***Notice of Meeting*** Public Document Pack

# Oxfordshire Joint Health Overview & Scrutiny Committee

## Thursday, 16 September 2010 at 10.00 am
## County Hall

**Membership**

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - Councillor Susanna Pressel

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| *Councillors:* | Tim Hallchurch MBE | Neil Owen | Don Seale |
| | Jenny Hannaby | John Sanders | Lawrie Stratford |
| *District Councillors:* | Christopher Hood | Rose Stratford | |
| | Jane Hanna OBE | Hilary Fenton | |
| *Co-optees:* | Ann Tomline | Dr Harry Dickinson | Mrs A. Wilkinson |

***Notes:*** ***There will be a pre-meeting for members of the Committee at 9:00 am on 16 September 2010.***
***There will be a lunch provided for members at 12:45 pm.***
***Date of next meeting: 11 November 2010***

**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:**

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| Chairman | - | Councillor Dr Peter Skolar<br>E.Mail: peter.skolar@oxfordshire.gov.uk |
| Committee Officer | - | *Julie Dean, Tel: (01865) 815322*<br>*julie.dean@oxfordshire.gov.uk* |

Tony Cloke
Assistant Head of Legal & Democratic Services

September 2010

## 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.

Health Scrutiny complements the work of the Patient and Public involvement Forums that exist for each of the NHS Trusts and Primary Care Trusts in Oxfordshire.

## 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

To approve the minutes of the meeting held on 8 July 2010 (**JHO3**) and to note for information any matters arising on them.

## 4. Speaking to or Petitioning the Committee

## 5. Liberating the NHS - the White Paper on Health

**10.30 am**

The recent White Paper and other related consultation papers set out a whole series of radical proposals for change to the NHS. The White Paper is now out for consultation with responses required by 11 October 2010. The proposals can be grouped together under three main headings:
Consideration of the White Paper will be in three parts:

Adult Social Care – A paper by the Director of Social & Community Services entitled 'Health White Paper' is attached at **JHO 5(a).**

Public Health
A report by the Director of Public Health is attached at **JHO 5(b).**

Implications for Oxfordshire County Council and the Implementation of the Proposals – to include the implications for the Oxfordshire Joint Health Overview & Scrutiny Committee and for the Health & Well Being Partnership Board – current and future. A report by the Health Scrutiny Advisor is attached at **JHO 5(c).**

A wide range of speakers from Health, the County Council and other interested organisations have been invited to address the Committee on the issues raised by the proposals.

Members of the Committee will be asked to consider their response to the consultation.

A copy of the White Paper entitled 'Equity and Excellence: Liberating the NHS' is enclosed together with two associated consultation papers entitled 'Liberating the NHS: Commissioning for Patients' and 'Liberating the NHS: Local democratic legitimacy in Health'.

## 6. Lessons from the IRP Review: The Importance of Community Engagement

**12.00 noon**

The Better Healthcare Programme for Banbury and the surrounding area has been a major community engagement project. With the advent of the White Paper, and talk of a 'Big Society', how can lessons learnt locally help to ensure that health services are designed and delivered with, and for, patients and the public? Julia Cartwright, Chair of the Community Partnership Forum, will share insights into the benefits of, and barriers to, collaborative working.

A copy of Julia Cartwright's presentation entitled 'Lessons from an IRP Review: The Importance of Community Engagement' is attached at **JHO 6.**

**LUNCH**

## 7. Nuffield Orthopaedic Centre (NOC) - update

**13:15 pm**

The Chief Executive of the Nuffield Orthopaedic Centre will speak to the Committee on the Centre's present position and its possible future position.

## 8. The Discharge of Patients from Acute Hospitals

**13:45 pm**

Representatives from Patient Voice, (a group of members of the former Oxfordshire Radcliffe Hospitals Trust (ORH) Patient & Public Involvement Forum), will present their report, which was been commissioned by the Oxfordshire LINk, on Discharge Procedures. They will be accompanied by a representative from the Oxfordshire LINk Steering Group.

Copies of the papers submitted by Patient Voice are attached at **JHO 8.**

## 9. Oxfordshire LINk Group – Information Share

**2.15 pm**

An update of the latest Oxfordshire LINk activity is attached at **JHO 9.**

## 10. Chairman's Report

**2.30 pm**

The Chairman will report on the meetings he has attended since the last meeting.

# Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

**The duty to declare …**
You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

**Whose interests are included …**
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

**When and what to declare …**
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

**Taking part if you have an interest …**
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

**"Prejudicial" interests …**
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

**What to do if your interest is prejudicial …**
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

**Exceptions …**
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

**Seeking Advice …**
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

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# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Thursday, 8 July 2010 commencing at 10.00 am and finishing at 1.38 pm

**Present:**

| | |
|---|---|
| **Voting Members:** | Councillor Dr Peter Skolar – in the Chair |
| | Councillor Jenny Hannaby<br>Councillor John Sanders<br>Councillor Lawrie Stratford<br>Councillor Susanna Pressel (Deputy Chairman)<br>District Councillor Rose Stratford<br>Councillor Mrs Anda Fitzgerald-O'Connor (In place of Councillor Tim Hallchurch MBE)<br>Councillor Ray Jelf (In place of Councillor Don Seale) |
| **Co-opted Members:** | Ann Tomline<br>Dr Harry Dickinson<br>Mrs A Wilkinson |
| **Officers:** | |
| Whole of meeting | Julie Dean and Roger Edwards (Corporate Core) |

*The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.*

## 39/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Alan Davies attended for Councillor Hilary Fenton; Councillor Ray Jelf for Councillor Don Seale; and Councillor Anda Fitzgerald-O'Connor for Councillor Tim Hallchurch MBE. Apologies were received from Councillors Neil Owen and Jane Hanna OBE.

The Committee congratulated Cllr Hanna on receiving her OBE.

## 40/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillor Lawrie Stratford and Councillor Rose Stratford both declared a personal interest in Agenda Item 7 on account of their membership of the Bicester Hospital

League of Friends. Councillor Dr Peter also declared a personal interest in Agenda Item 7, on account of his membership of Henley Town Council.

**41/10 MINUTES**
(Agenda No. 3)

The Minutes of the meeting held on 20 May were approved and signed, subject to the addition of a recommendation (e) in Minute 32/10 at the bottom of page 8, to read as follows:

'request the Working Group to submit their report to the next meeting of this Committee.'

**42/10 SPEAKING TO OR PETITIONING THE COMMITTEE**
(Agenda No. 4)

The Chairman had given his agreement to the following people addressing the meeting:

- Councillor John Sanders, speaking in his capacity of local member, addressed the Committee on the Silver Star Maternity Unit – Item 10 Information Share;
- Patrick Taylor, Chief Executive, Oxfordshire MIND and Alex Taylor, Manager, Bridewell Organic Gardens – Agenda Item 9 – Chairman's Report – 'Keeping People Well Project Group.'

Councillor John Sanders expressed concern at the lack of notice given of the closure of the Silver Star Maternity Unit, John Radcliffe Hospital, resulting in an article in the Oxford Mail in which members of the public had expressed their worries about the risks relating to the closure. He asked for details of the planned closure and a timetable leading to its re-opening.

Andrew Stevens, Director of Planning & Information and Susan Brown, Senior Communications Officer, Oxford Radcliffe Hospitals NHS Trust had been invited to attend the meeting in order to respond to questions from the Committee. They commented that there had been a significant amount of miscommunication on the part of the media with regard to the situation and welcomed the opportunity to give a true account of the changes to the service. They informed the meeting of the following:

- The service was not closing, exactly the same range of services would be available over the summer months;
- The plans were to reconfigure the service over the summer months, as had happened in previous years, by reducing the number of floors from where the service was provided, from 3 to 2, in order to respond to demand for the service, staff holidays etc;
- The sole driver for the temporary closure was patient safety and midwifery contracts, there being fewer midwives recruited to contracts, due to staff summer holidays;
- In order to provide the same quality of care and effectiveness, services were to be rationalised with a reduced resource base;

- The Trust had monitored issues such as caesarean and mortality rates in past years and there had been no evidence that they had risen in the summer months. There was a 5 - 7% sub set of high risk elements to the service which had to be taken into account; but the Trust also had to ensure that they were looking to the safety of the other 93%. Therefore, in order to deploy resources to their full effectiveness, it was necessary to reduce the number of floors from which the service was provided over the summer;
- Any problems which had arisen in the past, the Trust had learnt from and thus the plans were more robust this year;
- There was no firm date for the reopening of the full service, it would depend on recruitment levels. However, last year the date was earlier than expected because the recruitment process had taken less time than was envisaged.

The Chairman thanked Andrew Stevens and Susan Brown for attending and asked if there would be any change to the level of service provided to the residents of Oxfordshire. Andrew Stevens responded that it was merely a transfer of location, rather than a change in the level of service. He added that the newly opened Oxford Spires Unit had been earmarked almost exclusively for local women and there were delivery suites for low risk women situated on the seventh floor. The element who were high risk would continue to be a discrete area.

Cllr Sanders responded that he had been reassured by the points they had made but asked why there had only been one week's notice of a planned closure? He added that he now understood why the Trust could not give a categorical reopening date, but staff and mothers would be reassured if a target date could be given. Mr Stevens explained that the plans had been worked up by managers previously, but, due to the nature of the change and the issues raised the previous year, the service had sought the approval of the Trust Board which had met two weeks prior to this meeting. Meetings had then taken place with staff during the week prior to this meeting. Once staff had been told, then a news release was sent to the local media. Unfortunately, by this time, incorrect and unhelpful had already gone out to the general public.

When asked how far the service would be reduced, Mr Stevens explained that there would only be a net reduction of four beds which would enable staff to operate over two floors only. He added that planning for beds was, as a matter of course, also informed by advance booking activity.

Mr Stevens undertook to notify Roger Edwards of the date when the service would reopen over three floors.

**43/10 OXFORDSHIRE LINK GROUP – INFORMATION SHARE**
(Agenda No. 5)

Mary Judge, a member of the Oxfordshire LINk Steering Group reported as follows:

- The Hearsay Report had now been published and the recommendations relating to Social & Community Care had been agreed and were being monitored by the LINk;
- Patient Voice were presenting the outcomes of their survey on Patient Discharge, which had been commissioned by the Oxfordshire LINk, to the

Oxford Radcliffe Hospitals NHS Trust shortly and were due to present the same to this Committee at their 16 September meeting;

- The LINk were experiencing difficulty in finding people able to take part in their report on self directed support and were working on how to circumvent the problems;
- They were working with the Neurological Alliance in relation to the development of services, including the Parkinson's Disease service;
- Oxfordshire LINk were discussing the future of LINks with their central office, whilst they awaited the White Paper;
- They intended to do some work with the Podiatry Service; and
- She asked how organisations like the LINk could assist with regard to the Public Health Annual report.

The Committee thanked Mary Judge for her update on the recent activities of the Oxfordshire LINk.

