OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 5 December 2013 commencing at 10.00 am and finishing at 2.00pm.

Present:

Voting Members:	Councillor Lawrie Stratford – in the Chair
	District Councillor Alison Thomson (Deputy Chairman) Councillor Kevin Bulmer Councillor Pete Handley Councillor Mark Lygo Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Martin Barrett District Councillor Dr Christopher Hood Councillor Susanna Pressel District Councillor Rose Stratford
Co-opted Members:	Dr Harry Dickinson, Dr Keith Ruddle and Mrs Anne Wilkinson.
Officers:	
Whole of meeting	Claire Phillips and Julie Dean (Chief Executive's Office); Director of Public Health

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

126/13 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

There were no apologies for absence or temporary appointments.

127/13 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

128/13 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 5 September 2013 were approved and signed subject to attendee Tina Asmal being altered to Tina Ashwell and the following amendment to line 1, page 5 (additions and amendments in bold)

'A ***nutritional*** plan was put in place ***for the duration of their stay if there were concerns and these*** were fed back to their GP on discharge.'

Matters Arising from the Minutes

With regard to Minute 122/13, paragraph 2, the Director of Public Health pointed out that it was vital that the broader Health community should try to focus together on topics. The Health and Wellbeing Board would take a joint, strategic view and this Committee would hold the outcomes to account. He added that officers were due to meet informally in the new year to look at how the different forward plans could be linked together.

129/13 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman of Healthwatch Oxfordshire, Larry Sanders, addressed the meeting giving an oral report on activities and short-term priorities.

He reported that some short- term priorities had been set, looking at issues which could be done relatively quickly. These topics included:

- access to GP appointments
- care homes – focusing on patient experience
- domiciliary care – in particular 15 minute visits
- whistle blowing

Keith Strangwood, Chairman of Keep the Horton General, read from his statement which had been circulated previously to members of the Committee. The Chairman agreed to it being appended to the Minutes.

130/13 CLINICAL COMMISSIONING GROUP STRATEGIC UPDATE

(Agenda No. 5)

Dr Stephen Richards, Oxfordshire Clinical Commissioning Group (OCCG) and Andrew Stevens, Director of Planning & Information, Oxford University Hospitals NHS Trust (OUHT) began by addressing some of the issues raised by Mr Strangwood with regard to services in the north of the County.

Mr Stevens advised the meeting that it had been necessary to make changes to the emergency general surgery service at the Horton Hospital, Banbury for clinical safety reasons that the OUHT were not able to foresee. The number of general surgeons at the hospital had reduced from 5 to 2 in a short space of time and the hospital was unable to recruit general surgeons as the changing medical standards issued by the Royal College of Surgeons had recommended that a patient should be treated by a

specialist surgeon. The decision had been taken to suspend this service at the Horton. An independent review conducted by the Royal College of Surgeons had supported this decision.

While putting in arrangements for an alternative pathway the Trust had listened to patient and GP feedback and had taken measures in the interests of patients. This had resulted in the establishment of an emergency clinic for minor operations such as the drainage of abscesses, the outcome of which had resulted in fewer transfers to the John Radcliffe. It had also been recognised that it would be possible to strengthen other pathways at the Horton Hospital, such as those for patients with thoracic or neurological problems. Assurance was given that full attention would be paid to improving the clinical outcomes for patients.

In conclusion he told the Committee that he saw a full and vibrant future for services at the Horton Hospital with far more patients being seen in the north of the county. However, some services would have to change and relocate to Oxford, not for cost reasons, but for clinical reasons. The Trust had been working with the OCCG and a consultation document would be submitted to the Committee for comment after the finalised strategies for the OCCG had been agreed.

Members of the Committee urged the Trust and the OCCG to consider holding a full public meeting in Banbury by the end of January 2014. During discussion the Committee asked that information on travel arrangements (particularly for travel in heavy traffic conditions) to Oxford for patients living in the north of the County who require emergency care be addressed. Mr Stephens responded that transport protocols had been agreed for patients.

