Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 8 March 2012 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Dr Christopher Hood

Councillors:	Jenny Hannaby Don Seale	C.H. Shouler Val Smith	Keith Strangwood Lawrie Stratford
District Councillors:	Hilary Hibbert-Biles Susanna Pressel	Rose Stratford Alison Thomson	
Co-optees:	Dr Harry Dickinson		Mrs A. Wilkinson

Notes:

Date of next meeting: *24 May 2012*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

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

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

Peter G. Clark

Peter G. Clark
County Solicitor

February 2012

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 8)

To approve the minutes (**JHO3**) of the meeting held on 19 January 2012 and to note for information any matters arising from them.

4. Co-opted members

Following interviews the Chairman will propose Keith Ruddle be confirmed as a co-opted member of the committee alongside Dr Harry Dickinson and Anne Wilkinson.

5. Speaking to or Petitioning the Committee

6. Public Health

10.15

The Director of Public Health will provide the committee with his regular report on matters of relevance and interest to the committee, including an update on the Health and Well-being Board.

7. Health social care and wellbeing in local government (Pages 9 - 36)

10.45

Jonathan McWilliam, Director of Public Health will present a joint report **(JHO7)** from himself and the Chief Executive, Directors of Children Education and Families and Social & Community Services, Oxfordshire County Council.

8. South Central Ambulance Trust - performance update (Pages 37 - 38)

11.25

Aubrey Bell, Area Manager, South Central Ambulance Trust will present an update report **(JHO8)** on the Trust's performance against the new indicator data.

Performance was last reported to the committee in September 2011 when it was requested that a further report be brought in 2012.

9. Update on the Chipping Norton First Aid Unit (Pages 39 - 40)

11.55

Ally Green, Transition Programme Lead, Oxfordshire Clinical Commissioning Group will provide an update **(JHO9)** on the pilot First Aid Unit in Chipping Norton which has been operating since April 2011.

10. Forward Plan (Pages 41 - 42)

12.10

The Chairman and scrutiny officer will present the draft 2012 work programme **(JHO10)** for the committee. Members are requested to bring forward any additional proposed items for consideration for inclusion.

11. Oxfordshire LINk Group – Information Share (Pages 43 - 44)

12.25

The regular update from the Oxfordshire LINk is attached (**JHO11**). Adrian Chant and Sue Butterworth from the LINk will be in attendance to answer any questions that members may have.

12. Chairman's Report

12.40

The Chairman will report on meetings etc that have taken place since the previous HOSC meeting.

13. Close of Meeting

12.50

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, i.e. 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, 19 January 2012 commencing at 10.00 am and finishing at 1.40 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Dr Christopher Hood (Deputy Chairman) Councillor Jenny Hannaby Councillor Don Seale Councillor C.H. Shouler Councillor Val Smith Councillor Lawrie Stratford Councillor Hilary Hibbert-Biles Councillor Susanna Pressel District Councillor Rose Stratford District Councillor Alison Thomson Councillor Ian Hudspeth
Co-opted Members:	Dr Harry Dickinson Ann Tomline Mrs Ann Wilkinson
Other Members in Attendance:	Councillor (for Agenda Item)
By Invitation:	
Officers:	
Whole of meeting	Claire Phillips Jonathan McWilliam
Part of meeting	
Agenda Item	**Officer Attending**
6	David Bradley (Chief Operating Officer), Jackie Thomas (Head of Service and Business Development) and Dr Rob Bale (Clinical Director) , Oxford Health
7	Maria Godfrey (Early Intervention Manager; Children, Education and Families)
8	Dr Stephen Richards (Chief Executive), Alan Webb (Director of Partnerships and Transition) Oxfordshire Clinical Commissioning Group (OCCG) and Francis Fairman (Clinical Effectiveness Principal from the NHS Cluster (PCT)

9 Lisa Gregory, Social and Community Services

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

1/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Councillor Keith Strangwood. Councillor Ian Hudspeth substituted for Councillor Strangwood.

2/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Councillors Rose Stratford and Lawrie Stratford declared an interest as members of the Bicester Hospital League of Friends.
Councillor Dr Peter Skolar declared an interest as a member of the Townlands Hospital League of Friends.
Councillor Jenny Hannaby declared an interest as a member of the Wantage Hospital League of Friends
Alison Thomson declared an interest as a member of the Faringdon Health and Social Care Group and as having family members with Coeliac's disease/gluten intolerance.

