OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 January 2011 commencing at 10.00 am and finishing at 1.00 p.m.

Present:

Voting Members:	Councillor Susanna Pressel – in the Chair
	Councillor Jenny Hannaby Councillor Neil Owen Councillor John Sanders Councillor Don Seale Councillor C.H. Shouler (In place of Councillor Tim Hallchurch MBE) Councillor Lawrie Stratford District Councillor Dr Christopher Hood District Councillor Rose Stratford District Councillor Hilary Fenton
Co-opted Members:	Mrs Ann Tomline Dr Harry Dickinson
Other Members in Attendance:	
By Invitation:	
Officers:	
Whole of meeting	Roger Edwards (Chief Executive's Office)
Part of meeting	Nick Welch (Social and Community Services) for Item 6

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

1/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Charles Shouler attended for Councillor Timothy Hallchurch and apologies were received from Mrs Anne Wilkinson and Councillors Jane Hanna and Dr Peter Skolar

2/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest

3/11 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 11 November 2010 were approved and signed subject to the following amendments to Item 9, "The Future of the Link Contract";

Lisa Gregory reported that Legal & Governance Services had advised that it would be deemed *unlawful* if the support for LINk was to be brought 'in-house' (within Social & Community Services).

Following discussion it was AGREED that the contract with Help & Care should not be extended and *should be* put out to tender once the funding situation was known.

4/11 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

There were no requests to speak to the Committee or to present petitions

5/11 PUBLIC HEALTH
(Agenda No. 5)

The Director of Public Health reported on the flu situation in Oxfordshire. Flu cases, he stated, are running at normal seasonal levels in Oxfordshire and below national levels in the South East generally. Unusually, with the present outbreak younger people seem to be affected most. There are plenty of anti-virals and vaccine available in the County.

In answer to a question from the Acting Chairman, the Director of Public Health stated that flu was not causing any particular winter pressures.

6/11 IMPLICATIONS OF THE HEALTH WHITE PAPER "EQUITY AND EXCELLENCE - LIBERATING THE NHS"
(Agenda No. 6)

The Chairman and Chief Executive of the PCT were joined by the Director of Public Health and the Head of Major Projects from the County Council to bring the Committee up to date on the latest position with regard to the restructuring of the local NHS and other matters.

The PCT Chairman emphasised the fact that, whatever is happening in changes to the local health economy, the PCT will remain accountable for commissioning quality services until April 2013. There are three main tasks at present:

i Managing the local health economy – i.e. the "day job"
ii Developing the Oxfordshire GP consortium
iii Creating the "cluster" authority with Buckinghamshire as required by he Department of Health

The Chief Executive expanded on these comments as follows:

GP Consortium

Following a report at the last HOSC meeting the GPs choice to create one countywide Consortium has now been confirmed with strong localities as a significant component. Six or seven localities will have devolved budgets within the Consortium with leaders appointed at locality level who would sit on the Consortium Board.

£2.5m will be available to the Consortium for 2011/12 to pay for additional running costs for the Consortium to develop its delivery capacity. This reflects the £2 per head required to be allocated as per the NHS Operating Framework which also indicated a financial figure for Consortium of £25 – £35 per head when fully established, but this would include all running costs including, for example, leases and external contracts.

The Consortium will have to deliver national priorities. How delivery takes place will be decided by the locality groups and patients should have an input into those decisions.

It is planned that the consortium will develop into its form during 2011/12 and run in shadow during 2012/13 and will formally come into being from April 2013 when PCTs finally are abolished as the statutory base. The launch of the Consortium, its plans and work plan is scheduled for 27 January at the Kassam Stadium. All GPs in Oxfordshire are invited, together with relevant external bodies. The HOSC Acting Chairman will be attending the launch.

PCT Consortium Transfer of Responsibilities

The Consortium will have to take on the work programme of the PCT related to the national funding position and the need for service redesign to release resources to fund emerging and new priorities. Consequently, the internal structure of the PCT is changing to reflect this merging of work functions as GPs become increasingly engaged in the mainstream PCT objectives. The PCT will also be seconding staff to work directly as Consortium staff to speed up the transition and involvement, particularly in the £35m savings programme the PCT has to achieve in 2011/12.

Everything must be done against the background of a reducing budget.

PCT Clustering Arrangements

The clustering in this part of South Central will be Oxfordshire, Buckinghamshire and Milton Keynes [Note: this has subsequently been changed to Oxfordshire and Buckinghamshire only] and there will be Chief Executive and Executive Team appointments commencing in March. There will be one Chief Executive for the cluster. Consequently the PCT functions will be reshaped under a new Executive Team although the PCTs will remain as the formal legal structure until their abolition in 2013.