The Committee expressed their disappointment with the level of output and the general organisation of the Oxfordshire LINK to date. They **AGREED** to request Mr Edwards to write to the Host organisation giving the reasons for their views. They also expressed a wish to invite a representative from Help & Care's procurement Team to come along to a meeting of this Committee.

## 44/10 PUBLIC HEALTH

(Agenda No. 6)

Dr McWilliam presented his fourth Annual Report (JHO6).

The aims of the Annual Report were:

1. To report on progress made in the last year and to set out challenges for the next year.
2. To galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire.
3. To emphasise two strongly emerging threats to public health; namely those posed by dementia and alcohol abuse.

Dr McWilliam set out progress made in relation to the five main long-term threats which were:

- Breaking the cycle of deprivation
- An ageing population – the 'demographic challenge'
- Mental Health and wellbeing
- Increasing obesity
- Fighting killer infections.

The threat posed by alcohol abuse took its place as the sixth long-term threat to health. Progress would be monitored in future reports. Long-term success would depend on achieving wide consensus across many organisations.

Dr McWilliam made reference to the speech made by the Secretary of State for Health the previous day which had highlighted the need for a stable Public Health service at national and local level and the need to judge by outcomes. He added the following:

- His concern for the public health function within Oxfordshire in the light of the government cuts and legislation changes, some examples being uncertainty around the future of this Committee and partnership changes;
- His hope for the future that the NHS, Public Health and Local Authorities will work together in partnership with a clear agreement on the prevention agenda; together with machinery in place to monitor measure and scrutinise. He emphasised the importance of the alliance between the OJHOSC and Public Health as an example of this, in that each were concerned with the population of Oxfordshire as a whole.

The two additional emerging threats to public health were welcomed by members of the Committee and, during the question and answer session which followed the following issues were highlighted:

- Many of the issues cited in the report entailed a behavioural change, for example, the combating of obesity;

- The importance of a good diet and exercise – Dr McWilliam agreed but commented on the lack of skills, time and life-style to grow and cook nourishing food as the nation did in the war-time period;

- The need for drugs abuse to be included with that of alcohol - Dr McWilliam responded that drugs issues had not emerged as a pressing concern in Oxfordshire – they were also illegal;

- Concern about alcohol promotions – Dr McWilliam agreed that price was certainly key with regard to the extent of the problem. Moreover, to be effective, a decision would have to be made by the Government at national level as to whether to grapple with the issues. Binge drinking was a big concern for this county and there was a need to do more on this;

- The question about the needs of people with more severe mental health problems when currently the PCT do not run rehabilitation or day care services. Could the Keeping People Well services be maintained or improved on a budget of £3 – 4k? Dr McWilliam responded that the mental health of the population did feature strongly in his report, together with an assertion that its ‘cinderella service’ reputation should be avoided. He added that if he continued to hear enduring messages and recommendations from bodies such as the OJHOSC, then action taken by Public Health on recommendations would be included in next year’s report for the Committee and others to scrutinise;

- Spending on family support should increase, given that two wards within Oxfordshire were included within the top 10% of the most deprived in the country. This is marked as only 'partly met' within the report. Dr McWilliam responded that family support was part of cornerstone working being undertaken with individual families by Children, Young People & Families. It was intended that more of this work would be undertaken in the future;

- The report did not address how Oxfordshire compares with other area with regard to the numbers in the population who have given up smoking and comparisons with regard to superbug control. Dr McWilliam responded that this county compared well with others with regard to the smoking statistics and there had been a significant improvement with the national average level regarding superbug incidence. He added that that the levels could be improved and that work must be ongoing;

- Members asked how the Committee could assist , given the alliance between the OJHOSC and Public Health. Dr McWilliam responded that the Committee should continue to scrutinise Public Health, share goals and align work programmes. He thanked the Committee for its continued interest in Public Health.

The Committee thanked Dr McWilliam for his excellent report and for his presentation. It was **AGREED** that this Committee should receive a tracking document on a regular basis giving details of outcomes in priority areas, to enable monitoring to take place.

## 45/10 PCT PROCUREMENT PROCESS - TOWNLANDS AND BICESTER HOSPITALS

(Agenda No. 7)

Work had been ongoing for a considerable time to develop new community hospitals in Henley and Bicester. This had included:

- Establishing a planning framework;
- Carrying out a number of surveys on the current sites;
- Looking at other site options in Bicester and work with key partners, including Cherwell District Council, on the wider developments in the area, such as the proposed eco town.

The PCT had been going through the process of finding a developer to take on the work of re-developing the hospitals. However, legal advice had led to a decision to restart the procurement process.

The purpose of this item was to give the Committee an opportunity to find out how this situation had arisen and what effect the delay would have on the future development of the hospitals.

Catherine Mountford, Director of Strategy & Quality, Oxfordshire PCT; Dr Michael Curry, Chairman , Bicester Community Hospital Engagement Forum and Dr Peter Ashby, General Practitioner, attended the meeting in place of Councillor Ian Reissman of the Townlands Steering Group (TSG).

Catherine Mountford expressed disappointment that the process had had to be re-started, but there had been no option but to cease development, given the level of risk involved, as advised by the Legal service. She added that it was deemed important to simplify the process as far as possible, given that a significant amount of work had already been completed on, for example, planning surveys etc. Moreover, there were plans to take to a business case to the September PCT Board involving two locations, which would include a preferred option. It was expected that approval would be received by May 2011, subject to planning permission. She assured the Committee that the PCT were working closely with the local communities.

Dr Michael Curry expressed also expressed regret that the project had been delayed by 6 months, but that a new, revised process was now to be drawn up. In his view, it was not possible to manage it via a committee process, rather it required input from an architect, and GP and nursing input also.

Dr Peter Ashby informed the Committee that the Steering Group, rather than taking a confrontational stance, had preferred to concentrate on working with the PCT to find a solution. He added that the PCT had given a commitment to re-provide the services currently offered by the hospital and the aim of the Group was to ensure that a hospital was kept open for the next 25 years. The Steering Group had asked the PCT to provide sufficient support and advice with which to deliver the Business Case for September.

During the debate, members of the Committee raised the following points:

- It was hoped that there would be no further problems with the legal side, in order to ensure success;
- There had been a lack of communication with the residents of Bicester with regard to the project. It was hoped that the PCT would be more vocal in managing the expectations of the local community;
- It was important to the residents of Bicester that the Hospital be situated within the centre of Bicester and that transport links to it would be considered;
- It was asked what guarantees there were that permission would be granted by the new coalition Government to proceed with the projects; and
- What had been the cost of procurement on the projects to date?
- It was important to avoid the staffing issues relating to TUPE which were experienced with the Chipping Norton development;
- Will revenue funding be ring-fenced?
- How could you guarantee that services will be commissioned which the clinicians may not want to use?

Catherine Mountford responded making the following points:

- With regard to the cost of procurement, most of the work had been undertaken by PCT staff as part of their job;
- A detailed survey had been undertaken at some of the external costs incurred to date and this had revealed that £90k had been spent on surveys, planning and vital information services etc; all of which would be used;
- Expectations were clear that capital was to be provided by the developer and that the NHS would pay the lease cost;
- The press had been notified of various events where the public would have the opportunity to receive information and ask questions, but it is always their prerogative as to whether they wished to attend or not;
- Transport and staffing issues would be picked up;
- Revenue funding was currently ring-fenced. The PCT were working closely with local commissioning groups;
- We are working with the clinical representatives via the PBS Consortia on required services.

The Committee thanked Catherine Mountford, Michael Curry MP and Peter Ashby for their attendance. They **AGREED** to keep a very close eye on the process.

## 46/10 DEMENTIA DIAGNOSIS PATHWAY

(Agenda No. 8)

Early diagnosis for people with dementia had been shown to have benefits in terms of patient and carer quality of life and independence. There was also evidence to show that there was a financial benefit as a result of delayed need for residential care.

In Oxfordshire, Quality and Outcomes Framework (QOF) data showed that 34% of people currently received a diagnosis of dementia. Memory clinics existed , provided by both Oxford Radcliffe Hospitals Trust (ORHT) and Oxfordshire & Buckinghamshire Mental Health Foundation Trust (OBMHFT). There was currently no clear pathway and no agreed service specification, leading to uneven levels of service and post diagnostic support. There was confusion amongst GPs around where to refer a patient with suspected dementia.

Building on recommendations in the National Dementia Strategy, the proposal was to commission an integrated Memory Assessment Service involving both providers working together to maximise the strengths of both. The need for an increase in the numbers receiving a diagnosis and current capacity issues would be partially addressed by enabling a specialist dementia nurse to undertake routine follow up appointments, moving to follow up appointments into community settings, such as GP surgeries; and freeing up consultant time for diagnosis and more complex cases. Agreed information and support would be provided at, or shortly after, diagnosis.

Duncan Saunders, Service Development Manager for Older People's Mental Health, Oxfordshire PCT and Marie Seaton, Head of Joint Commissioning, Older People, attended to present the business case, which was attached to the Agenda at **JHO8(a)),** and describe what consultation has taken place to date **(JHO8(b)).** The

proposed Care Pathway for early diagnosis in Dementia, was also attached at **JHO8(c)).**

Following the presentation, members welcomed the proposals and raised the following questions/issues:

- The quality of life will decrease for the carer as well as the sufferer as the disease progresses;
- Sufferers can become quite isolated within their own homes – a good residential home can assist in giving them a better quality of life. is there a more holistic support available for them?
- Care homes can be very expensive, if sufferers could be kept safely within their own homes, this would be the best option. Are the resources given to it sufficient?
- Can there be more done to diagnose younger people with dementia?
- Day centres are an important stimulation for sufferers;
- Is access to drugs restricted?
- Have you taken note of the increase in numbers of older people living in rural areas?
- Shouldn't there be more GP's specialising in dementia treatment/care?

Duncan Saunders responded to the above points as follows:

- Much of the above questions has been covered by the overall work on the Dementia Strategy, for example, work around improving standards of care in some care homes. Also making sure that admissions, where possible, are planned from the early days of diagnosis;
- It was hoped that the pathway would make it easier for younger people (ie aged 65 and under) to get a diagnosis and be referred according to their needs;
- The overall numbers of people suffering from Dementia were projected to be quite small, because the population of Oxford City is younger;
- Oxfordshire adhere's to NICE guidelines with regard to access to dementia drugs;
- Ideally, finance permitting, it would be beneficial to have GPs training in diagnosis. To increase the level of diagnosis one would also need to employ specialist nurses;
- It was hoped that that awareness could be raised through the provision of specific guidelines.

The Committee thanked Duncan Saunders and Marie Seaton for their attendance and for responding to questions. They wished them well, stating that they believed the proposals were the correct way forward.

**47/10 CHAIRMAN'S REPORT**
(Agenda No. 9)

The Chairman updated the Committee on the following issues/meetings he had attended:

South Central Ambulance Service (SCAS)

Roger Edwards reported that a number of meetings had taken place with the South Central Ambulance Services as part of a project undertaken by the informal South Central Scrutiny Group which looked at the underperformance of SCAS access targets in rural areas. A number of recommendations had emerged from this review which had been formulated in a letter to the commissioners, together with a number of further questions. A response was awaited.

