there are 43 practices offering this service within Oxfordshire and 32 in Buckinghamshire.

5. Dental services

NHS Buckinghamshire & Oxfordshire currently has 196 dental contracts.

Dental contracts are assessed for performance as a contractual requirement twice yearly; at mid year and at year end. Delivery of units of dental activity and quality measures are reviewed and actions resulting from this process include repayment of under delivered activity, carry forward of under delivered activity to the following contract year and agreements on management of over delivery. Additionally, monthly dental contract review meetings take place where under or over performing contracts are identified and actions are agreed by the team, ensuring any performance issues are managed on an ongoing basis with each contractor as required.

The Primary Care commissioning and contracting team continues to focus on improving access to NHS services, which is both a local and national priority. Currently, a total of 335,449 people (54 % of the resident population) in Oxfordshire and 229,695 people (44.85% of the resident population) in Buckinghamshire have accessed an NHS dentist within the previous 24 months as of August 2012.

Two new practices have opened in Oxfordshire in recent months, one in Witney and one in the St Clements area of Oxford. Both have been welcomed by local people in these areas. A new practice is due to open in Chesham, Buckinghamshire in autumn/winter 2012.

Further planned developments in 2012/13 include the use of additional non-recurring monies to pilot a mobile service taking services to the most deprived wards in Oxfordshire and a Specialist Restorative dental service, funded from shared dental monies. The mobile service will be in Oxfordshire between November and January 2013 and work has now commenced on the identification of sites and the communications plan to underpin this service. In Buckinghamshire additional non-recurrent dental activity has been commissioned from existing providers to be delivered by 30th September 2012. A consultant led restorative assessment and treatment planning service has been recently procured by NHS Buckinghamshire and Oxfordshire and the service will be in place from October 2012. To support the provision of specialist Restorative Care a parallel Any Qualified Provider (AQP) process has been implemented to support the reduction in referrals to dental teaching hospitals and provision of more locally accessible services across Buckinghamshire, Oxfordshire and Berkshire.

Joint working across NHS Buckinghamshire & Oxfordshire and NHS Berkshire is already in place on a number of service reviews. A consultation with the dental profession on a proposed new Orthodontic contract from 1st April 2013 was launched on 12th June 2012 with the aim of contract offers being made to practices by the end of September 2012. The contract proposes Quality, Innovation, Productivity and Prevention (QIPP) gains via a new pricing structure and the introduction of key performance indicators (KPIs).

As part of the new NHS reforms, the Thames Valley PCT clusters have been identified as a pilot site for the establishment of Local Professional Networks (LPNs) to work alongside the NHS Commissioning Board Local Area Teams (LATs). A workshop was held with key stakeholders in June to look at how to take this forward with the aim of the Thames Valley LPN operating in shadow form by the end of 2012.

6. Primary Medical Services

Currently, there are three types of GP contract – general medical services, personal medical services and alternative provider medical services. PMS and APMS have elements that are agreed locally with PCTs. The intention of the new NHS Commissioning Board is to apply a single operating model nationally to the commissioning GP services and move all practices to a standard contract over the next two to three years.

The total number medical contracts across the cluster area is 141, split by the following contract type;

GMS = 120,
PMS = 18
APMS = 3

PCTs can enter APMS contracts with any individual or organisation that meets the provider conditions set out in GMS Directions. This includes the independent sector, voluntary sector, not-for-profit organisations, NHS Trusts, other PCTs, Foundation Trusts, or even GMS and PMS practices. If PCTs contract with GMS / PMS practices via APMS, the practice would hold a separate APMS contract alongside their GMS / PMS contract.

Out of a total of 82 GP practices in Oxfordshire, three of them are APMS contracts held between the PCT and the following provider organisations;

Luther Street Medical Centre	Oxford Health Foundation Trust
Deer Park MC	Assura/Virgin Healthcare
Banbury Health Centre	Principal Medical Services (PML)

Each contract is agreed locally and contains a series of key performance indicators agreed with the contractor. The contracts are monitored by the PCT meeting with the contractor on a quarterly basis, this is a contractual requirement.

Access to primary care continues to be a theme of government policy. The Department of Health have introduced the Patient Choice programme. This has a variety of initiatives including Patient Choice Pilot and the introduction of Inner and Outer Boundaries.

The Patient Choice Pilot involves practices in pilot sites (Westminster, City of London, Tower Hamlets, Nottingham and Manchester). This means a Buckinghamshire or Oxfordshire resident could permanently register with a practice in say Westminster whilst still remaining a Buckinghamshire or Oxfordshire resident. This has implications if the patient requires care closer to their home residence. A Local Enhanced Service has therefore been introduced to allow Buckinghamshire and Oxfordshire practices to treat patients who have registered with a pilot site.

The Patient choice programme also introduces the concept of inner and outer boundaries. An inner boundary is the practices traditional practice boundary. An outer boundary is where a practice is prepared to maintain registration if a patient moves out of the inner boundary. It is for patients registered with the practice who move subsequently outside the practice boundary. Practices have recently agreed their extended boundaries with the PCT.

The work on boundaries sits alongside contract stabilisation work. Contracts for have been checked to ensure that they meet all current legislation and where necessary any contract variations are being issued to ensure completeness prior to transfer to the NHSCB.

The National Patient Survey results for 2011/12 are now published and the results of questions relating to the quality of care are now included on each individual practices NHS Choices web page. PCT results show NHS Oxfordshire scoring 91% for patients having an overall good patient experience, 86% of patients would recommend their practice and 85% of patients had a good experience of accessing their GP Practice. NHS Buckinghamshire scoring 90% for patients having an overall good patient experience, 85% of patients would recommend their practice and 80% of patients had a good experience of accessing their GP Practice. Access to primary care is also a theme which is highlighted via the Patient Participation Survey conducted as part of the practices Directed Enhanced Service (DES) for 11/12, 74% of Practices achieved one or more of the elements in year one of the DES.