The Committee asked why the issues relating to general surgery had not been anticipated within contingency plans for services. Mr Stephens responded that this had been anticipated via patient engagement with the Better Healthcare Programme for the Horton. As a result, the number of patients seen in the Emergency Trauma Clinic had been increased. The training of surgeons had also been raised as a part of this Programme, but unfortunately emergency action had had to be taken. The Trust would have liked to have addressed this in a planned way.

The Committee asked whether consideration had been given to the formation of a rota of surgeons able to perform emergency surgery at the Horton Hospital. Mr Stephens responded that the Trust wanted to increase the volume of routine day surgery at the Horton site but it would not be viable, however, to construct an emergency rota which spanned both sites.

Dr Richards informed the Committee that the OCCG's Governing Body had supported the cessation of emergency surgery on health & safety grounds in line with the changes in national clinical quality standards. In the meantime a detailed patient survey audit was being undertaken to provide evidence of users who had been through the service, before commissioners could make informed decisions about whether to reinstate the service. In addition, any change would require the support of the GP community. Dr Richards said the clinical audits of patient outcomes would be required before engagement at a public meeting. There would also need to be a dialogue with lead GP commissioners in the rest of the county to balance the clinical

view. Thus, to give a better informed views, a full year's local data collection (March 2014) would be required, together with views collected from a patient questionnaire. Members agreed that an informed decision would require the three pieces of information to be considered.

The Committee **AGREED** to request the Trust/OCCG to hold two public consultation meetings in the Banbury area by the end of January 2014 and the outcomes to come to the 27 February 2014 meeting of this Committee. This would serve to give members an idea of the views aired by the public and therefore an idea of whether further consultation should be recommended.

Dr Stephen Richards introduced the OCCG briefing paper (JHO5) which updated the Committee on various topical issues. He reported a decision to add an extra evening consultation meeting on the shaping of the Strategy on 7 January 2014 to the schedule. External consultants were currently working alongside the clinical and management teams to help improve the financial situation, the cost of which was coming from the current management budget and would not incur costs to the system. It was hoped that the costs of this support, together with some internal support, would leave the OCCG in as good a position not to need this level of support in the future. He added that the revised governance model was considered to be more sustainable from a financial point of view over the next 5/10 years, whilst retaining strong clinical leadership.

Dr Richards confirmed that Oxfordshire had received £10.1 million of winter pressures funding from central government which would be spread across the health system. He confirmed the money had been received in good time so that it could be spent on the initiatives which would have the biggest impact.

Dr Richards explained that OCCG believed that Outcome Based Commissioning was the viable route for certain services and offered to attend a future meeting of this Committee to discuss this work. He explained that the OCCG Governing Body had approved the principles of the business cases for Outcome Based Commissioning but expressed recognition of the need to work more collaboratively by continuing to strengthen the dialogue with the public and major providers.

Dr Richards noted and agreed to provide information on the amount of GP referrals to consultants and the length of time between the first consultant's appointment and the second.

Dr Richards was thanked for his report and for making himself available to answer questions from the Committee.

131/13 THE FUTURE OF COMMUNITY AND MENTAL HEALTH IN OXFORDSHIRE

(Agenda No. 6)

Eddie McLaughlin, Anne Brierley and Ros Alstead from Oxford Health (OH) attended the meeting to discuss their plans for remodelling community and mental health services and their approach to safety and security. The Committee had before them the briefing documents (all at **JHO6**).

In response to questions from members, the speakers confirmed that OH was implementing its new model for mental health and older people's care and addressing any logistical problems. OH was working with the Community Hospitals with regard to the provision of care on a geographical basis. It was noted that there were two specialist single sex wards located in the Littlemore Hospital.

Mental Health referrals to the service could be received from patients directly or from members of the public. Mr McLaughlan confirmed that there could be delays in accessing urgent care, for example when a patient was sectioned under the Mental Health Act, when social workers had to be present, as this was dependent upon demand for their time.