In response to representations from the South Central Scrutiny Group, SCAS had set up a workshop to look at the way vehicles were deployed in rural areas as part of a departmental review. Furthermore they had invited major stakeholders to attend a meeting held in Newbury to discuss it. He added that there were some good outcomes emerging from this piece of work, which would be submitted to a future meeting.

The Chairman pointed out that an important outcome of the project would be an admission from SCAS that the national targets Service Level Agreement was different in rural areas and that they depended on an average figure. He asked the Committee if it was prepared to accept that there was an inequity of access to rural areas compared to urban areas; given that there was no guarantee of the £6m funding required to guarantee equity of access. He pointed out the deemed failure and the frustrations inherent in not meeting the target when arriving 1 second after the 8 minutes, whereas a floor level of , say, 95% arrival in 11 minutes would be more realistic. He also pointed out also that the new Government were removing NHS targets and replacing them with the concept of 'outcomes'.

Members of the Committee joined in seeing the sense in the Government's decision, believing that a realistic and pragmatic view was required. It was pointed out that different thresholds could then be placed on different circumstances, for example, there could be different outcome threshold placed on the area within the Oxford ring road compared with the outside. It was added, however, that priority had to be given to lobbying the Government for additional funding for rural services; indeed that there should be adequate monitoring of performance leading to service improvement, if necessary.

Keeping People Well (KPW) – Re - commissioning of Day Services provided by Voluntary and Community Services for Adults with Mental Health Problems.

At the last meeting, following representations from members of the public and a full discussion, it had been decided that a working group be formed (Minute 32/10 refers) comprising three members of the Committee, to work with the PCT commissioners to ensure that :

(1) The KPW service level outcomes were equitable, there was equity of access and that the current level of service was maintained and/or improved;
(2) That the process had been transparent throughout; and
(3) Whether a full public consultation was required.

A report by the Working Group would be submitted to the next meeting on 16 September 2010.

Two representatives from two voluntary organisations had requested to address the Committee at this point on the Agenda, at which an update from the Working Group was due to be given. Patrick Taylor, Chief Executive of Oxfordshire MIND and Alex Taylor, Manager of Bridewell Organic Gardens attended the meeting making the following points:

Patrick Taylor

- A variety of important services were provided from different voluntary organisations, under the umbrella of MIND, and funded from KPW; some , for example, providing information and some helping people back to work, all providing a life-line to a large number of people with a mental health problem. He expressed a hope that the need to gather evidence of these services would be written into the task of the Working Group;
- He also expressed his concern over the £300k cut in the MIND budget, stating that the £300k was needed, given the Creating a Healthy Oxfordshire agenda and its emphasis on establishing early preventative measures.

Alex Taylor

- He informed the Committee that the PCT were not funding the charity as a part of the budget cuts;
- The PCT had identified a need to save £80m per annum, which amounted to a 9% cut overall. In his view the charity sector were being disproportionately penalised;
- OCC had invested a significant amount in the development of small charities, particularly in rural areas. Without this funding it would be difficult for them to continue. The KPW could jeopardise the benefits these charities provide to people with a mental health problem.

Members of the Committee agreed that the work undertaken by charitable organisations was valued greatly and gave their reassurance that this Committee was doing all it could to have a voice at the table. Mr Taylor was encouraged to correspond with the Working Group, submitting the appropriate evidential information.

Dennis Preece, Chairman of the Programme Board overseeing the BMH project for Oxfordshire and Alan Webb, Director of Service Redesign, Oxfordshire PCT attended the meeting in order to respond to questions from the Committee. Alan Webb thanked members for their input, and challenge to date, but stated that he needed to check whether there could be any Committee involvement in the procurement process (in the form of observer status), as promised at the last meeting. Whilst this was accepted, the Committee asked Mr Webb if alternate arrangements could be made for some kind of involvement.

In response to various questions from the Committee Messrs Preece and Webb commented as follows:

- Local voluntary organisations had already been encouraged to make an open tender;
- Selection criteria will be based on a range of issues of which financial viability will be one, but bidders will be permitted to join together in a consortium. It would be possible within the process to go out to tender

in such a way that small local groups could bid for part of the service providing for a small local area;

- It had been confirmed that there will be a budget cut amounting to £300k, the largest percentage of which would come from the OCC budget. The PCT had to be realistic, outcome focussed, but required services to provide value for money and deliver within budget;
- The membership of the Project Board included GPs, specialist consultants from the OBMHFT, representatives from the PCT commissioning team , users and carers;
- (Mr Preece) Over the last 25 years, he had been involved in many consultations, but had never encountered a better one than this in terms of input. Hundreds of people and organisations affected by these proposals had been consulted and listened to;
- Within the KPW budget there would be set aside some service user initiatives which was in keeping with the aim to adopt a bottom up approach; and
- The PCT had flagged up with the smaller charities that they could work with other groups to come up with a viable bid.

Meeting with Sir Jonathan Michael, Chief Executive of ORH

The Chairman and Roger Edwards had met with the new Chief Executive of the ORH.

Opening of new Darzi Centre, Banbury.

Roger Edwards and the Chairman reported their attendance at the opening of the new Darzi Centre in Banbury , at the invitation of the local member. They commented that the building was impressive and well used , with good open access to the medical centre, had very enthusiastic staff, and had developed a large base of patients ranging from local residents, to the homeless and travellers.

Meeting with the Chair of the Community Forum, Banbury, Julia Cartwright

The Community Forum would continue in existence for a further six months in order to oversee the implementation of the ORH contract to provide a consultant delivered, not led, service. He congratulated members of the Committee on the successful outcome and the effective part it had played in the outcome. He had met up with the Keep the Horton Local Group, members of Banbury Town Council and the Prime Minister to celebrate the outcome. The involvement of this Committee would now cease, unless further issues arose.

**48/10 INFORMATION SHARE**
(Agenda No. 10)

There were no items for information put forward.

..... in the Chair

Date of signing .....

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**ITEM 5(a)**

**OXFORDSHIRE HEALTH OVERVIEW & SCRUTINY COMMITTEE**
**16 SEPTEMBER 2010**

# HEALTH WHITE PAPER

**Report by Director for Social & Community Services**

## Introduction

1. In July, the Government published its proposals for the National Health Service in a Health White Paper "Equity and excellence: Liberating the NHS". This paper was supported by a number of other publications, the most important of which are "Liberating the NHS: Commissioning for patients", "Liberating the NHS: Local democratic legitimacy in health" and "Liberating the NHS: Transparency in outcomes – a framework for the NHS".

2. The deadline for comments is 5th October 2010. It is proposed that the response is agreed by the Leader of the County Council and the Cabinet Member for Adult Services in the light of the comments made at the three meetings that will be held in public to discuss this and other reports. The Joint Health Overview and Scrutiny Committee may decide to submit its own response separate to that of the County Council.

3. This report is not a summary of the four documents (which would not be feasible given the range of the material they contain). Nor does it focus on all the issues set out in the report. For example, issues like whether GP consortia should be responsible for commissioning £80 billion of NHS services is one which is the subject of considerable national debate. Instead, this report assumes that the broad principles set out in the White Paper will be implemented (since this reflects the wishes of the recently elected Coalition Government). The focus of this report is on the implications for the County Council and setting out potential issues with the way that the proposals will be implemented.

4. Those issues have been grouped into five themes:

   - The focus on patients
   - The focus on outcomes
   - The proposed commissioning arrangements
   - The role of the Local Authority
   - Joint working between health and social care

5. There are two further reports; one from the Director of Public Health on the implications for public health and one on the specific implications for the Joint Health Overview and Scrutiny Committee and democratic accountability generally. In addition, members have been sent a summary of the documents published by the Government.

## Focus on patients

6. The White paper emphasises the importance of putting patients and the public first. "Shared decision making will be the norm: *no decision about me without me*" (page 3)

7. This approach should be welcomed. It echoes the approach that has developed within adult social care through Putting People First. The White Paper also supports the principle of personal health budgets (paragraph 2.22) which are being piloted here in Oxfordshire by NHS Oxfordshire.

8. If the patient and the public are to be put first, then it is important that the way that the NHS is accountable to them is clear to all concerned. The White Paper sets out the following aspiration: "The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level" (page 4). Will this emphasis on clinical leadership always be for the benefit of the patient and the public?

9. Furthermore, Commissioning for Patients identifies that GP consortia will be accountable to the proposed NHS Commissioning Board (paragraph 1.14). How will conflicts (between the expectations of patients/the public and the NHS Commissioning Board) be managed? The role of the proposed local HealthWatch will be crucial. The current Local Involvement Network (LINk) will become the local HealthWatch. The proposed wider role of the local HealthWatch should be welcomed. However, does the Care Quality Commission (CQC) have the capacity and skills to oversee HealthWatch England?

10. The Government's proposals about the local HealthWatch does raise one financial issue. The funding of the LINk comes through the Area Based Grant which is no longer ring fenced. Is the Government intending to ring-fence the grant for the local HealthWatch? Clarification on this point would be helpful.

## Focus on outcomes

11. There is a very strong emphasis throughout all the documents that the NHS should be assessed on the basis of outcomes for patients and the public. "The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets" (page 4 of the White paper). Page 8 of the White Paper identifies some relatively poor outcomes of the NHS compared with other countries. This approach is seen as building on the work of Lord Darzi in his report "High Quality Care for All: NHS Next Stage Review Final Report".

12. This emphasis on outcomes should be particularly welcomed. However, these must not be defined narrowly. To take continence for example, the measure of success should not be the success of operations designed to

address incontinence but the number of people who suffer from incontinence. It is not appropriate to carry on with a situation where the standard health service response to incontinence in an older person is often to give them a pad.

13. If this emphasis on outcomes is to work then the outcomes must be carefully defined. The Government intends to issue the "first NHS Outcomes Framework" in the light of the Spending Review. Outcomes will be supported by quality standards developed by the National Institute of Health and Clinical Excellence (NICE). The first three (on stroke, dementia, and prevention of venous thromboembolism) were published in June. Within the next 5 years, NICE expects to produce 150 standards which will include quality standards for social care.

14. It will also be important that payment systems reward outcomes and not activity. The White Paper recognises this: "Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality." (page 4) The White Paper also emphasises the importance of the payment arrangements being transparent. Both of these points should be supported.

15. However, it is not clear that the mechanisms set out in the various documents to determine payments will deliver this. There will be central prescription of the payment systems (by the NHS Commissioning Board) and separately centrally prescribed prices by the economic regulator (Monitor). How is central prescription of payments systems and prices consistent with effective local commissioning? Furthemore, what incentive does it give to providers such as the acute trusts to work to reduce the number of patients treated outside of hospitals. Adult social care has nearly 20 years experience of commissioning services where there is no central prescription. The commitment to extend (centrally prescribed) payments by results to new areas of health service commissioning is unwelcome and likely to lead to poor outcomes and poorer value for money.