During 2012/13 the majority of practices have participated in the Patient Participation DES. Its purpose is to ensure that patients are involved in decisions about the range and quality of services provided and commissioned by their practice. It aims to encourage and reward practices for routinely asking for and acting on the views of their patients. This includes patients being involved in decisions that lead to changes to the services their practice provides or commissions, either directly or in its capacity as gatekeeper to other services. The DES aims to promote the proactive engagement of patients through the use of effective Patient Reference Groups (PRGs) and to seek views from practice patients through the use of a local practice survey. The outcomes of the engagement and the views of patients are to be published on the practice website.

One aspect that practices may wish to focus on is excellent access into the practice, and also from the practice to other services in its role as coordinator of care, facilitating access to other health and social care providers. Access has many dimensions; the relative importance of these will vary according to the specific needs of the registered population. These dimensions include:

- lists being open to all
- hours of opening with the ability to be seen urgently when clinically necessary, as well
- the ability to book ahead
- continuity of care
- range of skills available – access to different professionals
- a choice of modes of contact which currently includes face-to-face, phone and
- electronic contact but can be developed further as technology allows
- geographical access, enabling care as close to home as possible.

Access must be flexible enough to meet the varying needs of individuals and requires sufficient capacity to meet the population's needs. Details of access arrangements (including opening hours) should be made widely available to the population to enable patients to exercise choice. Participating practices

will establish a Patient Reference Group (PRG). This may be a formal Patient Participation Group (PPG) or a similar group that is representative of the practice population, which would feed in its views alongside the findings from the surveys and agree with the practice the priority areas for possible change. This would result in an action plan to be agreed between the practice and the PRG.

Practices taking part in this DES also carry out a properly constituted survey of a sample of the practice's patients looking at a broad range of areas which could include convenience of access (opening times, ability to book ahead, ability to be seen quickly, telephone answering), patients' experience of the treatment and service they receive, the physical environment in the surgery and other issues specific to each practice.

During the last year in Oxfordshire new surgeries have been opened in Witney, Windrush Health Centre and in Oxford, Jericho Health Centre and in Buckinghamshire, the Chess Medical Centre in Chesham. In addition, through a programme of PCT minor capital grant funding, an extension of the medical centre in Eynsham has been completed and smaller improvements have been carried out to surgeries in Sonning Common, Bampton, Burford, Benson, Henley, central Oxford and Cutteslowe. The minor capital grant funding approval process for 2012/13 is currently underway with recommendations to support further improvements to premises for the delivery of patient care and improving standards and to ensure that NHS dental practices are able to meet the national standards for the decontamination of equipment.

Quality and Outcomes Framework (QOF) achievement for 2011-12 has been finalised and a report analysing changes in achievement, prevalence and exception reporting has been produced for the Quality Management Group. Of the 82 Oxfordshire practices 28 were visited in 2011-12, overall achievement for Oxfordshire was 96.78%. Of the 59 Buckinghamshire practices 21 were visited in 2011-12, overall achievement for Buckinghamshire was 97.02%.

Across the PCT cluster the team has worked with the Clinical Commissioning Groups (CCGs) Leads to ensure that the focus of the Quality and Productivity indicators in the QOF are aligned with the CCG priorities for reducing elective referrals and non elective admissions. This ensures that individual clinicians in every practice are focussed on these priorities and that peer review discussion takes place at CCG level.

As part of clustering working arrangements, and in advance of a national single operating model for primary care, alignment of processes for visits and contract monitoring are being reviewed. In Buckinghamshire contract monitoring visits have been combined with QOF visits over the past two years. Elements of contract monitoring are included in the e-profile which practices complete and submit annually. In Oxfordshire visits are targeted

where clinical governance or other performance data or contract monitoring information triggers concern.

The Cluster Quality Management Group receives updates from any contractual visits and contract monitoring processes that raise issues about contractual performance. Concerns regarding an individual contractors' performance is managed through the cluster Concerns Group in compliance with the NHS Performers List Regulations.

Enhanced Services are currently commissioned through primary care contracting vehicles and can be commissioned from a range of other services (e.g. community pharmacies). They currently comprise of Local Enhanced Services (LESs) – schemes agreed by PCTs in response to local needs and priorities, and Directed Enhanced Services (DESs) – schemes that PCTs are required to establish, linked to national priorities and agreements. PCTs must offer DES's to all their practices but uptake by practices is voluntary.

From April 2013 the NHSCB will be responsible for commissioning primary care services under the GP contract. At the same time, it is an essential feature of the reforms that CCGs should be able to commission a range of community-based services, including primary care services, to improve quality and outcomes for patients. Where the provider for these services might be a GP practice, CCGs will need to be able to demonstrate that those services:

- clearly meet local health needs and have been planned appropriately;
- go beyond the scope of the GP contract; and
- the appropriate procurement approach is used.

Such services will be commissioned using the NHS standard contract rather than the GP contract (as current 'local enhanced services' are). Subject to transitional arrangements (to be confirmed), the resources currently associated with local enhanced services (with the exception of public health services) will form part of CCGs' baseline allocations, so that they can determine how best to use these resources.

The estimated amount that will transfer to Oxfordshire and Buckinghamshire CCGs, based on the current commissioning of medical LES's, is £3.9m.

Managing potential conflicts of interest appropriately is needed to protect the integrity of the NHS commissioning system and protect CCGs and GP practices from any perceptions of wrong-doing. The NHSCB has produced a "code of conduct" for managing conflicts of interest where GP practices are potential providers of CCG-commissioned services. This sets out additional safeguards that CCGs are advised to use when commissioning services for which GP practices could be potential providers and it is anticipated that the NHS Commissioning Board will incorporate the code of conduct, alongside the general safeguards described in *Towards establishment: Creating responsive and accountable CCGs*, into the guidance that it publishes for CCGs in relation to managing conflicts of interest.

CCGs will need to decide, subject to the proposed Department of Health (DH) regulations on procurement and choice, and subject to current procurement rules set out in the Public Contracts Regulations 2006, where it is appropriate to commission community-based services through competitive tender or an Any Qualified Provider (AQP) approach and where through single tender. In general, commissioning through competitive tender or AQP will introduce greater transparency and help reduce the scope for conflicts. There may, however, be circumstances where CCGs could reasonably commission services from GP practices on a single tender basis, i.e. where they are the only capable providers or where the service is of minimal value.