3/12 MINUTES
(Agenda No. 3)

The minutes of the meeting on 10 November were agreed and signed subject to minor corrections.

It was agreed to circulate the response from the Leader of the Council to the Committee's letter about a Cabinet member for Health.

4/12 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

Bryan Mitchell and Tracey Taylor from My Life My Choice gave a presentation on the subject of Annual Healthchecks for people with Learning Disabilities.

The presentation noted that Annual Healthchecks for people with Learning Disabilities were introduced in 2008 as a result of the 2007 MENCAP's report "Death by Indifference" and subsequent public enquiry "Health Care for All". The take-up of these healthchecks in Oxfordshire stands at 41% which is below the national average

of 49%. The benefit of these healthchecks is that they often uncover previously unknown health issues.

My Life My Choice is a charity which works to improve the quality of life for people with learning disabilities in Oxfordshire. It has worked with to provide free consultancy and training to GP practices on this issues but has found practices, the PCT and Strategic Health Authority not to be responsive to calls to improve take-up of these healthchecks.

Tracey Taylor posed the following questions to the committee and asked for its support in gaining answers to them from the PCT.

1. What is the Action Plan of NHS Oxfordshire to improve the quality and take up of health checks?
2. Who is responsible for leading NHS Oxfordshire in this?
3. What are GPs doing to increase the take up of health checks in Oxfordshire practices?

The committee thanked Tracey Taylor for her presentation and supported the issue wholly, committing to press NHS Oxfordshire to bring a report in response to a future meeting.

5/12 PUBLIC HEALTH
(Agenda No. 5)

Dr Jonathan McWilliam (Director of Public Health) presented his fifth Annual Report. In his presentation he highlighted;

- The demographic challenge and breaking the cycle of deprivation remain the two major priorities
- Obesity – we are bucking the national trend reflecting good partnership working
- Good progress on mental health commissioning
- Alcohol consumption continues to increase. Last year the focus was on harm minimisation as people are not yet ready to hear the prevention message.
- Reduction in killer diseases has seen an improvement
- Persistence in partnership working is needed

In response to questions from members of the committee the following points were noted;

- GP commissioning through localities and the integration with social care provide the opportunity for rural proofing services
- Breaking the cycle of deprivation remains hard to shift due to the persistence of issues within the target families. The commitment of large organisations to target this is crucial and the mainstreaming happening through the new Early Intervention Service is very positive.
- The Health and Well-being Board will set out plans for how different organisations can work together to tackle the issues related to demographic change

- The success of local healthwalks was acknowledged but concerns were noted about the awareness and publicity of these especially through GPs.
- There was some discussion about whether we should be campaigning for a higher minimum alcohol unit price, taxing sugary drinks and to encourage the Police to prosecute licensees who continue to serve those who are already drunk.
- Rates of TB are quite stable and that we have improved at early identification and completing treatment.
- The lack of healthchecks entry points was a factor potentially affecting the number of cases being brought into the country.
- Judgements on mental health in the report appeared complacent but partners had been consulted.
- There were concerns about the number of people prescribed medication for depression and hyperactive children.
- Clear targets for breaking the cycle of deprivation are needed
- The role of partnerships is important especially the evolving Local Enterprise Partnership.
- The need to work closely with Education to have an impact on the prevention agenda was emphasised.
- There is nothing in the report about drugs as figures from the Drug and Alcohol Action Team are good and the area of concern is alcohol.
- Strong prevention messages were thought to often be more effective as shock tactics change behaviours but acknowledged that such messages take a long time to have an impact.

Jonathan McWilliam undertook to circulate recent documents on the role of Public Health in Local Authorities and the Integration of Health and Social Care.

He also agreed to provide more information on Teenage pregnancy hotspots.

It was **AGREED** that the Director of Public Health's report would come to the HOSC prior to Cabinet in future years.

6/12 COMMUNITY MENTAL HEALTH TEAMS; UPDATE ON PROGRESS AND FUTURE PLANS

(Agenda No. 6)

David Bradley (Chief Operating Officer), Jackie Thomas (Head of Service and Business Development) and Dr Rob Bale (Clinical Director) from Oxford Health presented the report which provided an update on the restructuring of the community mental health teams.

Members expressed serious concerns about the impact of the changes on the services. In response to questions from members there was discussion of the following points,

- Co-location of teams is to try and reduce the spend on premises. The consolidation has been around administrative bases.