16. One proposal which may help to address this is that "We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources." (paragraph 2.17, Commissioning for Patients)

17. The other issue relating to outcomes is that there appears to be some presumption that improving health outcomes is primarily the responsibility of the NHS (GPs, commissioners and providers). Evidence suggests that other agencies have critically important roles to play e.g. the role of District Councils for leisure, housing, planning and environmental health; the role of the County Council for transport and trading standards. This needs to be recognized.

## The proposed commissioning arrangements

18. Commissioning is sometimes confused with contracting. However, it is much wider than that. Commissioning for Patients defines it as: "understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality" (paragraph 1.7) This description is consistent with the approach developed by adult social care over the last 20 years.

19. Commissioning for Patients goes on to set out how commissioning should work in the future: "Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them." (paragraph 1.14)

20. From a practical point of view: "It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect the views of their patients' needs and their own referral intentions." (paragraph 1.15) GP Consortia will be able to buy in support and decide whether they want to collaborate across consortia through say a lead commissioner. Support may be bought in from "external organisations, including local authorities, private and voluntary sector bodies". (paragraph 2.13)

21. Much of the debate about the principle of GP led commissioning has focused not on the principle of whether this should happen but whether it will work in practice. It is clear from the comments above that the Government recognise that the way in which it will be implemented is critical to its success. Ultimately the focus of GPs and their practices will be on the health and wellbeing of their patients. They will want to have commissioning arrangements which enable them to continue to focus on that.

22. Local authorities have the potential to help with this. Local authorities already lead on commissioning some health services (such as health services for adults with learning disabilities here in Oxfordshire). They also work closely with PCTs on commissioning other health services. Examples in Oxfordshire include the work that has been done on stroke, falls and continence. Both approaches are endorsed in Commissioning for patients (see paragraphs 6.8 and 6.11). Local authorities also have the expertise and experience that has been developed over the last 20 years in commissioning adult social care services. It will be important that we explore with GPs here in Oxfordshire in

conjunction with the PCT what role the County Council can play to support the work of the GP consortia.

## The role of the local authority

23. Local authorities will have "greater responsibility in four areas:
    - leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
    - supporting local voice, and the exercise of patient choice;
    - promoting joined up commissioning of local NHS services, social care and health improvement; and
    - leading on local health improvement and prevention activity." (paragraph 10, Local Democratic Legitimacy in Health).

24. To some extent, the first three of these roles exist at the moment (the fourth would be a new role for local authorities although the Director of Public Health has been a joint post for several years). The key issue will be the power and influence that the local authority will have to carry out these roles effectively. The details about this are not yet available although there are some positive statements of principle in the reports which should be welcomed.

25. One critical element will be the role of the health and wellbeing board which will be created by statute. The Government makes clear that this will "take on the function of joining up the commissioning of local NHS services, social care and health improvement." (paragraph 4.17, White Paper). This should be welcomed.

26. Oxfordshire has had a Health and Well-Being Partnership Board for 3 years. This does not have executive powers (in contrast to the Government's proposals) so runs the risk of becoming a "talking shop". The existing Board has tried to counter that by focusing on its key priorities (ageing successfully, obesity and mental well-being). Discussions will need to take place with all stakeholders but particularly GPs (who are already represented on the Board) to turn the existing Board into an effective decision making forum. We shall also need to review its role vis-à-vis the Children's Trust – an issue raised in Local Democratic Legitimacy in Health.

27. To achieve the objective of becoming an effective decision making forum, it will be crucial that the Board is focused on that role. For this reason, I would agree with the view that it does not make sense to include the scrutiny functions currently carried out by the Joint Health Overview and Scrutiny Committee. This is not a trivial activity as those involved in the work of the Committee will testify and it can play a crucial role in challenging proposed changes within the NHS (such as the proposals for the Horton).

28. The Government has also given some indication of its thinking on the overall approach to adult social care. "We want a sustainable adult social care system that gives people support and freedom to live the life they choose, with dignity. We recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including

carers. We will seek to break down barriers between health and social care funding to encourage preventative action" (paragraph 1.17, White Paper). Its vision for adult social care is promised later this year. The Government has now set up the Commission on the funding of long term care which will report next summer. A White Paper on adult social care is promised for the autumn of 2011 followed by legislation.

## Joint working between health and social care

29. There are repeated references in the documents to the importance of joint working between health and social care. For example, ""With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder." (paragraph 11, Local Democratic Legitimacy in Health). And also from the same document: "The aim is to ensure coherent and coordinated local commissioning plans across the NHS, social care and public health, for example in relation to mental health, older people's or children's care, with intelligence and insight about people's wants and needs systematically shaping and commissioning decisions." (paragraph 32)

30. This emphasis on joint working must be welcomed not least because it is what the patient/service user/citizen wants. How this might work is not yet clear but the Government has given a commitment to consult widely on options to ensure health and social care works seamlessly together.

31. The Government has also recognised that existing arrangements to encourage joint working between health and social care have not worked well enough. It is important for Oxfordshire members to appreciate that the close working here is not typical of what happens elsewhere in England. It is also important to note that there is scope to improve joint working here notably in terms of work with people with long term conditions especially older people.

32. The Government is right to emphasise that stronger joint working will help unlock efficiencies. There is clear evidence of this here in Oxfordshire from our joint arrangements for learning disabilities where we have good outcomes at a low cost. However, to deliver this, the necessary infrastructure needs to be in place supported by appropriate attitudes from all partners.

33. For joint working between the commissioning of health and social care to work, then policy and financial decisions must come together into a single place. The White Paper declares that "NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia" (paragraph 4.19). Is this consistent with the commitment to joint working?

34. What would be effective would be for the Government to prescribe in the forthcoming legislation that joint commissioning and pooled budgets must apply in appropriate circumstances (learning disabilities, mental health, supporting people with long term conditions). This would mean that public resources are used in the most appropriate way based on the needs of the

local population. Thus our responds to question 6 posed in Local democratic legitimacy in health should be that we do want joint working to be underpinned by statutory powers.

35. However, if there is to be a statutory power requiring joint working through the pooling of resources then GPs are rightly going to expect there to be some governance in place which constrains the ability of the local authority to arbitrarily reduce spending on adult social care (and expect the consequences to be picked up from health resources). This could be managed through the health and wellbeing board.

## RECOMMENDATION

36. **Members are asked to give their comments on the ideas set out in this report.**

JOHN JACKSON
Director for Social & Community Services

Contact Officer; John Jackson Tel: (01865) 323574

September 2010

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# Public Health in Oxfordshire: Implications of the Coalition Government's Plans.

**Purpose of this paper**

This paper has three purposes:

1. **To inform** a wide audience about the implications of the coalition government's plans for the Public Health of Oxfordshire.
2. **To analyse** the implications for Public Health in Oxfordshire
3. **To propose the way forward**.

**Introduction**

The Secretary of State for Health has set out his vision for Public Health in England in recent speeches and White Papers as part of the broader coalition government's plans.
This vision aims to improve the public's health and strengthen Public Health services as a priority.
To achieve this it is proposed to create a new National Public Health service (PHS), separate from the NHS, including an enhanced role in health improvement for Local Authorities at local level.
The PHS will be 'functional' from April 2012 and will 'go live' as statutory bodies from April 2013.

A Public Health White Paper will be published in December 2010 to set out the detail of the new National Public Health Service (PHS). Nonetheless there is sufficient information already in the public domain to describe the broad thrust of the proposals and to prepare for the future.

There are real opportunities for improving health in Oxfordshire through these plans, but skilful navigation will be required to keep the gains made in recent years and build on these further.

Gains in the Public's Health are made by individuals, carers, voluntary organisations, GPs, nurses, social workers, hospital doctors, transport planners, housing officers, environmental health departments, managers, scrutiny committee and leaders of organisations.
The role of Oxfordshire's Public Health department is to lead, prioritise and focus the effort of all these individuals and organisations. Disruption to the work of the Public Health Department should therefore be minimised during the coming months of transition.

This paper sets out the thrust of the new national plans and provides an analysis of the strengths, weaknesses, opportunities and threats for the Public Health of Oxfordshire in the situation.

The paper concludes with proposals for next steps to be taken to maximise the opportunities and minimise the threats.

**Summarising the vision of the Secretary of State for Health**

The Secretary of State takes a broad view of health. He is as concerned about the underlying causes of ill-health rooted in society as in health services themselves. This is to be welcomed.
His vision is of a well-informed and fully engaged public served by three main public sector organisations, called here the 'Three Pillars'. The Three Pillars are:

1. The NHS.
2. Local Authorities - in this case most mention is made of top-tier Local Authorities.
3. The new national Public Health Service (PHS).

The main features of each of these ***in terms of Public Health and health improvement*** are set out below.

**Overall Coordination**

The Secretary of State will chair a Cabinet Subcommittee with representatives of all government departments including the Department for Communities and Local Government. This will be responsible for coordinating a joined up approach to health. This includes traditional health services, Public Health, social care, education etc and will include wider aspects of health such as transport, housing and environmental issues.

**The NHS:**

- will retain its traditional values of universality and care which is free at the point of delivery
- will have a clear commissioning-provider split with more autonomy for NHS trusts
- will have its commissioning function coordinated nationally by a new commissioning board
- will be delivered at local level by GP commissioning consortia
- NB there is no requirement to have co-terminus boundaries with LAs