7. The future of primary care commissioning

NHS Commissioning Board

Once formally established in April 2013, the NHSCB will be the national element of the commissioning system in England, ensuring that the NHS is truly a national health service for England. It will support, develop and hold to account an effective and comprehensive system of health commissioning, including commissioning by clinical commissioning groups, and drive improvements in quality and outcomes as measured at national level through the NHS Outcomes Framework.

The NHSCB will directly commission around one fifth of the total value of NHS services, namely:

- GP services, community pharmacy, and primary ophthalmic services (mainly NHS sight tests);
- all dental services - primary, community, hospital;
- specialised services;
- high-secure psychiatric services;
- offender health;
- some aspects of healthcare for members of the armed forces and their families; and
- public health services (screening, immunisation, services for children aged 0-5 including health visiting) on behalf of Public Health England.

In commissioning these services, its role is equivalent to a CCG or other commissioner in that they must commission services within available resources from providers who, where they provide a regulated activity, are registered with the Care Quality Commission (CQC). Legally, from April 2013 a GP or dental practice cannot provide any services without a CQC registration. In the event that a practice fails their CQC registration, they would be required to take urgent actions but unless patient safety is at risk they would be registered with conditions. In terms of a practice failing CQC standards, and their registration is withdrawn immediately, the NHSCB is currently working with the CQC to provide a policy for dealing with such situations as part of the single operating model.

The NHSCB should drive continuous quality improvement through the contracting process, and manage the delivery of those services through contract management. In relation to primary care, the NHSCB will have responsibility for overseeing the quality of primary care provision, including performance management of individual GP practices and making sure all the doctors are competent and fit to practice. The NHSCB will also maintain a performers list that will require local management at Local Area Team (LAT) level. This will include all primary care professionals who have been assessed as being suitable to hold NHS contracts for the provision of primary care. For GPs, this assessment will include information received as part of the routine medical revalidation cycle and the Responsible Officers within the NHSCB will act as the link between the revalidation process and the maintenance of the performers list. Where a GP is removed from the performers list due to concerns about the quality of care they are providing, the NHSCB will inform the GMC who will consider whether regulatory action is also required.

The NHSCB will need to assure itself of the quality of services that they commission, looking to the CQC in terms of whether a provider is compliant with the 'essential standards of quality and safety', as well as monitoring its own information and intelligence about providers.

Local Area Teams

The future responsibility for directly commissioned services, including primary care, will be the responsibility of the NHSCB under the operations directorate. This responsibility will be discharged through 4 regional teams and 27 local area teams (LATS) with 7 of those teams in the South of England region. The Thames Valley LAT will cover Berkshire, Oxfordshire and Buckinghamshire with a population of 1.9 million, working with 10 CCGs and 8 Health and Wellbeing Boards. Matthew Tait, currently the cluster Chief Executive, has been appointed as the Thames Valley LAT senior Director designate.

Primary care commissioning will sit within the LAT commissioning directorate and operate under a single operating model to ensure consistency across England. The Commissioning Director designate appointed is Helen Clanchy who will commence in post 1st December 2012.

Dr Geoff Payne - Cluster Medical Director/ TV LAT Medical Director Designate

Ginny Hope - Assistant Director of Primary Care Commissioning

1st November 2012

This page is intentionally left blank

NHS
Buckinghamshire and Oxfordshire Cluster

Banbury Health Centre Report for the Oxfordshire Joint Health Overview and Scrutiny Committee meeting

1. Purpose

1.1 The purpose of this paper is to provide background and an update on the contract performance of the Banbury Health Centre (GP-led Health Centre).

2. Introduction

2.1 The Banbury Health Centre (HC) commenced services on 15th October 2009 following PCT Board approval on 29 January 2009. The procurement was part of the national Equitable Access programme led by Lord Darzi. Each PCT was required to commission a GP-led health centre in their area to deliver the core criteria set;

- Core GP services
- Maximising opportunities to integrate and co-locate with other community-based services, including social care
- Easily accessible locations
- Open 8am-8pm, 7 days a week
- Bookable GP appointments and walk in services
- Registered and non-registered patients

2.2 The primary aims for this contract, as approved by the PCT Board, were:

- To increase access to GP led primary care services for the Oxfordshire population.
- To address some of the inequalities in GP access, by targeting areas of Oxfordshire that currently are less well served by primary care medical services and other services such as NHS dental services.
- To reduce levels of deprivation and health inequalities by providing improved access for hard to reach groups;
- To help address demographic changes including population growth.

2.3 Following a competitive tender process the APMS contract was awarded to Principal Medical Services (PML).

3. Background

3.1 NHS Oxfordshire had previously identified Banbury as an area where patients told us that it was more difficult to register with a GP practice and to get an appointment with a GP. At times there had been several of the Banbury practices requesting “open but full list” status approval from the PCT. The Joint Strategic Needs Assessment and the Director of Public Health’s annual reports also identified local wards as some of the most deprived in the county and nationally.

3.2 The public health profile of Banbury showed significant health inequalities compared to other parts of Oxfordshire and a need to break the cycle of deprivation. There are significant health outcome inequalities within Banbury with a difference in

life expectancy of 15 years between the best and worst wards. There is also a large difference in life expectancy between males and females.[1]

3.3 The Oxfordshire 2030 Partnership plan (2011) for improving quality of life in Oxfordshire indicates that Cherwell's population increased by almost 12% between 1991 and 2001 and by a further 4.5% since. Growth predictions of a further 8% by 2016 and a cumulative 15.6% by 2026 are significantly higher than regional and national rates. Most of the recent growth has been in Banbury and Bicester and this is predicted to continue.

3.4 In addition, the PCT Board approved the co-location of NHS dental services along side the GP-led Health Centre as Banbury was identified as a priority area to improve access to NHS dental services. A new NHS dental practice opened in February 2010.