- The model of care has not changed with people continuing to be seen in their homes. Though the need to balance the number of people coming into clinics and those being seen at home.
- The variation in size of locality teams reflects consideration of issues other than just population size such as deprivation.
- In response to concerns about the lack of information about psychology or psycho-therapy services it was noted that the paper is not a mental health strategy and therefore does not cover all elements of the service.
- Oxford Health was attempting balance the issue of consistency of services between inpatient and CMHTs. It was felt that the new way of working was improved as there are fewer consultants working on inpatient wards enabling more consistency on the in-patient side.
- Referrals from GPs to memory clinics and access to consultants is being made very easy.

It was **AGREED** to bring a report with performance and outcome information to the July meeting when audited figures for the service will be available.

7/12 EARLY INTERVENTION HUBS AND HEALTH MATTERS

(Agenda No. 7)

Maria Godfrey (Early Intervention Manager; Children, Education and Families) presented the report. She highlighted that the service started in September so is still in its early days but that the aim has been to build on earlier work to integrate work with families and deliver services for vulnerable children from one place.

It was noted that Health Service colleagues had been involved in the service from the beginning and that further work is planned with health and social care colleagues in the spring to test care pathways.

Members asked to have more information about the performance of the service and it was **AGREED** that a report would be brought to the July meeting.

It was noted that the specification for Children's Centres will measure outcomes and will continue to integrate with the work of the Early Intervention Service including at management level.

Members were keen that Children's Centres and the Early Intervention Service work with midwives and health visitors.

It was noted that a number of voluntary groups had successfully bid for Big Society Funding to establish community run youth facilities.

8/12 QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PROGRAMME AND PLANNED CARE DISINVESTMENT

(Agenda No. 8)

Dr Stephen Richards (Chief Executive) and Alan Webb (Director of Partnerships and Transition at OCCG) from the Oxfordshire Clinical Commissioning Group (OCCG) and Francis Fairman (Clinical Effectiveness Principal from the NHS Cluster (PCT)) introduced the report. The presentation emphasised that the QIPP proposals were clinically led and aimed at ensuring spending has most impact. It was noted that Oxfordshire is already very efficient and there is a lot of integration between providers for example in the Older People's pool.

Dr Richards noted that this year proposals must have clinical sign up therefore informal consultation is already underway with

The committee requested early sight of the proposals for disinvestment in order to make a judgement as to whether they constituted major service change requiring consultation.

Cllr Hannaby asked what the likely timescale to bring delayed transfers of care down to which it was confirmed that the aim is still to bring numbers down to 40 by March 2012.

Cllr Seale questioned why health funding per head of population in Oxfordshire is so low. The response to which was that central government calculations take into account the health and wealth of the population and that the focus should be on making most effective use of the resources we have.

There was some discussion on the proposal to review the prescription of gluten free foods. It was noted that consultation with the Coeliac society and other users was underway.

The committee was reassured to hear that quality and patient concerns are an important part of proposals as well as value for money considerations.

Ann Tomline highlighted the over provision of medicines as a potential area for savings to be made.

It was **AGREED** that the Chairman would discuss with CCG/PCT how to manage the committee's involvement and consideration of the QIPP proposals.

9/12 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 9)

Lisa Gregory updated the Committee on the latest position regarding HealthWatch implementation of which has been delayed until April 2013. Comments on the recent Oxfordshire discussion document are welcomed up to mid February.

It was confirmed that the intention is to keep to the same timescale for developing the specification as originally planned.

The regular LINk report was presented by Sue Butterworth and Adrian Chant. Outcomes of the mental health Hearsay event which will be outlined in a report to

feed into the mental health strategy and a new piece of 'enter and view' work around care homes.

Members asked to see the mental health report when it is available.

The upcoming Oxfordshire Wheel personalisation event at the Kassam stadium in March was publicised.

10/12 CHAIRMAN'S REPORT

(Agenda No. 10)

The Chairman reported on the following meetings in which he had taken part:

- First meeting of the Informal Shadow Health and Wellbeing Board
- Feedback session on the outcome of listening exercise on the new Healthwatch
- Informal progress meeting with the Clinical Commissioning Group Chief Executive and senior officers on the new organisation and development.
- Regular catch up meeting with the Chief Executive and Senior officers from Oxford Health about funding priorities and community hospitals.

11/12 CLOSE OF MEETING

(Agenda No. 11)

The meeting closed at 13.40.