**Local Authorities:**

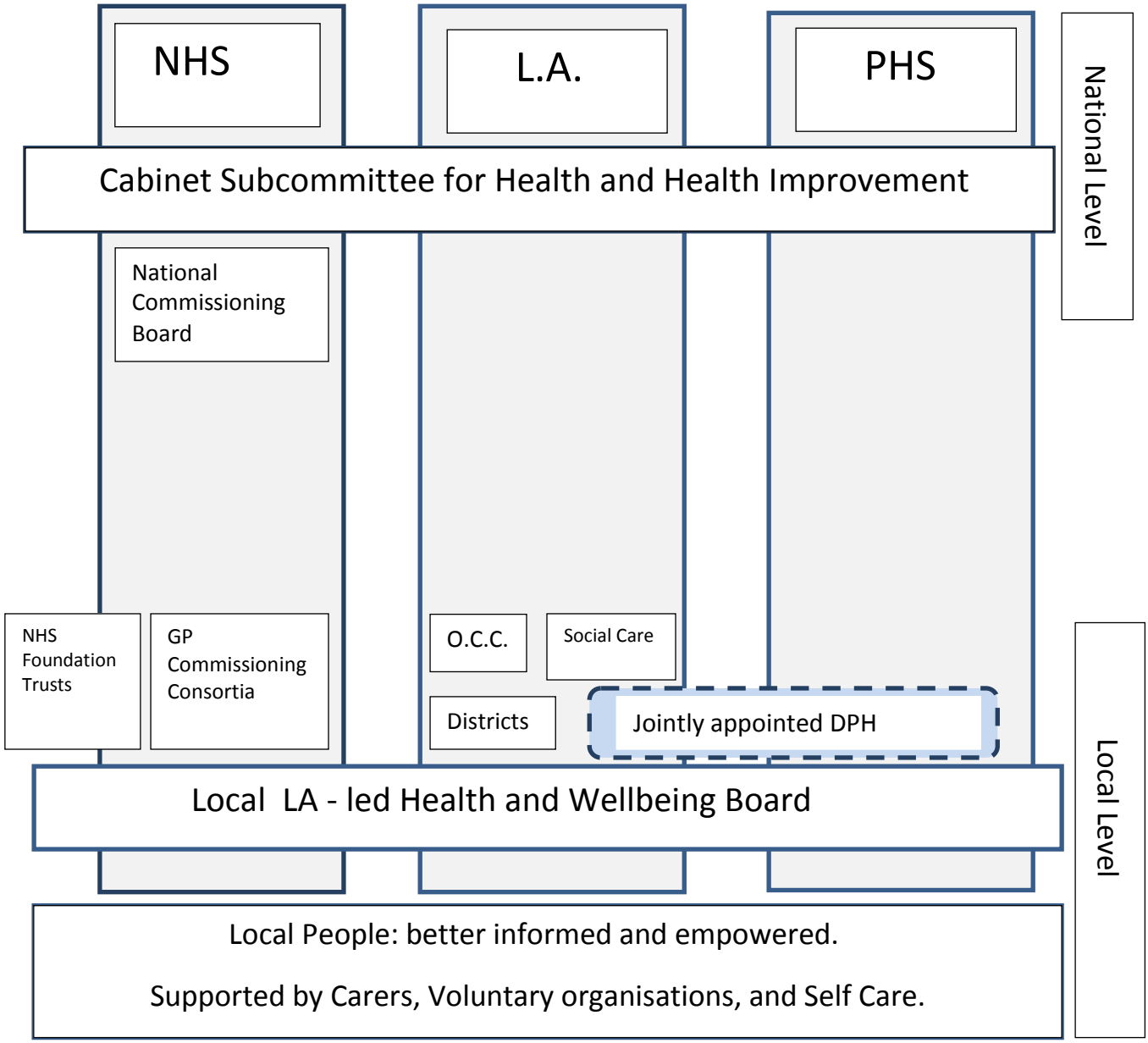
- will have increased responsibilities to coordinate overall health policy for an area, joining together in particular the work of local government, the NHS and the new National Public Health service. The favoured option for doing this is through a Health and Well-being Board at local level, led by Local Authorities. This is proposed to incorporate the current Health Scrutiny Function
- will have increased responsibilities for ' health improvement '
- will employ the local Director of Public Health, who will be jointly appointed by the National Public Health service
- will oversee a new ring-fenced budget which will be managed by the Director of Public Health
- will be accountable for achieving improved outcomes for the public's health
- NB white paper setting out the future of long term care, with implications for adult social care, is expected during 2011

**The National Public Health Service:**

- will have clear managerial ' line-of-sight ' from the Secretary of State and the Chief Medical Officer down to Local Authorities, the local Director of Public Health and thus to the public
- Will be accountable for a range of activities including: health promotion, disease prevention, health inequalities, immunisation, screening, assessing local needs, control of communicable diseases, emergency planning in the NHS and specialist support to the local commissioning of organisations
- Will bring together a number of existing bodies, including Public Health services which are currently within the NHS, regional Public Health Observatories and the Health Protection Agency

These relationships are summarised in the diagram below.

# Diagram Summarising Coalition Government Proposals for the Main Health Organisations.




The diagram shows the three main 'pillars' of the 'health system' in coalition thinking, namely the NHS, LAs and the PHS. The national level is shown at the top of the diagram and the local level at the bottom. The known components of each pillar are set out in boxes on the respective pillar.

The two horizontal boxes which cut across all pillars show the two main mechanisms proposed to join-up public sector action. These are the Cabinet Sub-Committee at national level and the mooted Health and Wellbeing Boards at local level.

**Implications of these changes for Public Health in Oxfordshire**

These are set out below as a SWOT analysis (Strengths, Weaknesses, Opportunities and threats) below.

| SWOT Analysis of Coalition Proposals for Public Health in Oxfordshire. | |
|---|---|
| **Strengths**<br>➢ Public Health is seen as a national priority.<br>➢ The secretary of state will provide leadership.<br>➢ There will be a national Public Health service (PHS).<br>➢ The anticipated white paper will set a clear direction. (December 2010)<br>➢ A ring-fenced budget for some PH activities.<br>➢ Clear alignment with local government and a stronger role for local democracy.<br>➢ Clear responsibility for health improvement in local government.<br>➢ Retention of the Health Scrutiny function.<br>➢ Proposals are based on a very broad view of health.<br>➢ Proposals imply an understanding of the social causes of ill-health.<br>➢ Preventing ill-health is a priority.<br>➢ Reducing inequalities is a priority.<br>➢ There is a clear role for a local Director of Public Health. | **Weaknesses.**<br>➢ Inevitable loss of momentum due to major restructuring.<br>➢ Staff uncertainty for a prolonged period.<br>➢ Potential loss of skilled staff.<br>➢ Oxfordshire has a larger than average Public Health Department - a nationally allocated budget is unlikely to cover current staff costs.<br>➢ The ring-fenced budget cannot cover costs of all PH programmes. These costs will remain in the NHS. This may cause confusion.<br>➢ The existing Public Health Department contains core NHS functions (e.g. medicines management and priority setting) which require complex disaggregation.<br>➢ Key facts are unclear while awaiting the PHS white paper e.g.<br>1. Division of responsibility between national, regional and local level.<br>2. Size and shape of a regional level.<br>3. The preferred future employer for local Public Health staff (only the DPH employer is certain, though there is no slot-in proposed for existing DsPH).<br>4. The division between commissioning and providing roles. |
| **Opportunities.**<br>➢ **There is an overarching opportunity to create a slimmer, leaner, more efficient and better focussed public sector across Oxfordshire.**<br>➢ Potential gains for the health of the people of Oxfordshire due to a clear PH role.<br>➢ Opportunity to retain the gains made in Public Health in recent years through a well-managed transitional process.<br>➢ Opportunity to continue the successful alliance between PH and LAs while keeping strong links with the NHS.<br>➢ The creative engagement of GPs in stronger Public Health programmes.<br>➢ The coordinating role of LAs could create a single set of priorities for the public sector across Oxfordshire.<br>➢ Potential economies of scale by commissioning parts of some PH programmes at multi-county level.<br>➢ A clear direction could be set by clear outcome measures to be improved. This should unite organisations in Oxfordshire if the lessons of Local Area Agreements are learned. | **Threats.**<br>➢ Planning blight.<br>➢ The general climate of public sector 'squeeze'.<br>➢ Potential 'cuts' in Public Health caused by inadequate national budgets.<br>➢ Insensitive handling of 'NHS management cost reductions' leading to inappropriate cuts to Public Health.<br>➢ Public Health must not be 'left behind' in the hiatus caused by a 'late' White paper in December 2010.<br>➢ It must not be assumed that PH is 'OK' because of the ring-fenced budget. Costs of PH programmes will still sit in core NHS budgets. These must be budgeted for.<br>➢ Possible lack of detailed understanding of PH work by some GP decision-makers.<br>➢ Considerable preparatory work will be needed by OCC, working with the NHS, as the 'receiving' organisation, but the OCC change agenda is already burgeoning.<br>➢ Tensions between public sector organisations due to a general squeeze on budgets – just when maximum cooperation is critical.<br>➢ Possible unwillingness of the new NHS to act on PH priorities.<br>➢ Possible unwillingness of LAs to embrace the new health improvement role fully.<br>➢ Outcome measures become another set of targets lacking local relevance.<br>➢ Lack of financial control of Foundation Trusts dwarfs the real priorities for health. |

**How Can We Maximise the Opportunities and Minimise the Threats?**
The overriding requirement is to secure the improvements made to the public's health over the last few years and to bring together speedily the relevant major stakeholders to agree a practical way forward for Oxfordshire's Public Health Department.

To do this it is recommended that we take the following practical steps:

**PHASE 1**
**September 2010 to December 2010 (i.e. when the Public Health White Paper is published)**
1. Clarify the current functions and work programmes of the Public Health Department including the direct and indirect budgets. This work is already well underway.
2. Ensure that public health is given due prominence in the transitional plans being formed by the PCT and the Strategic Health Authority (SHA).
3. Ensure that these plans contain clear proposals for the retention by the NHS of:
   - commissioning budgets required for public health programmes which will stay within the NHS
   - core NHS functions currently contained within the Department of Public Health which will be required by the NHS in the future (e.g. medicines management, priority setting and others)
4. Create, as part of these processes, a high-level task-and-finish group which will drive the Public Health transition. This should be balanced equally between the PCT as the ' donor organisation ' and OCC as the 'receiving organisation '. This will include representation from the PCT, LAs, the Public Health Department and GPs and should actively involve the Health Overview and Scrutiny Committee (HOSC).

**PHASE 2**
**December 2010 to the formal inception of the PHS**
Once the Public Health White Paper is released, the way forward will be clear. The actions required are:

1. A detailed transitional plan for Public Health functions and programs will be drawn up from December 2010 onwards. This must include critical human resource issues e.g. a timetable for restructuring and/or transfer of current staff.
2. The implementation of the transitional plan should be overseen by the high-level task-and-finish group specified above.

**Conclusions**
1. The Coalition Government's proposals for health incorporate significant opportunities for strengthening the Public Health of Oxfordshire.
2. The opportunities are balanced by very real threats as set out in this paper. These must be minimised by careful preparation involving the main stakeholders: the PCT, LAs, the Public Health Department and GPs.
3. These opportunities will not be realised without detailed preparatory work, considerable effort and the willing co-operation and engagement of public sector bodies across Oxfordshire.
4. A new high level group is proposed to lead this work.
5. This detailed work will dominate Public Health activity over the coming months.

**Recommendation**
**Public sector organisations in Oxfordshire should work closely together over the coming months to secure the continuation of a successful Public Health function for the future.**
**It is recommended that a high-level group, led by the major public sector stakeholders is set up to achieve this.**

**Jonathan McWilliam**
**Director of Public Health for Oxfordshire**
29th of August 2010

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**ITEM JHO5(c)**

# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE – 16 SEPTEMBER 2010

## EQUITY AND EXCELLENCE: LIBERATING THE NHS

## LOCAL DEMOCRATIC LEGITIMACY IN HEALTH

## DEMOCRATIC ACCOUNTABILITY (INCLUDING THE IMPLICATIONS FOR THE HOSC AND THE HEALTH AND WELLBEING PARTNERSHIP BOARD - CURRENT AND FUTURE)

## Introduction

1. Included within in the Department of Health's (DH) white paper and subsequent papers are a number of proposals for changes to the way that democratic accountability would be organised in the future. This paper will concentrate on what the government refers to as "Local Democratic Legitimacy in Health". It will briefly remind members of the present position; describe what change is proposed and provide some discussion/ comment on the proposals.