4. Delivering increased access

4.1 The total number of registered patients was 2,700 as at 31/08/12 compared with the contracted target of 2,547.

4.2 The total number of unregistered patients seen since opening to 31/08/12 is 26,000.

Day	GP Practice opening times
Monday	8 am to 8 pm
Tuesday	8 am to 8 pm
Wednesday	8 am to 8 pm
Thursday	8 am to 8 pm
Friday	8 am to 8 pm
Saturday	8 am to 8 pm
Sunday	8 am to 8 pm

4.3 A GP is on site at all times during opening hours as per the contract specification and the telephone lines are also open throughout this period.

5. Addressing inequalities in access to GP services

5.1 The Banbury Health Centre has achieved registrations from deprived areas. In a random sample of 17% of the patient list, the post code breakdown was as follows:

Grimsbury & Castle	55.81%
Bretch Hill (Ruscote)	18.37%
Neithrops	13.49%
Easington	6.98%

[1] The HNA stated: Almost twice as many small areas (Super Output Areas) in Oxfordshire are in the top 10% most deprived areas in England in terms of income deprivation compared with 2004 (nine instead of five). Banbury Ruscote no longer features as one of the most deprived areas but Banbury Grimsbury and Castle is one of five areas in which deprivation has increased to the point where it is now amongst the most deprived areas in England.

These stark figures illustrate well the cycle of deprivation in parts of Banbury. Addressing this has been identified as a key priority in the PCT's strategic aim of improving services for children and families in areas of deprivation.

East villages	2.79%
West villages	1.86%
Other	0.70%

5.2 Some 74% of the patient list reside in the two most deprived areas of Banbury, i.e. Grimsbury & Castle and Bretch Hill/Ruscote. If the parts of the Neithrops that are also considered particularly deprived are added, this increases to over 87% of our list. A very small proportion of the population reside in the relatively affluent areas of Easington and surrounding villages.

5.3 Hard to reach groups
The Banbury Health Centre continues to attract hard-to–reach groups such as those people from ethnic minority groups. In a similar random sample conducted over 9 months, immigrants who had never been previously registered with the NHS made up 21.25% of the practice population and the data showed that a significant number of these immigrants were resident in Banbury for several years before they registered, confirming the need for more access to primary care services in Banbury.

5.4 This population are most likely to live in the deprived wards and indicates that the service is successful in attracting those from minority ethnic backgrounds into primary care. One contributing factor may be due to the use of Language Line, and allow the opportunity for non-English speaking patients to access 20 minutes for appointments when deemed necessary. A second reason reported by patients is that this population finds it difficult to take time off work to attend the for GP services, being fearful of their job security. The extended opening hours gives greater flexibility to attend ensuring equity of access to routine primary healthcare services. Practice system data shows that 70% of appointments for registered patients at the weekend are for working age patients.

5.5 Ethnic minorities: 46.82% of the registered population are non-British or non-white ethnic groups, and 21.5% report that their main spoken language is other than English. Of these, the largest group is Polish (14.5% of total registered list), followed by Arabic (3.5%), Shona (2%) and Portugese (1.8%).

5.6 Expectant mothers and young families - of the total practice population 12.5% are under 4 years old, which represents nearly 200% of the expected baseline figure for this age group. They also have 28.5% in the age group 25 – 35, again representing nearly 200% of the normal baseline figure for this age group. The PCT's Strategic Plan identified children and young families living in areas of deprivation, and especially in Banbury, as a priority group. Young mothers find Banbury Health Centre easy to access, not only because of its location but also because of its extended opening hours. There is a designated Health Visitor working to improve the health outcomes of this group. Banbury Health Centre has a high proportion of complex families and families who are disadvantaged. For example, the families in the Women's Refuge are complex families because of their history, and present significant risk of adverse outcomes for the children. The mothers themselves generally have very low self-esteem and need greater support for anxiety and depression.

5.7 Transient population - represent 6.5% of the practice population and the Banbury Health Centre attracts a transient population, e.g. the travelling community, with more a chaotic life-style as the service appeals to families who find the constraints of regular services difficult to access. A significant number of homeless

patients (no fixed abode) now have access to primary care services attending through the Banbury Young Homeless Centre and the Beacon Centre.

5.8 People with drug addictions – Banbury Health Centre has GPs with the relevant training to treat patients with drug addictions who work cooperatively with the designated drugs worker and SMART (addiction support services) team also located in the same building.

5.9 Young people – Banbury Health Centre provides services to young people, including emergency contraception, Chlamydia screening and other sexual health services. Since opening to June 2012 Emergency Contraception (Levonelle) has been issued to 44 registered patients, 30% of whom have been under the age of 20. In addition to this, Levonelle is consistently one of the top 10 drugs issued to unregistered patients, and since opening Banbury Health Centre has issued Levonelle 341 times to unregistered patients, and 25% of this number has been issued to patients under the age of 20.

6. Integration within the local healthcare community

6.1 An important aspect of the successful implementation of this contract was that Banbury Health Centre fully integrated within the local community of GP practices, and there should be local ownership of services. From the outset PML have been successful in recruiting and retaining local clinicians and healthcare professionals who understand the requirements of the contract. There is a stable team of clinicians who trained in the Oxfordshire GP Vocational Training Scheme and are known to the healthcare community. In addition, as locums are needed to backfill for holidays or maternity leave, PML hold a bank of locally trained and experienced GPs to fill these hours. Only when absolutely necessary do they use locums from out of area.

6.2 This approach brought local knowledge and experience into the service from the outset. Current successful local systems, custom and practice were automatically carried forward into the Banbury Health Centre creating an opportunity for greater integration and consistency of approach with other local health services, whilst providing a stable environment for cooperation, innovation and new working practice.

6.3 A GP representative is member of the Oxfordshire Clinical Commissioning Group (OCCG) North Locality Group since October 2009, attending regular meetings in a new capacity as Deputy Chair of the Group.

7. Contract Performance

7.1 The contract is monitored by quarterly reviews with the practice producing a regular report to be discussed at the review meeting. The meetings are attended by clinicians and managers from both PML and NHS Oxfordshire.

7.2 The 10th Quarterly Report (1 January 2012 – 31 March 2012) shows good overall performance against delivery of the contract and key performance indicators (KPI) attached. There are 3 performance achievement bands, A – C, each indicator has a different target score set by national and local criteria. The bands represent increasing levels of achievement with A being the highest and to which the contractor should aspire.