..... in the Chair

Date of signing .....

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Health Overview Scrutiny Committee

8th March 2012

Health, Wellbeing and Social Care: New Roles for Local Authorities

Joint report by Jonathan McWilliam, Director for Public Health Joanna Simons, Chief Executive, John Jackson, Director for Social & Community Services, Jim Leivers, Interim Director for Children Education and Families

1. Introduction

1.1. There is a sea change in national policy regarding health, well-being and social care which puts Local Authorities centre stage.

1.2. A wealth of government policy has appeared over the past eighteen months which, when taken in the round, points the way forward. When looking particularly at the direction of recent policy, it is clear that local government has a major and developing role to play.

1.3. *This gives the County Council a tremendous opportunity to set the direction for health and healthcare in Oxfordshire.*

1.4. From April 2013, this lead role will be centred on leading, championing, shaping, influencing and challenging health policy in its broadest sense across Oxfordshire. (The wide range of relevant policy papers are referenced at Annex 1).

1.5. The latest government policy documents give Local Authorities new powers, duties and opportunities to serve local people better.

1.6. In addition, local government increasingly also commissions and provides what amounts to a 'wellness service', while the NHS leads on early detection and treatment of disease.

1.7. In some senses this is a 'back to the future ' scenario mirroring social policy from the mid-19th century onwards, with local authorities taking an overview of the factors in society underpinning health, and acting through leadership, influence, championing and providing a safety net for those less able to help themselves. In the last century the emphasis was on clean water, sewerage, clean air and overcrowding, now the emphasis is on the social factors underpinning health, health promotion, fighting inequalities and improving the quality of local NHS services.

1.8. These changes are wide ranging, and affect every cabinet portfolio and every directorate within the council.

1.9. The time is now ripe to set out these policies and their implications so councillors can consider setting a new course for the County Council. This paper explores these issues and sets out the implications and opportunities.

Purpose of this Report

1.10. This paper has 3 purposes:

- To Brief Councillors on changes to government policy, new roles for LAs and the rapidly changing NHS architecture.
- To set out new responsibilities and duties.
- To describe the implications and opportunities for Oxfordshire County Council and describe possible future directions for the consideration of Councillors.

1.11. Because the subject is complex and multifaceted, this paper is set out in a number of sections as follows:

- An overview of the new role of LAs in Health and Wellbeing and social care
- The particular opportunities open to Oxfordshire
- The Expanding remit of the Health and Wellbeing Board (H&WB), the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy JHWS)
- The new remit for public health in local government
- The role of services for children and young people
- Integration and the future of health and social care for adults
- The new NHS architecture: Clinical Commissioning Groups, the NHS Commissioning Board and NHS Commissioning Support Services
- Implications for the scrutiny function
- The role of District Councils
- Implications for public involvement and Localism.

1.12. A final section then draws together all of these strands and sets out the implications, opportunities and possible direction of travel for the Council.

1.13 Annex 2 provides a useful diagram describing the wide range of social factors that influence health - these are known in the jargon as the 'Broader Determinants of Health'.

2. An overview of the new role of Local Authorities in Health, Wellbeing and Social Care

2.1. This section describes the full range of roles Local Authorities will play in health wellbeing and social care from April 2013. Taken in the round it can be seen that Local Authorities are now major 'players' in health and wellbeing. The full range of roles, duties and accountabilities includes:

- **A Community Leadership role:** Creating a framework within which a multitude of organisations and interests can come together to improve health.

- **Health strategy for the County:** through leading the **Health and wellbeing Board** and creating a **Health and Wellbeing Strategy.**

- **Holding Clinical Commissioning Groups to account** (CCGs - the 'GP commissioners') for adherence to the agreed Health and Wellbeing Strategy, 'signing off' the Clinical Commissioning Group accreditation process in April 2013 and contributing to their annual assessment.

- **Scrutiny Role:** The Health Overview and Scrutiny Committee continues to scrutinise the full range of services affecting health and continues to scrutinise the NHS. The other Scrutiny Committees will continue to scrutinise Council services, and scrutiny of the public health function will now be added.

- Leading the **further integration of health and social care**

- Accountability for the **Public Health of the County** and for a new range of services commissioned by the public health directorate. (These services and their interplay with existing County Council services are clearly set out in a companion document.)

- **Joint accountability for the County's health knowledge-base** plus a knowledge of community assets set out in the **Joint Strategic Needs Assessment** (JSNA).