2. The DH has set a consultation deadline of 11th October 2011 and members may wish to agree a response to the consultation. Aspects to consider when preparing a response are included towards the end of the paper.

## The present position

### *Health overview and scrutiny*

3. Health Overview and Scrutiny Committees (HOSCs) were set up in 2003 with the aim of strengthening the way that public and patients views and concerns were to be represented in relation to health matters. This was in response to concerns that there was a "democratic deficit" within the NHS with decisions being taken by unelected boards and officials with little or no consultation with the public.

4. HOSCs were expected to take an overview of health services and planning within the area and to scrutinise priority areas to identify whether they met local needs effectively. HOSCs were given powers to:

5. Review and scrutinise any matter relating to the planning, provision and operation of local health services

6. Make reports and recommendations to local NHS bodies and local authorities on any matter reviewed or scrutinised

7. Require the attendance of officers of local NHS bodies to answer questions and provide explanations about the planning, provision and operation of health services

8.
9. Require NHS bodies to provide information about the planning, provision and operation of health services

10. Refer matters to the Secretary of State for Health:

    (a) where the committee is concerned that consultation on substantial variation or development of services has been inadequate
    (b) where the committee considers that the proposal is not in the interests of the local health service

11. In such cases the Secretary of State would call in the Independent Reconfiguration Panel (IRP) to investigate and report back before responding to the referral.

12. NHS bodies were required to:

- Provide information requested by the overview and scrutiny committee
- Attend before committees to answer questions
- Respond to HOSC reports and recommendations within 28 days
- Consult the HOSC on any proposals they may have under consideration for substantial developments or variations to services. (Locally the HOSC has the primary role in deciding whether or not a development or variation should be seen as “substantial”).

13. They are also required to “consult and involve” patients and the public in any proposals for change.

***PPIFs and LINks***

14. Also in 2003 the Government abolished Community Health Councils (CHCs) and replaced them with Patients Forums (PPIFs). PPIFs were intended to help improve the quality of NHS services by bringing to trusts and PCTs the views and experiences of patients, their carers and families.

15. There was a PPIF in every NHS trust, NHS Foundation trust and PCT in England. Their primary roles were to:

- Monitor and review NHS delivery
- Seek the views of the public about those services
- Make recommendations to the NHS accordingly

16. In Oxfordshire a close working relationship was developed between the HOSC and the PPIFs. The PPIFs had their own spot on the HOSC agenda

and PPIF members participated on a number of committees and working groups.

17. PPIFs were abolished on 31st March 2008 and replaced by Local Involvement Networks (LINks).

18. LINks are funded (via a non-ring fenced budget provided by the Government) and performance managed by the local authority. Their remit was extended beyond that of the PPIFs to include social care services. They are expected to give citizens a stronger voice in how their health and social care services are delivered. Their role is to find out what people want, monitor local services and to use their powers to hold them to account. LINks have the power to refer issues to the HOSC.

19. It is recognised generally that LINks have taken a long time to get going. Within Oxfordshire however there does continue to be something of the connection between the HOSC and the LINk that existed with the PPIFs in that the LINk has its own regular spot on the HOSC agenda.

## White paper proposals

20. The proposals in the white paper are part of the coalition government's emphasis on "localism". The proposals are also intended to strengthen the role of patients and the public in shaping health services. Legislative changes required to implement all the above proposals will be included in a Health Bill this autumn, subject to responses to the consultation. It is proposed that local authorities would establish shadow arrangements in 2011 in preparation for statutory changes in 2012.

## The issues covered by the consultation

21. The white paper and subsequent documents include proposals that would involve:
    - local authorities taking on local public health improvement functions
    - a lead role for local authorities in promoting integration
    - the reconstitution of existing Local Involvement Networks (LINks) into "Local HealthWatch" organisations, acting as "independent consumer champions" accountable to local authorities
    - The HOSC losing its statutory powers which would be transferred to the Health and Wellbeing Board

22. The consultation paper proposes greater responsibility for local authorities in the four areas outlined below. While not all may appear to be directly related to local democratic legitimacy in health, they all need to be considered to put the white paper proposals into context.

## Leading joint strategic needs assessments

23. Local authorities would be given responsibility for leading joint strategic needs assessments (JSNA) across health and local government and promoting joint

commissioning between GP consortia and local authorities. They would not have any direct healthcare commissioning role, but would be expected to "influence" local commissioning decisions about NHS services.

## Supporting "local voice"

24. It is proposed that LINks, in becoming local "HealthWatch" organisations, would be "more like a citizen's advice bureau" with additional responsibilities. These would include supporting individuals, e.g. in choosing a GP, and a local NHS complaints advocacy services which would replace the Independent Complaints Advocacy Service (ICAS) that would be abolished. The latter would be commissioned by local authorities "through local or national HealthWatch" (a new body to form part of the Care Quality Commission (CQC). Details around this are a little hazy.

25. Local authorities would "continue to fund HealthWatch and contract for their services" and have powers to intervene and re-tender contracts in cases of under-performance. The consultation paper makes no distinction between the current host organisations for LINks, currently commissioned by local authorities, and the LINks themselves. That could suggest that similar arrangements would be maintained as to those that exist now. There is nothing to say how LINks could be improved constitutionally or otherwise to help them to undertake this enhanced role. There would, the white paper says, be additional funding to pay for the wider responsibilities of HealthWatch.

## Promoting joined up commissioning of local NHS services, social care and health improvement

26. The consultation paper is clear that integrated working between health and social care should increase. It indicates that the Government favours the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing.

27. It is suggested that Health and Wellbeing Boards should be set up within the local authority and become statutory partnerships to co-ordinate joint working. They would also lead the JSNA, support joint commissioning and other joint activity and "undertake a scrutiny role in relation to major service redesign".

28. The boards would "have a lead role" in determining the strategy and allocation of any local application of place-based budgets for health. Their members, the white paper suggests, would include the Leader or Directly Elected Mayor of the local authority, representatives of social care, NHS commissioners, patient champions, including a representative of HealthWatch and Directors of Public Health. The consultation document suggests that there is some "novelty" in bringing together elected members and officials in this way.

*Transfer of statutory health overview and scrutiny functions*

29. It is proposed that the current statutory functions of health overview and scrutiny committees, including the power of referral to the Secretary of State, would transfer to the Health and Wellbeing Board. The role of the IRP would remain as now.

30. It is also suggested that a separate formal health scrutiny function should continue within the local authority to scrutinise the work of the Health and Wellbeing Board but with none of the current statutory health scrutiny powers.

**Leading on local health improvement, prevention and public health**

31. The consultation paper proposes the transfer of responsibility and funding from the NHS to local authorities from 2012 for local health improvement activity, including the prevention of ill-health by addressing "lifestyle factors such as smoking, alcohol, diet and physical exercise". A national Public Health Service (PHS) would be created to "integrate and streamline" health improvement and protection and emergency planning, with an increased emphasis on research, analysis and evaluation.

32. It is proposed that local Directors of Public Health be jointly appointed by local authorities and the PHS and employed by local authorities with a ring-fenced health improvement budget allocated by the PHS. Local authorities would be able to commission providers of NHS care to provide health improvement services. It would seem likely, although it is not specifically stated anywhere, that the Health and Wellbeing Board would have a role in this commissioning process.

## Discussion and comment

33. The white paper proposes giving local authorities a greater role in tackling health issues with Health and Wellbeing Board assuming a central role. They would be the main vehicles for bringing together and co-ordinating all of the local bodies that have an impact on health and ensuring that the partnerships work.

34. This must lead to concerns about the proposal to transfer statutory health scrutiny powers to the proposed Health and Wellbeing Board. How independent could such a Board be when it could be central to many of the decisions that are to be scrutinised?

35. Furthermore, how realistic would it be to expect that a separate health scrutiny function could be carried out without those powers? It is generally recognised that the HOSC in Oxfordshire has been successful in working with NHS bodies and other interested bodies and individuals to develop good patient and public consultation in health. However, while much of that success has been brought about by building and maintaining good relationships, there is no doubt that the statutory powers have had a major effect.

36. For example, it could be argued that maternity and paediatric services at the Horton General Hospital would not have been retained without the HOSC having the power to refer the matter to the Secretary of State. Also, would

there now be a community hospital in Oxford and would the South Central Ambulance Service be taking the issue of rural services quite so seriously without the HOSC having its powers?

37. While answers to those questions cannot of course be given with any certainty, it seems quite clear that proposals in the White Paper and subsequent documents are, at the very least, likely to lead to confusion. Who for example would scrutinise the performance of partnerships? The Health and Wellbeing Board which would have the role of co-ordinating those very partnerships and so could not be described as independent or the HOSC which would have no statutory power to do anything about any plans or decisions relating to health matters?

38. Surely it would make sense to leave the statutory powers with the HOSCs to enable them to scrutinise effectively? Scrutiny should be seen to be independent of those planning services. Members may wish to respond to the consultation on this issue.

39. No doubt members will find interesting the proposal to transform LINks into HealthWatch. LINks have not been a great success anywhere, largely because of the very weak structures with which they were saddled. It is generally recognised that they have struggled to make any sort of impact on services. Just changing the name and giving them a seat on the Health and Wellbeing Board is not going to improve matters. If LINks are going to have any success they must be properly funded; have a proper structure and sufficient support staff.

## Conclusion

40. There are aspects of the proposals that give rise to concerns around "democratic legitimacy". Members may wish to consider whether they have a view on:

I. Whether HOSCs should retain all of their existing powers and continue to have the statutory health scrutiny role rather than that being transferred to the Health and Wellbeing Board

II. How HealthWatch could be made to be more effective than LINks and provide a real voice for health and social care service users. For example that HealthWatch should be funded adequately and provided with an effective constitution and support to enable it to function effectively

# EQUITY AND EXCELLENCE: LIBERATING THE NHS – THE NHS WHITE PAPER

The coalition Government has published its much anticipated white paper on the NHS. Called "Equity and excellence: Liberating the NHS", the paper sets out a vision for an NHS that, by 2013, will look very different from how it looks now. There are major implications for both the NHS and local authority.

Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are to be abolished and GPs will be responsible for commissioning the majority of services. The profile of Public Health will be increased and local authorities will employ the Director of Public Health and have responsibility for local health improvement. The LA will also have a major role in integrating health and social care.

The statutory responsibilities of the Health Overview and Scrutiny Committee will, it appears, be subsumed into a statutory Health and Wellbeing Board although some form of Health Scrutiny Committee would be retained but without statutory powers.