7.3 Out of a total of 33 KPI's for the registered patient element of the contract 73% are achieved at band A, 9% at band B and 18% at band C.

7.4 Out of a total of 14 KPI's for the unregistered element of the contract 93% are achieved at band A and 7% at band C.

7.5 The contractor has an agreed plan with the PCT for each KPI achieving below band A.

8. Quality and Outcome Framework

8.1 The annual QOF results show good progress and for 2011/12 a score that is above the Oxfordshire average score.

2011/12	Clinical	Organisational	Additional services	Patient Experience	Total	Oxon Average	National Average
Max Points	661.00	262.00	44.00	33.00	1000		
Banbury HC Achievement (11/12)	635.15	261.30	44.00	33.00	973.45	967.77	*

*National Average for 11/12 will be available in October 2012

2010/11	Clinical	Organisational	Additional services	Patient Experience	Total	Oxon Average 10/11	National Average (10/11)
Max Points	697.00	167.50	44.00	91.50	1000		
Banbury HC Achievement (10/11)	617.86	166.50	44.00	33.00	861.36	969.62	946.6

9. Patient Experience

9.1 The Ipos MORI Patient Satisfaction Survey results for July 2011 – March 2012 are attached and show that Banbury HC has achieved scores that are either above or close to the Oxfordshire PCT average scores.

10. Conclusion

10.1 The current contractor PML is consistently delivering the service requirements of the contract to a high standard within the contract value.

Lead Director: Dr Geoff Payne, Cluster Medical Director, NHS Buckinghamshire & Oxfordshire Cluster

Ginny Hope, Assistant Director of Primary Care, NHS Buckinghamshire & Oxfordshire Cluster

This page is intentionally left blank

Learning Disability Annual Health Checks DES
Oxfordshire PCT Plan for 2012/13
UPDATE NOVEMBER 2012

This report is an update to that presented to the Health Overview and Scrutiny Committee in June this year. It outlines Oxfordshire PCT's position on the provision of annual health checks to people with learning disability and reports progress so far this year.

Background
The Learning Disability Directed Enhanced Service was first issued to practices in April 2008 and has continued up to the current year. The DES aims to ensure that all people on Local Authority Learning Disability registers with a moderate or severe learning disability receive an annual health check according to an agreed protocol, known as the Cardiff Health Check.

Achievement for the first four years across the county was as follows:

2008/9	24%
2009/10	29%
2010/11	40%
2011/12	46%

The provision of an Annual Health Check for people with a Learning Disability is provided through a Directed Enhanced Service. The PCT must make this service specification available to all practices in Oxfordshire, but as with all enhanced services, it is the decision of the practice whether to provide the health check to eligible patients.

This year, 78 out of 82 practices have signed up to offer annual health checks.

This service is not written into GP contracts and compliance cannot be enforced. However, Oxfordshire PCT encourages practices to participate in enhanced services as they demonstrate good practice. We will continue to promote health checks with both GP practices, providers of care to people with LD, people with LD and their families and/or carers.

Actions in place to increase the number of annual health checks offered/provided

Plan for 2012/13 – midyear update:

LD Liaison nurses:

- continue to help practices access Learning Disability Teams and advise on eligibility to services
- are providing refresher training as requested on importance of Annual Health Checks to provider primary care practices and carer groups
- continue to help practices with production of accessible Annual Health Check letters
- continue to help practices identify 'hard to reach' or more vulnerable people on their LD register
- Continue to provide support for practices to source alternatives to other Annual Health Check models/ templates

The PCT Patient Advice and Liaison Service has previously made an offer through relevant organisations that any person having difficulty getting a health check should ring the helpline at the PCT and we will arrange for a health check to be made available. The situation remains that no requests have been made but this contingency will continue to be available throughout the life of the enhanced service.

A PCT primary care manager continues to meet with the Liaison nurses to assess level of uptake and discuss any issues surrounding delivery of the service. A copy of the nurses report on last financial year and plan for 2012/13 (July 2012) is attached at Appendix B

Planned target for 2012/13 – 55%
The DES runs until March 2013. If the National Commissioning Board takes the decision to continue the DES in 2013/14 we would aim to achieve a further 10% increase, taking the overall level to 65%

Since June this year both the PCT and the Liaison nurses have carried out surveys with both primary care providers and people with a learning disability. The aim of surveys is to find out more about how patients are being contacted, what difficulties there are and why patients may choose not to have health checks

A PCT audit of number of health checks carried out up to end of September 2012 reveals low uptake so far, however, historically, practices have offered the annual checks in the second half of each year owing to early training requirements in Year 1 of the DES.

The PCT sent a written request to all practices currently offering health checks to their learning disabled population asking if they had any information regarding why patients or carers were failing to take up or refusing offers of an annual health check. Twenty five practices responded and key points noted are as follows:

- Majority of responding practices send three letters to the patients. If there is no response to those letters then some will try to phone the patient/carer or record no response

- Some parents/carers have stated that patient does not wish to have a health check as they see their GPs on a regular basis anyway.

- Practices state that appointments are often changed or cancelled

- Offers of undertaking health checks at home seem to be most efficient way to avoid non attendance at practice premises and achieve higher uptake. Home visits are particularly useful when carrying out checks on those who live together in the community.

Both the PCT and the GP liaison nurses will continue to work with practices, care providers and patients to ensure that good practice is shared and the offer of an annual health check is taken up as much as possible.

5.11.2012
Angie Eachus
Programme Manager, Primary Care Contracts
NHS Oxfordshire

Oxfordshire Clinical Commissioning Group

NHS

Update from the Oxfordshire Clinical Commissioning Group (OCCG)

1. Authorisation

For the September meeting of the Health Overview and Scrutiny meeting, an update was provided on how OCCG is progressing towards taking statutory responsibility for planning and purchasing healthcare for people in Oxfordshire in April 2013 when NHS Oxfordshire is disbanded.