- A leadership role in coordinating the efforts of many organisations, particularly District and City Councils and the criminal justice system through **tackling the 'Broader Determinants of health'** - (e.g. health aspects of community safety, housing policy, recreation, community safety and leisure services)

- Coordination of services to achieve a **'Healthy start in life'** coordinated by the newly formed **Children and Young Peoples' Partnership Board** - Including family intervention and the troubled families initiative.- Plus, from 2015 the likely return of **Health Visiting** services to Local Government.

- Coordination of services to achieve **'A healthy old age'** through health promotion, disease prevention and integration of health and social care.

- Existing accountability for **child and adult Social Care.**

- The health improvement role of many services currently within the **Transport, Environment and Economy briefs**. (e.g. the health enhancing potential of spatial planning, economic development, transport planning, links to District Authority planning systems and the

role of the Local Authority in developing healthy 'places' within the county).

- Bringing together the **views of the public, service users, carers and advocacy group regarding health issues** through the local democratic mandate of Councillors, through commissioning the new Healthwatch Service and through running a Public Involvement Board as part of the Health and Wellbeing Board arrangements.

- A widening remit in **emergency planning, protection of the public from disease and responding to emergencies** through regaining the public Health function in 2013. This includes providing a new 24/7 out of hours response service to handle a wide range of issues including pandemics, dirty bombs and the health impact of natural disasters.

3. The particular opportunities open to Oxfordshire

3.1. Oxfordshire is in a unique position to capitalise on these changes. The reasons are as follows:

- The County Council has shown itself to be willing and capable of the flexibility and adaptability to take on new emerging roles, and taking the tough decisions necessary to make them a reality.

- We have excellent relationships with our partners when compared with elsewhere.

- We have a single, almost co-terminous Clinical Commissioning Group which gives us a tremendous advantage. We have already placed them in the heart of our Health and Well-Being Board arrangements, and relationships between the Clinical Commissioning Group and all County Council services are close.

- We already have a high level of integration of health and social care with some of the largest pooled budgets in the country; this creates a platform for further integration.

- We are building on an existing nationally acclaimed JSNA which we have been building up over the previous four years.

- The Public Health team are at the forefront of integrated working with local authorities - a relationship that will shortly be showcased as a national exemplar.

3.2. Taken together, these factors mean that Oxfordshire is well placed to position itself in the vanguard of Local Authorities in taking on the new roles described in this paper.

4. The expanding remit of the Health and Wellbeing Board (H&WB), the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)

4.1. The remit of the health and well-being Board is increasing with each successive document emanating from central government. A summary of powers and duties of LAs and NHS organisations is included at Annex 3. The main points are:

- Local authority led H&WBs are increasingly seen as the overseer of health in counties across England - rather like a local 'Ministry of Health and Wellbeing' with the chair acting as Minister.

- The basic function of the H&WB is to set a strategic direction for health, well-being and social care across a patch, pulling together the efforts of local government the NHS and the new Healthwatch organisations.

- H&WBs are also increasingly seen as a means to hold Clinical Commissioning Groups if their actions diverge significantly from the agreed Joint Health and Wellbeing Strategy. Should the concern be serious the Health and Wellbeing Board has the right of appeal to the NHS Commissioning Board.

- The H&WB is also empowered to take a view on the fitness of the local Clinical Commissioning Group to carry out its functions.

- The H&WB is also accountable for delivering the JSNA. As mentioned above, given the quality of Oxfordshire's existing JSNA, we are building on a position of strength here. The JSNA will pull together a very wide range of local information on health and the factors underpinning health and will use it to formulate strategic priorities for action in the County. The JSNA is now the joint responsibility of the Local Authority and the Clinical Commissioning Group.

- The JSNA will become a driving force in health and social care planning. It needs to be refreshed by March 2012 and completely overhauled by March 2013.