The main headlines with particular relevance to the County Council are:

- PCTs and SHAs will be abolished
- Most commissioning will become the responsibility of local GP consortia and every GP practice will be required to be a member of a consortium as a corollary of holding a registered list of patients
- A new Public Health Service will be created that will bring together existing health improvement and protection bodies
- PCT responsibilities for local health improvement will be transferred to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service
- The "*critical interdependence"* between the NHS and the adult social care system in securing better outcomes for people, including carers is recognised and more will be done to break down barriers between health and social care funding to encourage preventative action
- Later this year the government will set out a vision for adult social care, to enable people to have greater control over their care and support and enjoy maximum independence and responsibility for their own lives
- The Department of Health will establish a commission on the funding of long-term care and support, to report within a year and produce recommendations for reforming the system of funding social care.
- A *"new independent consumer champion"* called HealthWatch England will be created and will sit within the Care Quality Commission (CQC)
- Local Involvement Networks (LINks) will become the local HealthWatch
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people

access and make choices about services, and supporting individuals who want to make a complaint
- The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes
- Building on the existing power of the local authority to promote local wellbeing new statutory *"Health and Wellbeing Boards"* will be established within local authorities. They will be responsible for joining up the commissioning of local NHS services, social care and health improvement
- Local authorities will therefore be responsible for:

    - Promoting integration and partnership working between the NHS, social care, public health and other local services and strategies
    - Leading joint strategic needs assessments, and promoting collaboration on local commissioning plans, including joint commissioning arrangements where each party so wishes
    - Building partnerships for service changes and priorities (although the NHS Commissioning Board and the Secretary of State will retain accountability for NHS commissioning decisions)

- The above responsibilities would replace the current statutory functions of the Health Overview and Scrutiny Committee (HOSC)

Many of the changes in the White Paper require primary legislation. The Queen's Speech included a major Health Bill in the legislative programme for this first Parliamentary session. The Government will introduce this in the autumn. The principal legislative reforms relevant to OCC will include:

- Enabling the creation of a Public Health Service, with a lead role on public health evidence and analysis
- Transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health
- Placing the Health and Social Care Information Centre, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining improvement in healthcare outcomes as the central purpose of the NHS
- Making the National Institute for Health and Clinical Excellence a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care
- Giving local authorities new functions to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health
- Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs

- Establishing HealthWatch as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch

The indicative timetable for the most relevant changes is:

- Health Bill introduced into Parliament during autumn 2010
- Public Health white paper by late 2010
- White paper on social care reform 2011
- Arrangements to support shadow health and wellbeing partnerships begin to be put into place in April 2011
- A comprehensive system of GP consortia will be put in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs
- In April 2012:

    - The NHS Commissioning Board will be fully established
    - New local authority health and wellbeing boards will be in place
    - The Public Health Service will be in place, with ring-fenced budgets and local health improvement led by Directors of Public Health in local authorities
    - HealthWatch will be established

- The NHS Commissioning Board will make allocations for 2013/14 directly to GP consortia in late 2012
- GP consortia will take on responsibility for commissioning in 2012/13
- SHAs to be abolished in 2012/13
- GP consortia will take full financial responsibility from April 2013 and PCTs will be abolished after that date
- NHS management costs reduced by over 45% by 2014

The Government states that they, *"are clear about the coherent strategy, and will engage people in understanding this and its implications".* They will consult on, *"how best to implement these changes"*, not, it should be noted, on whether or not PCTs should be abolished and GPs given the responsibility for commissioning.

In particular, the Department of Health is seeking comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill. **Comments should be sent by 5th October**.

As always there is uncertainty around some of the specifics however it is clear that there is going to be major change ahead for both the NHS and local government in the area of health.

**Possible questions raised by the White Paper**

- What must be done to ensure that health services across Oxfordshire continue to provide equity of access, equity of outcome and improvement in the quality and safety of services for patients and carers?
- How best (and how quickly) should the transition to the new arrangements take place?
- What would be the most effective way of providing support to GPs in their commissioning role?
- How could Health and Wellbeing Boards be configured to ensure that they are effective as co-ordinators of healthcare, social care and health improvement?
- Should Health and Wellbeing Boards be given the statutory powers that lie at present with the HOSC or should the HOSC retain those powers?
- What would need to happen to support the development of an effective local HealthWatch?
- How should local people be involved in developing options for change to service provision?

RE 1 September 2010

# Lessons from an IRP Review:
## The Importance of Community Engagement

Presentation to HOSC 16th September

Julia Cartwright

Chair, Community Partnership Forum

# Situation in 2008

- The IRP has rejected the proposals referred to them by the SoS
- The advocates (ORHT/PCT) and opponents of the proposals (community) have invested significant commitment and emotion in promoting/opposing the proposals respectively.
- Engagement needed: ‘Healthcare professionals working with the public to improve the health communities they serve’.

# Barriers to Engagement

- There is not a clear understanding of what is needed to enable effective engagement.
- There is no recognition of the likely barriers to engagement.
- The purpose and benefits of engagement are not clear to all parties.
- There is no attention to detail.

# Better Healthcare Programme

- Good project management & leadership.
- The right people got involved.
- Ability to challenge the process & decision making.
- Adequately resourced.
- Transparent.
- Those involved felt valued & part of team effort.

# Situation in 2010 – Benefits of Engagement

- Improved and developing strategic relationships with ORHT/CDC/GPs and local community.
- Partnership working enables best use of healthcare resources & access to them.
- A better informed public.
- Positive platform for GP commissioning & the ‘Equity & Excellence’ agenda.

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# STUDY OF HOSPITAL DISCHARGE PROCEDURE
undertaken by PATIENT VOICE for Oxfordshire LINK

**Part I. INTRODUCTION:**

1. Over the last three months of 2009 Patient Voice had received a number of adverse comments about delays in discharge, particularly from delivery of medication from Pharmacy. Patients had to wait on the ward or in the JR discharge lounge for considerable time or were taken home for collection of medication later. The problem causes irritation, disquiet, even distress.

2. A project was commissioned in March 2010 by Oxfordshire LINK:

"to undertake research based on questionnaires completed by patients who had been discharged from the ORH NHS Trust, possibly the NOC in the last six months" on recommendation of the Stewardship Group the study was extended to include comments, observations from Group Practices about degree of satisfaction with the discharge information.

3. The work was carried out over three months - mid-March to mid-June - accessing potential patients through local newspapers and radio, social groups (eg TWG, retirement/care homes - see acknowledgments ) with a letter sent to all practice managers in Oxfordshire. There was a total of 54 individual patient replies and answers/comments from 21 Group Practices.

4. The report is given in 2 parts with precise recommendations at the conclusion of each section:

- collated patients' experience which is essentially QUANTITATIVE,
- observation/comments on the discharge system by General Practitioners which is mainly QUALITATIVE,
- with a summary of main concerns, causes with recommendations given in the next paragraph.

5. SUMMARY of CONCLUSIONS AND RECOMMENDATIONS:

a) a fair assessment of patients' discharge is COULD DO BETTER with room for IMPROVEMENT.

b) priority should be given to a fine-tuning of existing systems so that the quality of patients' experience is ENHANCED. Post- operative, at completion of hospital treatment, patients want to leave for home as soon as practicable, delays of over 90 minutes are likely to cause anxiety and distress to patients, family, carers as all simply want to return home, not have to wait longer, far worse if there is no estimate for the delay.

c) there will be significant improvement by eliminating potential blocks in supplying discharge medication - by far the main problem area - this will save staff time and create more positive experience for patients.

d) it is essential to involve all levels of staff in suggesting ways to improve and then implement them; the Quality Circle approach has achieved much in all forms of work activity.

**Part II. ANALYSIS of PATIENTS' QUESTIONNAIRES**

1. There was a total of 54 completed with 34 JR, 10 NOC, 5 Churchill, 2 Horton Gen., 2 Community H., 1 Children's H ; of these 26 stated satisfactory discharge with 2 qualified satisfaction; 26 were not satisfied.

NB: 4 from the 'satisfied group' had experienced some delay and are included in the total of 30 for this analysis.

2. Reasons given for the delay were:

| | |
|---|---|
| on the ward | 8, |
| medical | 3, |
| nursing | 2, |
| porterage | 2, |
| lack of wheel chair | 2, |
| WAITING EDICATION | 30. |

NB: there is some overlap in numbers and categories as most waiting medication also included one other category in their reply.

3. Further analysis of 'waiting for medication' gave:

- WHERE:

| | |
|---|---|
| 24 | wards |
| 5 | discharge lounge (JR) |
| 1 | pharmacy |

- LENGTH of TIME:

| | |
|---|---|
| 5 | 30 mins, |
| 1 | 45 mins, |
| 4 | one hour, |
| 1 | 90 mins, |
| 3 | two hours, |
| 5 | three hours, |
| 5 | four hours, |
| 6 | over four hours. |

Over 50 % had to wait 3 hours or more, which is certainly not an acceptable standard as patients need to get home.

4. HOW STAFF HANDLED DELAY:

| | YES | NO |
|---|---|---|
| - given reason/explanation | 15 | 15 |
| - estimate of time | 10 | 20 |
| - apology offered | 15 | 15 |
| - medication collected later | 8 | 22 |

While nursing staff may not be able to give any estimate of time for medication

delivery, it is reasonable to expect them to offer simple apology for the delay but again in half the sample no apology was offered.

There were 8 occasions where someone had to return to collect medication; one had to travel back from Witney to the JR - never a speedy journey - the next day and a husband whose wife was very frail, had to return twice to get the prescription, having to make a round trip of 25 miles each time. In another example where incorrect medication had been ordered, the patient's relative refused to leave elderly person alone for some hours to collect but happily a manager delivered to their home.

5. ADDITIONAL COMMENTS:

Technically these must be classed as anecdotal but they have validity as patients have taken time to complete the comments box and provide additional insight:

- food in JR (private ward as an emergency) described as 'unpalatable'; same person on transfer to St Luke's was full of praise for the food there,
- one patient offered the information that NOC medication is dispensed from the Churchill pharmacy with possible delays from the extra link in the supply chain,
- two patients attending NOC for a second operation avoided the lengthy delays experienced at the first admission by self-discharge and went a local chemist shop to buy OTC painkillers,
- at JR there was error in dosage (double prescribed amount) detected by the patient but not understood by two foreign nurses; it required senior nurse to check with ward doctor and pharmacy so causing a lengthy delay,
- a patient at the Churchill made two suggestions for improvements to the procedures:
  - routinely for straightforward cases medication prescribed in advance of discharge,
  - ensure that all junior doctors have been trained in discharge procedures - not learning by discovery.

6. RECOMMENDATIONS:

There is a clear case for a simple REVIEW of discharge procedures on wards to remove potential problems/blocks:

- with routine/standard treatment examine feasibility of prescribing medication in advance of discharge and perhaps anticipate where a non-stock drug has to be requisitioned elsewhere,
- particularly at NOC because of extra supply link with Churchill and for simple painkillers,
- where a delay is unavoidable, then duty nurses should be able to give some estimate of delay time which would be a big help for family or carers to plan collection of patient.
- it should be standard practice for staff to offer a simple apology as a matter of courtesy.

All of these are basic operational procedures in the retail and business sectors; NHS should not be an exception.

## Part III. COMMENTS ON DISCHARGE PROCEDURES BY GENERAL PRACTITIONERS

1. Detailed replies were received from 21 practices - just over 25% of the total number of practices in Oxfordshire PCT - which is a good response from busy people prepared to give time to make detailed comments and suggestions to improve quality of information.