The NHS Commissioning Board (NHSCB) is reviewing evidence submitted by CCGs to satisfy the 119 criteria that fall within six domains:

1. A strong clinical and multi-professional focus which brings real added value.
2. Meaningful engagement with patients, carers and their communities.
3. Clear and credible plans which continue to deliver the Quality, Innovations, Productivity and Prevention (QIPP) challenge within financial resources, in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies.
4. Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commissioning all the services for which they are responsible.
5. Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.
6. Great leaders who individually and collectively can make a real difference.

Since the last update OCCG have hosted a visit from members of the NHSCB who wanted to further explore the remaining 30 unmet criteria required for authorisation.

During the visit, the NHSCB panel members carefully questioned members of OCCG about a number of key areas including their constitution and accountability, arrangements for safeguarding, their financial plans and arrangements for engagement.

Feedback following the visit confirmed that a further 21 criteria had been met, leaving just nine needing further work:

- Three related to the constitution, the specific wording not adequately reflecting the national model and the two way accountability not being clear for member practices. OCCG plans to review the constitution with member practices during January and so will address these criteria at that stage.

- Three relate to the clear and credible plan. OCCG will update its Operational and Quality, Innovation, Productivity and Prevention (QIPP) Plan which includes developing further the financial plans for 13/14, 14/15 and 15/16. OCCG will continue to monitor delivery of the current plan and mitigation where plans are not on course.
- One relates to arrangements for safeguarding. Until OCCG is a statutory body it is working under the arrangements agreed for the PCT. It is reviewing these and making appropriate amendments where necessary so that arrangements are in place for OCCG on 1 April 2013.
- Two related to commissioning support arrangements, the capability to manage the commissioning support arrangements provided and having plans to formally procure commissioning support between 2013 and 2016. OCCG has made progress in appointing to its senior structure and so believes the first of these is now met. It is also developing outline plans for procuring commissioning support whilst national guidance is awaited.

The national timetable for authorisation has been amended slightly and the NHSCB are currently considering what conditions might apply to OCCG before allowing further information to be provided which should ensure six of the criteria are met leaving those relating to the constitution to be addressed in the new year. A final decision will be made by the NHSCB in December and this will be announced publicly.

2. Appointing to the new structure of OCCG

An offer has been made for the final director post to be recruited to – the Director of Partnerships and Development. This is a key role on the executive team and will have a lead for all joint commissioning and all commissioning for pan-Oxfordshire.

All Assistant Director posts have been appointed to and a staff consultation on the remaining structure of the organisation has been completed. It is anticipated that recruitment to the structure will begin on 7 November 2012.

3. Developing Public Involvement within OCCG

Informing and engaging with the public is important for the development of OCCG, especially during this time of change and transition. It is vital that OCCG develops its stakeholder relations, including the way it seeks and uses feedback to inform decision making in developing health services for the people of Oxfordshire.

OCCG is seeking to build on the platform established by NHS Oxfordshire to develop and extend its own relationships with the public so that people living in Oxfordshire and working within the NHS locally feel informed and included in its work.

Following the launch of the new clinical commissioning model for Oxfordshire in January 2011, a communications and engagement approach was put into place in order for GPs leading the development to begin to develop relationships and enter into dialogue with the local population and other key stakeholders. Developing and running public events played a central role in this process.

With engagement and involvement from our local population and other key stakeholders, through public events and a public consultation, a Communications and Engagement Strategy was put forward and agreed by OCCG in December 2011. This Strategy provided a framework for improving and strengthening the quality and delivery of communications and engagement activities to support OCCG in all aspects of its work.

3.1 Developing Patient Participation Groups

Part of implementing the OCCG Communications and Engagement Strategy was to develop local patient participation groups (PPGs) in more of the practices within Oxfordshire. The aim of this was to facilitate grass roots patient and public engagement. PPGs vary in their ability to influence decision making and there is no set way in which they work; the aims and working of each group entirely depends on local needs. However they should have a common aim of making sure that their GP practice puts the patient, and improving health, at the heart of everything it does.

PPGs are one of many routes to gain more local engagement and it is important to reflect on and identify the opportunities to engage afforded by working with the voluntary sector, the charitable sector, local faith groups and a variety of community groups as well as strengthening PPGs.

To understand more about how practices are developing their PPGs an audit of Oxfordshire practices was undertaken; this gave OCCG information about the number and effectiveness of PPGs within Oxfordshire. Through this work OCCG have been able to identify practices that would benefit from support in developing their existing PPGs and offer support to those who would like help establishing a practice PPG. This work has commenced and is on-going with the support of the Local Involvement Network (LINks).

3.2 Developing Public Locality Forums

During the OCCG Communications and Engagement Strategy consultation OCCG asked members of the public about a proposed model for locality engagement (see appendix a); concerns were raised about the look and feel of the structure of the model and the detail of how it would be implemented to help promote inclusive engagement in decision making:

- Participants told us that the structure was too hierarchical and needed to be revised.
- Feedback also indicated that the term “Citizen Forum” was not well liked and hard to associate with.
- More than one public representative at locality and OCCG Board levels would be desirable.

As a result of the feedback on the model, the development of the Health and Wellbeing Structure and a developing understanding OCCG public involvement needs, as the organisation and Localities grew, the proposed model was not progressed and instead work was been undertaken to develop OCCG’s reach in lots of different areas.

Work to replace the model identified in the Communications and Engagement Strategy is to develop Public Locality Forums associated with each Locality; this will enable OCCG to ensure that the public voice is heard throughout the commissioning process from decisions made by practices through to the locality groups and onto the Board level, commissioning for the whole county. We are progressing these currently in all Localities and hope to have a forum in place for each locality by April 2012. Each forum's focus and form will be different as localities differ however the underlying aim is to get public involvement at locality level to feed into OCCG decision making and service redesign as well as the forums being able to raise issues locally; however essentially the purpose will be the same - to create a mechanism by which the OCCG Locality Groups can have two way engagement and involvement with their public on their decision making going forward.

3.3 Establishing the Public Involvement Network

Since the establishment of OCCG we have worked closely with our local population and key stakeholders in order to develop the routes and methods to involve and engage with our local population.