In response to a question, Mr McLaughlan advised that the Trust did receive alerts of vulnerable people from the general public about people living alone at home with deteriorating mental health , and this was acted upon with the appropriate support. He added that with regard to patient self referrals who present with enduring mental health problems, arrangements were made for them to return into the system as necessary. To allow ease of access, GPs would also be able to fit directly into slots for hospital care on a 'Choose and Book' basis.

Concerns were raised by members regarding support for people who did not have the mental capacity to operate their personal health budget(PHB). OH confirmed that they would continue to work with the Department of Health to find an appropriate model of support.

Respite for carers was raised. OH stated that they were very committed to giving the right service for carers, this being one of the key priorities for the Health & Wellbeing Board. Carers breaks could be accessed via GPs.

As requested, the OH gave an update on safety plans following two recent security breaches. A CQC briefing focusing on physical security had been prepared and the subsequent actions for the Trust had now been signed off.

Members felt that there was a need to back up the report with substantive information and data, for example, with information of staffing levels and approaches taken with patients presenting with various problems. Ros Alstead agreed to provide this information advising that the Trust held a considerable amount of information which informed on whether services were effective. Furthermore, base line assessments could be done at the start and end of treatment, and at points in between.

The Committee thanked the representatives for their attendance. They accepted an invitation to return to a future meeting to review how the new model was working in practice.

132/13 PERFORMANCE FOCUS: DELAYED TRANSFERS OF CARE

(Agenda No. 7)

The following leaders of the Health and Social Care community presented a report **(JHO7**) on the issue of delayed transfers of care (DTOC) in Oxfordshire.

John Jackson, Oxfordshire County Council
Dr Stephen Richards, Dr Barbara Batty and Kirsteen Murray (specialist consultant in DTOC) - Oxfordshire Clinical Commissioning Group
Sarah Randle and Dr James Price - Oxford University Hospitals NHS Trust
Yvonne Taylor and Anne Brierley, Oxford Health NHS Foundation Trust

The aim of this session was to understand the complex issues involved in the integrated DTOC pathway and for the Committee to gain confidence in the future plans.

In response to a question, Kirsteen Murray, consultant, said that local leaders were very committed to solving the problems associated with DTOC in Oxfordshire and were working together despite financial difficulties within their own organisations. She added that their particular interests had influenced it also. John Jackson commented on the need for organisations to look at the entire pathway and not just their part.

Yvonne Taylor pointed out that one year ago the Discharge Pathway Policy had been introduced, which had resulted in targets reaching an 80% discharge rate, sometimes 92%. The 20% that was not working had been due to the fact that people's needs, particular those of older people, could not be met in a single pathway. She added that an example of an improvement as a result of the Policy was the reduction of the average length of stay in hospital from 22 days to 19, resulting in the opportunity to take in more admissions. A single point of access had also been introduced, the outcome of which was a more consistent average figure of 20 delays when previously there had been 30 – 40. They were working to dovetail Social Care into a 7 day per week hospital presence instead of 5 in order to increase the rate of discharges over the weekends so as to avoid problems for other organisations involved, such as domiciliary care. Advance notification from the Community Hospitals of social care required by patients on discharge had improved. John Jackson added that for the past year a provider had been commissioned to produce care packages from home as a continuation of the discharge process. A new provider had begun work that week with a key priority to secure an immediate response and this would be monitored closely.

Access to care more generally was being considered by the OCC/OCCG Joint Management Group, one of its aims being to bring more people, such as Health Care apprentices, into the social care agenda to meet the rising demand in the domiciliary care market (number as well as size of care packages now needed).

Parallel working on assessments between health and social care was considered to be an important area by members as delays in assessments had existed for a

number of years. Complicated assessments could be completed in 10 minutes but there were a small number of complex assessments that could take a very long time as needs may have to be met across multiple areas and this could skew the average assessment time. Health and Social Care were doing a piece of work aimed at managing the level of demand and to reduce the average time to do assessments from 3 days to one day.