2. Out of total of 21, three were satisfied with present system, three simply referred to the PCT survey of July to September 2009 (see paragraph 6 below); the other 15 suggested improvements or problem areas.

3. The department causing most concern is A & E as there can be a delay of up to one month for receipt of discharge letter and then often of poor quality. This may reflect the inherent pressure in A & E workloads.

4. ANALYSIS of CONCERNS and DISSATISFACTIONS:

a) Criticisms of speed of delivery was raised by 4 practices. NHS target is for discharge letter to be received within 48 hours; in the PCT 2009 audit 43% of ORH letters met the target time, 46% of NOC letters. NHS target for outpatient letters is receipt within 10 days of the appointment with ORH getting 63% and NOC 42% in the audit.

b) Comment was made by 12 practices about quality of information in the discharge letter:
   - spread over too many pages
   - suggest restricted to one sheet
   - too small to read
   - alter font size in computer text
   - often incomplete
   - standard template would solve this
   - variable in quality of information
   - again agreed template ensure standard quality
   - often simple information gaps
   - template requiring full completion
   - not enough information in an electronic form
   - ensure revised template covers necessary items
   - lack correct information
   - revised template
   - no need for paper copy of patient letter
   - sometimes illegible
   - solution in electronic form
   - lacks vital information on medication
   - have 'medication' panel in template
   - no flagging for 'AT RISK' patient
   - again include prominently placed panel
   - need clarification of GP action
   - incorporated in template
   - similar clarity on follow up.

5. One senior partner suggested form of template for electronic completion with these sections:
- presenting complaint
- final diagnosis
- summary of investigation results
- new medication, medication stopped, reasons for change
- follow up date
- highlight 'ACTION NOW'.

with this additional note: some narrative is helpful as little value in ticking a series of boxes but danger of losing key items in a lengthy narrative; eg drug changes.

6. The return with 15 practices expressing some criticism of present letters from hospitals represents 18.3% almost a fifth of practices; however the Oxfordshire PCT survey - July to September 2009 gives a final summary table for Quality of letter as SATISFACTORY: with a target of 98%; ORHT at 90%; and NOC at 88%. The variance to the PV return can be explained by the simplistic 'ticking of box' of the PCT survey as purely number collection whereas narrative comments were given in replies to the present PV study which has accessed QUALITY of comment. It is vital that the concerns expressed by GPs are not only recognized but IMPLEMENTED in the recommended review.

7. RECOMMENDATIONS:

There is a clear, simple message:

a) a revised format for discharge letter put into a standardised template which provides the essential information suggested above, contained within one panel on a computer screen, to be sent electronically,

b) such a revised form will save time, reduce chance for error and ensure speed of delivery - thus making best use of time for hospital and practice doctors,

c)it is essential to involve GPs in the design as end users,

d) new format should be introduced with precise description of what is required in each panel or box on the form,

e) it should become standard practice that all junior doctors at the start of their placement receive training in use/completion of form.

**Patient Voice - June 2010.**

**LINKS: PROPOSAL SUBMITTED BY PATIENT VOICE**

STUDY OF HOSPITAL DISCHARGE with particular reference to MEDICATION COLLECTION.

Patient Voice has received a number of adverse comments about delay in discharge, particularly about slowness of medication delivery from the Pharmacy. In some cases patients have been transferred to the Discharge Lounge, waiting long periods on the ward or been taken home by family or friends who have had to return later to collect the medication. The problem causes irritation, disquiet even distress; there can be long delays at weekends.

PROJECT OUTLINE

To undertake research based on questionnaires completed by patients who have been discharged from the ORH NHS Trust, possibly the NOC, in the last six months.

TO ASCERTAIN

How the discharge was handled.

Was the process satisfactory and speedy.

If delays in discharge, for what reasons.

Analyse Pharmacy dispensing ideas/suggestions to improve the process.

PROJECT DESIGN

Development, testing and production of questionnaire.

Data collection from local groups, WI, Probus, residential care homes, possibly with notices in GP/Health centres.

Appeal in the media – via the questionnaire.

Collation and analysis to complete research report.

Presentation of report to the Stewardship Group for delivery to ORH and NOC

OBJECTIVE OF REPORT

Highlight main concerns and their causes.

Suggest possible solution.

Compile set of recommendations.

COMPLETION OF PROJECT

Three months from the commencement of the Project.

ADDITIONAL INFORMATION

Members of Patient Voice have collective experience over five years of gathering data from hospital patients, family and carers.

All had CRB clearance and the competency of their social and interviewing skills were fully recognised by the overseeing organisation for PPI Forums

9.2.10
(LINKS PROJECT1)

**PATIENT VOICE**

STUDY OF HOSPITAL DISCHARGE with particular reference to MEDICATION COLLECTION.

RESEARCH THE QUALITY OF MEDICAL INFORMATION sent to General Practitioners following the discharge of their patients from the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre in the last 6 months.

We attach:
(a) Proposal submitted by Patient Voice dated 9.2.10.
(b) Copy of the commissioned report on discharge procedures in Oxfordshire
(c) Patient's Questionnaire
(d) Letter to Practice Managers
A statement of the agreed objectives is given in part I, para 2 of the report

ACKNOWLEDGMENTS:

We wish to acknowledge the following organisations who have assisted us in our studies:

The Oxford Times
The Oxford Mail
The Banbury Guardian
The Witney Gazette
BBC Oxford ("Drive Watch": Bill Heine)
Radio Cherwell (Hospital Radio Station)
Help and Care office staff in Witney for keying in the questionnaire and letter, reproducing copies, handling enquiries and passing the replies to Patient Voice
ORH Retirement Association, Buttercross Probus, Oxfordshire Joint Health Overview and Scrutiny Committee, Health and Social Care Panel, Pegasus Grange and many other Associations too numerous to mention.

Patient Voice is grateful to these organisations for allowing us to speak to their members to tell them about our research and for their interest.

We thank the General Practitioners in Oxfordshire for their co-operation and support.

Patient Voice acknowledges the members of the team who have all worked extremely hard in their individual ways to collect the information and ensure it was fair and accurate: Frank Lucraft who collated and analysed the information and prepared the report, Patricia Harris, John Lant, Elizabeth Audars, Chris Ringwood, Gwen Hunt, Vera Ilic, Tom Griffin and Jacqueline Pearce-Gervis.

Finally, Patient Voice would like to hear what action the Stewardship Group of the Oxfordshire LINk will be taking as a result of these studies.

24.6.10
(DPReport1)

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JHO9

Your voice on local health and social care

**Oxfordshire Local Involvement Network**
**Update for Oxfordshire Joint Health Overview and Scrutiny Committee meeting 16th Sept 2010**

Recent public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have been scoped and prioritised for additional 'task and finish' projects during the remainder of this year. These are described below alongside existing projects.

**Ongoing projects/engagement:**
**Self Directed Support (Personal Budgets)**
An interim report and update has been presented at the 7th September meeting of Adult Services Scrutiny Committee. That report in available on request. The final report will be available at the 26th October ASSC meeting.

**Drug Recovery Project (DRP)**
The LINk held a meeting in public on 29th June at West Oxford Community Centre to provide an update for those who attended the first LINk meeting about the DRP and advise what has happened since. The new Residential Detoxification Project is due to be launched in the Autumn. Full reports from the LINk project group and Commissioners is available from meeting minutes of OJHOSC and in the 2009-10 LINk Annual Report.

**'Social Care' Hearsay**
Following publication of the full report in June, the next update is due in September. SCS have advised the LINk Host in detail about progress with the five priority recommendations from service users and carers and an update about improvements and changes in development will be made available to all participants and the wider LINk. From October SCS aim to publish monthly updates on the web including performance targets. In the September update attendees of the event will be asked if they wish to attend a December meeting to ask questions of senior staff on progress. The next Hearsay event will take place in March 2011 to hear what has been achieved during the year and to set further recommendations for 2011-12. The full report can be obtained from the LINk office or
www.makesachange.org.uk/cms/site/news/oxfordshire/hearsay-report.aspx

**'Health' Hearsay event**
The LINk is in discussion with the Nuffield Orthopaedic Centre and PCT to plan an event with service users and carers later in the year, along similar lines to the successful Social Care event. The likely focus will be on NOC Outpatient services. Further details will be available shortly.

**New projects:**
The following have been scoped and prioritised from approximately 190 recently gathered & collated issues and will be subject to further development and invitations to form small project groups:

Podiatry: availability of services and waiting times.
Community Mental Health Services: waiting times and availability of therapy services.
GP appointments: local systems and extended hours service.

**Partnerships:**
Alongside the main work programme, the LINk is working alongside various Oxfordshire groups and organisations in order to improve or develop services and to provide the LINk with a wider base of interested participants:

Oxfordshire Unlimited
Assisting in the development of this User Led Organisation for those with physical disabilities in Oxfordshire. This partnership project is providing Unlimited with the ability to develop its membership and become better known throughout the county and hence to offer to the community a key reference base for information and services in the future.

Oxfordshire Neurological Alliance
LINk is providing ongoing support in establishing a local branch, supporting ONA to publicise its work and raise public awareness, the LINk has helped ONA to produce promotional materials, publish a website and to provide additional channels of contact with local people.

Patient Voice
Hospital discharge procedure survey, commissioned by the LINk from Patient Voice, has been completed. A report is being be presented to OJHOSC at this meeting.

Community Chest / 'Have a Say' Fund
The LINk wants local people to have a voice and to make a change. We recognise the difficulties facing small groups & organisations with limited finances and the LINk will be offering the chance to apply for small grants (maximum £500 each). Constituted voluntary and community groups are invited to put forward proposals that meet the LINk remit and grant priorities: Engaging with local people so that they can have their say on health and social care issues that affect them personally or the population as a whole; Engaging with people who use health and social care services; Engaging with groups and organisations who are helping to supply people with appropriate health and social care services. Applications will be assessed by LINk SG and Host representatives.

**LINk Engagement and Promotion**

HealthBus Roadshow

Oxfordshire residents still have the chance to visit the HealthBus and give their views on local health and social care services. The LINk is 'driving' a HealthBus on a cross-county roadshow through the summer and autumn. The HealthBus has already visited several locations from Abingdon, Didcot, Witney and Cowley Oxford, to Bicester and Banbury and provides people with an straightforward method to have their say about the services they use in their own communities. People can find out more about the LINk, alongside other health and social care information in participation with local service providers. Future LINk projects will be assessed from the information gathered via the HealthBus and through feedback from other engagement and promotional activities carried out by the LINk staff team.

The **LINk Annual Report** for 2009-10 is available via the office or can be downloaded from www.makesachange.org.uk/cms/site/news/oxfordshire/oxfordshire-link-annual-report.aspx

**Newsletters and bulletins** can be found at www.makesachange.org.uk/cms/site/news/oxfordshire/latest-oxfordshire-link-newsletter.aspx

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*Update 31/08/10*

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