Compared with the 151 PCTs there are likely to be 500 GP consortia and so a number of them will be too small to be internally sustainable and will need to commission support from other organisations to deliver their key functions. Oxfordshire will have choice due to the size of the Consortium and that was one of the reasons that this solution was pursued. The impact of clustering will increase the speed of transition and indeed the role of the cluster is to ensure consortium development and also to have oversight of 2011/12 and 2012/13 Operating Plans and ensure successful delivery.

Provider Organisations

a NOC/ORH Merger

The PCT is supportive of this merger as clinical benefits should be derived and also internal savings which will support the providers in achieving their tariff efficiency challenge, i.e. all providers are subject to a 2% price drop in 2011/12 compared with 2010/11. Timetable for the merger is understood to be summer 2011.

b CHO/OBMHFT

This is proceeding well. Co-operation and Competition Panel approval had been gained prior to Christmas and Monitor is positive that the merger can proceed. That confidence arises from their latest investigations and trust meetings. Timetable is April 2011.

c Foundation Trust Pipeline

All providers have to attain Foundation Trust status or alternatives which allow the same goal to be achieved and so ORH is aiming for this in April 2013. From the PCT perspective issues which have to be resolved are:

- the impact of the service redesign which will remove activity from ORH and which needs to be aligned with their financial projections
- resolving the DTOC problem as this creates great operational instability. There is a need to be clear as to how systems are improved and how additional money from the NHS to Social Services ensures that the system gains from this planned usage
- performance of key standards also has to be improved

d Ridgeway Partnership

This Trust is aiming for FT status. It will be marginal due to its size and the potential downside of losing contracts, particularly those related to social services; those which are more price sensitive than the more fixed tariff world of the NHS. Its goal, if successful, is November 2011.

PCT Restructuring

Meanwhile the PCT is required to reduce its running costs and this week issued a consultation document within the PCT for changes to its structure which enables it to reduce posts to meet its savings target. £4.3m has to be saved and this, after a range of measures, could mean a number of posts being removed compulsorily should other means not be successful.

County Council Perspective

The Head of Major Projects explained that the County Council, the PCT and GPs are working positively to develop the consortium. The present Health and Wellbeing Board and Children's Trust will have to change and joint arrangements and pooled budgets will need to be carefully managed.

The new Health and Wellbeing Board will be the subject of a formal paper soon with an aim for it to be established by April. Members agreed that they would expect that the Board would be subject of scrutiny by the HOSC.

HealthWatch would be represented on the Board and would ensure that patient experiences and views would inform the Board's work.

Public Health

The Director of Public Health presented a paper that identified the following strengths, weaknesses, threats and opportunities;

Implications of Coalition Proposals for Public Health in Oxfordshire : January 2011

Overall since the last HOSC update in August, the strengths and opportunities have increased and the weaknesses and threats have diminished.

SWOT Analysis of Coalition Proposals for Public Health in Oxfordshire.	
Strengths	**Weaknesses.**
➢ Public Health is seen as a national priority. ➢ The Secretary of State will provide leadership. ➢ The Public Health White Paper has set out a clear direction which matches Oxfordshire's planning assumptions (December 2010). ➢ **There will be a national Public Health service called Public Health England from 2012** ➢ **There will be a local public health service in LA's from 2013/14.** ➢ **A Public Health Transition Group has been set up to oversee the move of Public Health to LA's with the HOSC Chairman as an active member.** This group is engaged in reviewing and restructuring the current PH department to meet new requirements and improve VFM. ➢ **A ring-fenced budget for some local PH activities around health improvement which becomes a LA responsibility.(shadow budget in 2012/13, 'live' in 2013/14)** ➢ The existing Public Health Department contains core NHS functions (e.g. medicines management and priority setting) which will be maintained to provide stability. ➢ The emergence of Health and Wellbeing Boards as the vehicle for joined-up working with a clear role for the DPH and local pathfinder status. ➢ Oxon has a lead role in our Region for finance and budgets.	➢ Inevitable loss of momentum due to major NHS reorganisation. ➢ Staff uncertainty . ➢ Potential loss of skilled staff. ➢ Oxfordshire has a larger than average Public Health Department - a nationally allocated budget is unlikely to cover current staff costs. ➢ The ring-fenced budget cannot cover costs of all PH programmes. These costs will remain in the NHS. This requires negotiation with commissioning GPs. ➢ Key facts remain unclear and await further DH policy papers e.g. 1. division of responsibility between national, regional and local level for communicable diseases and emergency planning 2. Size and shape of a regional level.