This includes working closer with our County and District Councils, via the Public Involvement Network, NHS partners and the voluntary/charitable sector to develop routes to access a wider audience.

OCCG is a key partner (and coordinator as we jointly fund the officer responsible for coordinating the PIN) in the development of the County's Public Involvement Network (PIN). The PIN is a mechanism being developed as part of the Health and Wellbeing (HWB) Board Infrastructure to ensure that representative opinions and experiences of Oxfordshire people underpin the strategy and commissioning carried out by Oxfordshire's Health and Wellbeing Board. The PIN includes people of all ages, circumstances, cultures and faiths, abilities and geographical locations across Oxfordshire. It is also responsible for ensuring that Oxfordshire's Voluntary, Community and Faith sectors are engaged and able to contribute their expertise and knowledge to influence and shape the debates. It is responsible for developing an Engagement Strategy and annual action plans covering the engagement activity of the shadow HWB Board and its partnership boards. Public representatives have also been appointed with the involvement of OCCG through formal recruitment process to sit on the partnership boards of the HWB Board structure.

3.4 Transfer of Talking Health

So far, OCCG has used the PCTs online consultation tool Talking Health. However, as part of the transition Talking Health has been transferred to OCCG to use as their online consultation and engagement tool. The system will enable OCCG to keep a self-maintaining, accurate record of people that want to be involved and have their say about their local NHS. As part of the transfer an audit was undertaken to review the list of people signed up to Talking Health and to ensure members were happy for their details to be transferred to OCCG.

When members of the public or organisations register to be involved, they can express their subject preferences. This enables us not only to inform them about the public of consultations that are meaningful and relevant to them, but also communicated in the way that people prefer e.g. via email or post.

Talking Health will enable OCCG staff to run consultation projects quickly and easily, to manage them online, create surveys, discussion groups or enable commenting on structured documents e.g. strategy documents.

Reports can also be generated at a touch of a button for each survey, a single project or all projects – providing accurate results and evidence of the OCCG's public involvement and engagement.

Talking Health also features a 'You Said, We did' section completes the circle of engagement – providing evidence of what has actually changed in Oxfordshire as a result of public feedback.

Currently OCCG have over 2000 members registered on Talking Health; a publicity campaign is due to be launched in the next month to encourage more people to sign up to the consultation system.

4. Next Shadow Governing Body (SGB) meeting in public

The next meeting of the Shadow Governing Body in public will take place on 4 December 2012. Papers will be published on the OCCG website on 28 November.

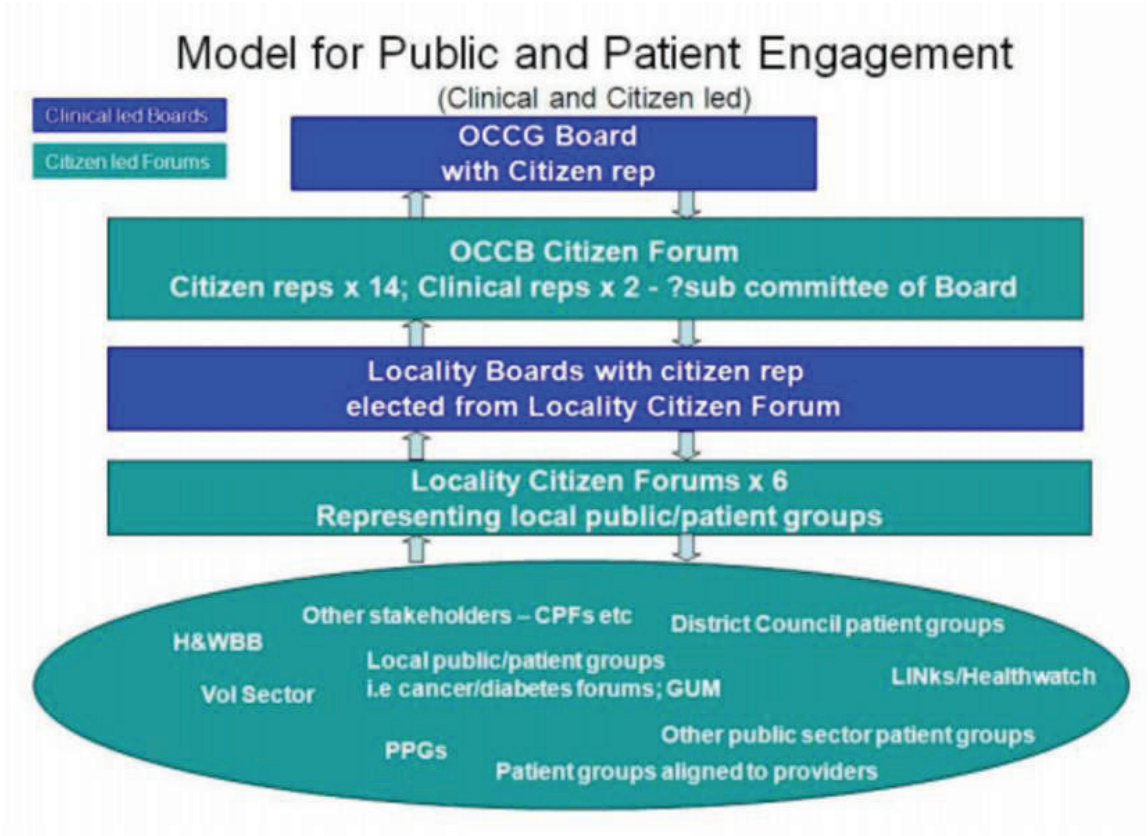
For more information:

For more information about the communications and engagement strategy please visit the OCCG website: Communications and Engagement Strategy - Oxfordshire Clinical Commissioning Group and for an update on implementation of the strategy please visits: http://www.oxfordshireccg.nhs.uk/involve-me/documents/CommunicationsandEngagementUpdate.pdf

1 November 2012

Oxfordshire Clinical Commissioning Group

Appendix a:


Model for Public and Patient Engagement
(Clinical and Citizen led)
Clinical led Boards
Citizen led Forums
OCCG Board
with Citizen rep
OCCB Citizen Forum
Citizen reps x 14; Clinical reps x 2 - ?sub committee of Board
Locality Boards with citizen rep
elected from Locality Citizen Forum
Locality Citizen Forums x 6
Representing local public/patient groups
Other stakeholders – CPFs etc
District Council patient groups
H&WBB
Local public/patient groups
i.e cancer/diabetes forums; GUM
LINks/Healthwatch
Vol Sector
Other public sector patient groups
PPGs
Patient groups aligned to providers

Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting 15th November 2012

Ongoing Health projects and engagement:
Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following project being undertaken. **N.B. The following update refers to LINk projects which have a Health remit only, unless there is joint interest, or commissioning, with Social Care services**

Maternity Services review

The project is now in its third month – the following summarises the current status:

Important to note that many positive comments have been received, which will be included within the final report. Recommendations, at the time of writing, will be centred on improvements which could be made in the support received after birth, for example:

- Breastfeeding – is pushed as best, then not followed up with the right level or regularity of support;

- Consistency of support – seeing many different health visitors after the birth, which leads to conflicting information being given; lack of signposting onto other services and inability to develop a relationship with professionals.

LINk is aware of the proposal to change the way in which OCCG will contract for Maternity Services from April 2013, through Outcome Based Commissioning, with the following indicators derived from key themes coming through local and national work on maternity outcomes. These can be summarised as:

- Choice of where and how to receive services
- Continuity of care especially one-to-one care in labour and birth
- Early access to services and reducing avoidable admissions to neonatal units
- Reducing differences in outcomes between communities and groups (e.g. breastfeeding)

Priority areas identified for Oxfordshire women: In September, the Joint Commissioning Team started early discussions with local users and representatives on what outcomes they would prioritise. These are summarised below:

- Breastfeeding
- Maternal mental health
- Continuity of care (especially in antenatal period)
- One to one care in labour
- Normal birth
- No unexpected admissions at term (40 weeks)

The above areas fall broadly in line with current LINk findings. The LINk review and outcomes will be taken into account for future Commissioning decisions.

LINk have also received formal requests to look into the issues with Wantage and Chipping Norton Maternity Units. The following statement has been received from OUH regarding Wantage: "Following the completion of the roof works at Wantage Community Hospital and a successful recruitment drive, the maternity unit at Wantage will reopen for births on the 26th November 2012".

'Enter and View' visits to Care Homes

The second series of visits to 30 care homes, ongoing from April 2012, has been completed. The report was presented to Adult Services Scrutiny Committee on 13th Nov and is included for information. An additional report regarding a visit to the Drug & Alcohol Detoxification service at Howard House is included here with reference to the earlier LINk project in 2010.

Mental Health Hearsay

A follow up event will take place on **6th December from 10.30am-1.00pm** at the Old Fire Station, Oxford, to hear progress on the action plan from the previous event, agreed with Oxford Health and the PCT/OCCG commissioners and which has also been considered by the Joint Management Group (JMG) and the Better Mental Health in Oxfordshire Board (BMHO).

OMEGA report into the system for referral and treatment of CFS/ME patients

The final report has been delayed a little due to difficulties in obtaining & verifying some of the statistical information. However, the intention is to table the report for members to consider in due course and to request feedback at the January HOSC meeting from members, together with the commissioner and providers. Copies of the report will be available following the meeting.

Adrian Chant (LINk Locality Manager)
01865 883488
Update 05/11/2012

LOCAL INVOLVEMENT NETWORK - visit to the Drug & Alcohol Detoxification residential facility at HOWARD HOUSE, OXFORD

In 2009 LINk reported to JHOSC that the Oxford DRP (Drug Recovery Project) in Walton Street, a drug and alcohol detoxification unit for homeless people had been closed without public consultation. JHOSC supported the LINk request that this service should be reprovided and after discussion the PCT and Drug and Alcohol Action Team opened Howard House in November 2010. The service is run by SMART. Two LINk members 'entered and viewed' Howard House on 14th June 2012:

This House is different from the other Care Homes visited by LINk members. It provides short (approximately ten week) courses to enable drug and alcohol addicts to detoxify. So the standard questionnaire provided by LINk (for homes catering for permanent elderly residents) is not appropriate. Nevertheless we tried to answer variations of the questions suggested.

The home was clean with a good smell. Staff and residents were welcoming. Furnishings and surroundings (including a garden) are pleasant and well-maintained - mostly by the residents as part of their treatment. The residents also do the catering (with advice). It has ten single bedrooms (all with private facilities). It is registered with CQC, but has not been inspected yet.

The ten residents usually comprise six men and four women (occasionally eight men and two women). About one third are drug addicts, one third alcoholics and one third both. Approximately half are homeless and Howard House receives housing benefit for them. The others have their own accommodation and their housing benefit has to pay to keep this accommodation for their return after treatment. This immediately leads to financial problems for Howard House as the budget is based on the provision at the previous treatment centre which catered almost entirely for homeless people.

Admission follows multi-professional assessments and there is a waiting list of about ten people.

Naturally most residents enter with fairly chaotic and unhealthy life-styles. There are mental health issues for many of them. As well as the drug reduction treatment, the staff also try to provide an orderly domestic programme including advice on healthy eating, cooking and conflict resolution.

We did not see any of the treatment, which consists of a mixture of structured group work and individual work. There are four full-time professional workers, plus a specialist addictions nurse and weekly visits from a specialist GP.

Howard House also has about ten volunteer 'mentors' - mostly past residents - who help to motivate those undergoing the treatment. Residents leaving the house will be accompanied by mentors at all times. There are classes onsite in gardening, yoga, acupuncture and art. Residents may go offsite for other activities (such as Alcoholics Anonymous). The hope is that after finishing the course, residents will continue with some of these activities.

The measure of success is whether residents complete the course - target 70% and actual result about 76%. Clearly a better measure would be whether they stay dry, but collecting this data is difficult. Some relapsed patients are given a second opportunity.

We were shown round by residents who were full of praise for the House and the programme. Disabled access could be improved.

Pamela Fletcher and Dermot Roaf
Authorised visitors

This page is intentionally left blank