In response to a question from the Committee as to why the numbers of people waiting for admission to a care home in the county was so high. Members were advised that although patient choice was paramount, this did result in a high number of delays as patients may not choose to go to a care home where there was space for a variety of reasons. There was also a concern that care homes could sometimes be seen as the default option when sufficient care could be given in the patient's own home. The average length of stay in a care home was increasing from 3 years to 5 years. The Team felt that there was a need to challenge the perception that a care home was the only option. Dr Richards said that the Integration Transformation Fund would help drive the change over the next 5 years so that more people received care at home.

Members noted that 100 intermediate care beds had just been purchased and awarded to a contractor in the south of the county. For optimum success intermediate care required the help of re-enablement and rehabilitation services. Dr Price highlighted the tension inherent in the system between the wish to deliver care very close to people's homes or to build bigger clusters of beds in larger facilities which could provide more staff for crisis care and a more economical service.

The question of community hospital provision was raised by Members. Dr Richards pointed out that the majority of community hospital beds were located in the south of the county and this needed to be addressed. Each bed needed to be more effectively used. It was in the OCCG's 5 Year Strategic Plan to look at this countywide. Community hospital care was a very good resource for Oxfordshire, however, with more ambulatory care, more diagnostics, more out-patient and day care, the provision may need to change. He said that care nearer the home, outside of acute care was the best way of delivery.

In response to comments from members about the 'unacceptable' waiting times for medicines upon patient discharge, OUHT confirmed they were working together with pharmacists to address the issue and employing pharmacists who could prescribe on the wards.

Speakers assured the Committee that there was no detrimental impact on performance as a result of the university's involvement with the Trust.

Members asked why there was an endemic, systemic problem in Oxfordshire and what it was that needed to be done. Dr Richards responded that Oxfordshire had a larger expenditure on bed care than many other areas. Demand was higher than

other counties and the challenge would be to convince the public that people could be supported in their own home for longer. Kirsteen Murray advised that a community services review was underway as part of the Older People's Programme to look at the proliferation of services to eliminate any duplication and ensure services were delivered effectively. The review would be complete by the end of June 2014. Part of the work was also to look at contract end dates to make them coterminous and then to retender them. Dr Richards concluded that major collaborative work looking at the benefits and potential dis-benefits of outcome-based contracting, increasing the older people pool and Integration Transformation Fund would take 3 – 5 years. The OCCG were optimistic that the outcomes of this work would be successful.

The Chairman on behalf of the Committee thanked all the representatives who had taken part, adding that it would be revisited in the future. He asked that in the meantime data specifying the length of delays and the age profile be submitted to the Committee.

133/13 THE CARE QUALITY COMMISSION'S APPROACH IN OXFORDSHIRE

(Agenda No. 8)

Teresa Anderson, Compliance Manager (Oxfordshire) and Nick Kerswell, Communications Manager for the Care Quality Commission (CQC) explained the role of the Commission, its work in Oxfordshire and the organisation's response to the Francis Report recommendations.

It was noted that OUHT had been identified as one of the next tranche of acute trusts to be inspected in February as part of the Foundation Trust application.

It was felt that even pre-announced inspections of such large trusts would uncover issues.

Members were advised that procedural information about the future inspection of primary care would be announced during the next week.

The CQC confirmed commissioners would be consulted before a provider was inspected and CQC representatives agreed to take back a request that local government modes of communications and quality systems be linked in to their new model.

Teresa Anderson and Nick Kerswell were thanked for their presentation.

134/13 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 9)

The Chairman gave a verbal update on meetings he had attended since the last formal meeting of the Committee.

It was requested that the Oxford Health's Annual Report be added to those items to be considered for inclusion in the Forward Plan. The current Forward Plan document was before the Committee at JHO9.

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JHO3

..... in the Chair

Date of signing