➢ Clear alignment with local government and a stronger role for local democracy. ➢ **The battle was won to keep the Health Scrutiny function independent.** ➢ Proposals are based on a very broad view of health. ➢ Preventing ill-health and reducing inequalities are priorities. ➢ **Support to the NHS and GP commissioning is a priority**. ➢ There is a clear role for a local Director of Public Health.	3. HR arrangements for the eventual transfer of Public Health staff.
Opportunities. ➢ **There is an overarching opportunity to create a slimmer, leaner, more efficient and better focussed public sector across Oxfordshire.** ➢ **There is an overarching opportunity to create a slimmer, leaner, more efficient and better focussed Public Health function across Oxfordshire that can live within its future budget.** ➢ Potential gains for the health of the people of Oxfordshire due to a clear PH role. ➢ Opportunity to retain the gains made in Public Health in recent years through a well-managed transitional process. ➢ The opportunity to create a strong Health and Wellbeing Board. ➢ Opportunity to continue the successful alliance between PH and LAs while keeping strong links with the NHS. ➢ The creative engagement of GPs in stronger Public Health programmes. ➢ The coordinating role of LAs could create a single set of priorities for the public sector across Oxfordshire. ➢ Potential economies of scale by commissioning parts of some PH programmes at multi-county level. ➢ 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.** ➢ Planning blight. ➢ The general climate of public sector 'squeeze'. ➢ Potential 'cuts' in Public Health caused by inadequate national budgets in 2012/13. ➢ Tensions between public sector organisations due to a general squeeze on budgets – just when maximum cooperation is critical. ➢ Possible unwillingness of the new NHS to act on PH priorities. ➢ Possible unwillingness of LAs to embrace the new health improvement role fully. ➢ Outcome measures become another set of targets lacking local relevance. ➢ Lack of financial control of Foundation Trusts dwarfs the real priorities for health.

Further information following member questions

The following statements were made in answer to a number of questions from members:

In the summer GPs will elect locality leaders to form the board of the new consortium and they will create the leadership model. The model will then have to be agreed by the national NHS Commissioning Board.

Budgets will be devolved as far down as possible to GPs but consideration of just what would be devolved and to whom is still going on.

The cluster will have a single Chief Executive and executive team but local issues and partnership working will continue to be dealt with locally as will Public Health. Pooled budgets and joint arrangements would be unaffected.

The cluster should not lead to any increase in costs. So far Oxfordshire PCT has remained comparatively stable but this could change as the cluster comes into being and staff begin to move across to support the consortium. Senior managers continue to work hard to maintain staff morale and motivation.

Locality working should not lead to a "post-code lottery" although there will inevitably be variations across the County simply because, for example, the City is very different from Henley and Goring. However the principles of providing the best quality health services for all would be maintained. The national Operating Framework will set priorities and consortia will be required to deliver those priorities. How that is done would be decided locally and patients would have an input into those decisions.

Accountability and leadership will sit with GPs but they will need the support of skilled and experienced managers. Consultation with patients and the public is very high on the agenda and GPs will have to decide how they intend doing that.

The change to consortium commissioning should not put small rural practices at risk. Work is ongoing to decide how funding would be allocated but, if it were to be done via a formula that relied on population, there could be difficulties related to the volatility of cost at a small population level.

7/11 SAFE AND SUSTAINABLE REVIEW - PAEDIATRIC CARDIAC SERVICES AT THE JOHN RADCLIFFE HOSPITAL

(Agenda No. 7)

A review of paediatric cardiac surgical services in England began in 2008 in response to long-standing concerns around the sustainability of the current service configuration for paediatric cardiac services. It was planned that proposals for change should go to public consultation in 2011. However, in October 2010 it was announced that the Joint Committee of Primary Care Trusts (JCPCT) would be advised that eventual options for reconfiguration to be put out for public consultation would not include the children's heart surgery service at the John Radcliffe Hospital. At the same time, the Trust was told that "not being included in options for consultation does not mean that the JCPCT has made any decision about the future of the service at the John Radcliffe Hospital".

Members wishes to address the apparent inconsistencies around consultation and to ascertain what the future consultation arrangements would be. The following speakers attended:

Jeremy Glyde – NHS Specialised Services Programme Director

Simon Jupp – South Central Specialised Services Director

Andrew Stevens – Director of Planning and Information at the Oxford Radcliffe Hospitals Trust

Dr Nick Archer – Lead Paediatric Cardiologist at the Oxford Radcliffe Hospitals Trust

Caroline Langridge }

Kim Holmwood } Young Hearts

Jude Kelly }

Jeremy Glyde started the discussion by explaining some of the background to the review and the decision to exclude the Oxford Radcliffe Hospitals Trust from the consultation.

There are long held concerns about the safety and sustainability of paediatric cardiac surgical services. It was considered that surgeons were spread too thinly across surgical centres (31 congenital cardiac surgeons spread over 11 surgical centres), leading to concerns around lack of 24/7 cover in smaller centres and the potential for sudden closure or suspension of smaller centres. The long-term aim would be to:

1. Reduce the number of centres
2. Implement new quality standards
3. Develop new cardiac networks

The review is being led by the National Specialised Commissioning Team (NSC Team) on behalf of the 10 Specialised Commissioning Groups (SCGs) in England and their constituent Primary Care Trusts.

No paediatric centres would be closed but some would lose specific functions such as surgery. If surgery were to be removed from Oxford, it is proposed that all other core non-interventional paediatric services would be retained. A key standard for future viability is that a surgical centre must undertake a minimum of 400 paediatric surgical procedures a year and have a minimum of 4 surgeons co-located on the same site. The review team will recommend to the JCPCT that the ORH Trust is unlikely to be able to meet these and other standards based on an assessment of the John Radcliffe (and all other surgical units) by an independent panel of experts led by Professor Sir Ian Kennedy. As only viable options can be put forward for consultation, it will be recommended to the JCPCT that the inclusion of the John Radcliffe in any option would make that option un-viable. Mr Glyde further explained that nothwithstanding the concerns about the Trust's ability to meet the standards the national review team had undertaken further analysis to test whether the inclusion of the John Radcliffe in potential options would improve access for children and families. However, this analysis suggested that this was not the case. It also suggested that the John Radcliffe Hospital could only meet the necessary critical mass of patients by removing heart surgery from both the Bristol and Southampton units; there was no confidence that the John Radcliffe Hospital would be able to manage a paediatric cardiology network covering such geography.

On behalf of the ORH Trust Andrew Stevens and Dr Archer commented that the Trust recognises the need for safety and sustainability. They also accept that the size of the set up at the John Radcliffe could be a problem. However the Trust considers that services should be looked at in the round and the review should recognise the importance of the wider paediatric services and the services provided for adult cardiac patients. Children grow into adults and the seamless transfer from one part of the service to the other is very important.

The ORH is in talks with Southampton University Hospital to develop proposals for a fully rounded integrated service with a larger surgical capacity.

Mr Stevens and Dr Archer contended that it would not be necessary to close heart surgery at Southampton and Bristol. There were other options that could be considered that would leave those hospitals and the JR with the ability to perform heart surgery. Other small, isolated hospitals could be closed and patients could be cared for in Oxford or Southampton.

The Young Hearts representatives stressed their support for the John Radcliffe and pointed out that parents are very satisfied with the service. They appreciated the importance and benefits of the "cradle to grave" service available in Oxford and expressed concern over the amount of travel that could be involved for patients and their families if Oxford were to be closed.

A lengthy discussion ended with Jeremy Glyde explaining that the consultation document would contain a number of options with the expert committee's preferences being expressed. The consultation will allow consultees to explain how other possible configurations, not included in the consultation document, could be appropriate.

Members **AGREED** that the consultation should form part of the agenda for the March HOSC meeting. In addition to the consultation document, they would expect to see the scoring system and total scores for each option and those excluded from the options.

8/11 KEEPING PEOPLE WELL - PLANS FOR THE FUTURE OF MENTAL HEALTH DAY SERVICES

(Agenda No. 8)

Fenella Trevillion and Ian Bottomley from the PCT; Benedict Lee of Restore and Stuart Reid from Oxfordshire Mind attended for this item to explain the outcome of the tendering process for day services provided by voluntary and community services for adults over the age of 18 who have mental health problems and the transition plan for implementing the new services.

It was explained that the new service would be very different from what exists at present. The service will be divided into wellbeing and recovery services. All patients will have a long-term plan that will be subject to regular review. Places will be available in the wellbeing service for everybody who needs it and, while referral to the recovery service will not be possible for all, the option for referral will always be kept under consideration.

There will be an increased spread of services across the County than at present although that will mean fewer places will be available in the City. However, the aim would be for more services to be available locally, for example in Banbury, thus reducing the need for people to come into Oxford.

The experience that has been built up in the City will be used to help the service reach out to BME communities.

Dr Dickinson, who had represented the HOSC as an observer of the preparation of the specification and tender, considered that it had been a good process with a satisfactory outcome.

Members congratulated the PCT on the process and expressed satisfaction with the outcome and the transition plan. The Committee would be pleased to receive a progress report in 12 months time.

9/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 9)

Dermot Roaf reported that the County Council plans to tender the service with the intention of appointing the new host by May 1st to run until the implementation of Health Watch. Funding will be less than now and it is not known at present what funding will be available for Health Watch.

There are two main projects being undertaken at present; one relating to care homes and the other, being undertaken on LINk's behalf by the Patients' Voices group, on hospital food.

Mary Judge reported on the care homes project. A random selection of 31 homes across Oxfordshire will be visited and reports made on each of them. The group will produce a report that will be made available to the HOSC.

The Committee thanked Mr Roaf and Mrs Judge for their contribution and stated that they look forward to viewing the report on care homes.

10/11 CHAIRMAN'S REPORT

(Agenda No. 10)

There was nothing to report that had not already been touched on in other agenda items.

..... in the Chair

Date of signing .....