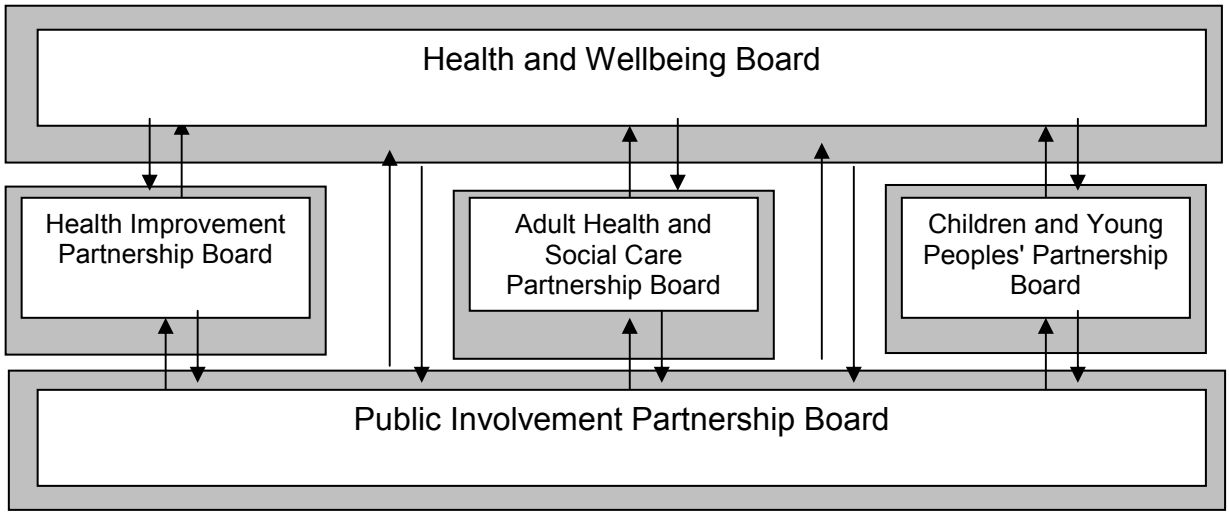
- The H&WB is also accountable for producing a joint health and well-being strategy. This is again a joint effort between local government and Clinical Commissioning Groups. Priority setting for a first health and well-being strategy for Oxfordshire is currently underway and the first strategy will be prepared to influence strategic priority setting in the County Council and the Clinical Commissioning Group later in 2012.

- Local Authorities are being encouraged to delegate functions and budgets to H&WBs where they feel this as appropriate so as to drive forward the integration of health and social care and tackle the broader determinants of health such as housing issues. This will include oversight of the existing substantial pooled budgets which will account to the board.

4.2. In summary, the H&WB is becoming an increasingly powerful body in overseeing the health of our population. We are confident that our local H&WB arrangements are fit for purpose and the 4 supporting Partnership

Boards give a depth and a practicality to this work that is lacking in other Counties. The H&WB will establish its priorities for its Health and Wellbeing Strategy at its next meeting in March 2012.

4.3. The H&WB structure is set out below as an aide memoire:



5. The new remit public health remit for local government

5.1. Oxfordshire has had a joint Director of Public Health since 2006. The Public health remit will return to Local Government control with a nationally allocated budget from April 2013. Working relationships between Public Health and Local Authorities are already extremely close and provide a solid foundation for the future.

5.2. New Guidance received in December 2011 sets out the Public Health remit of local government. It is summarised in the 5 functions below.

The public health role in leadership and strategic Influence

5.3. The Local Authority will be accountable for the overall state of health of its population and will work with other organisations and the public to secure improvements against a national framework of outcomes. The Director of Public Health (DPH) will be a statutory appointment as a 'chief officer' of local Government alongside Directors of Social Care and Directors of Children's Services. The DPH is seen as the overall officer 'health lead' for the Local Authority. This role can be used to influence work on health improvement across the County, working with the H&WB, district councils, the community safety partnership and a wide range of other organisations. The DPH role as the lead officer on the health improvement partnership board will be well placed to take this work forward.

The direct commissioning role of public health

5.4. Local Authorities will be responsible for commissioning a range of Public Health services. Detail of these is given in a companion document. A list of the services is included in the box below. These services will be required to meet a national outcomes framework, but some services are also specifically mandated by law.

5.5. Practical details about these services are fully explained in the companion document.

Public Health Services Proposed for commissioning by Local Authorities

• tobacco control and smoking cessation services • alcohol and drug misuse services • public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people) • the National Child Measurement Programme • interventions to tackle obesity such as community lifestyle and weight management services • locally-led nutrition initiatives • dental public health services • accidental injury prevention • population level interventions to reduce and prevent birth defects • behavioural and lifestyle campaigns to prevent cancer and long-term conditions • local initiatives on workplace health • public mental health services	• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes • comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention) • local initiatives to reduce excess deaths as a result of seasonal mortality • the local authority role in dealing with health protection incidents, outbreaks and emergencies • public health aspects of promotion of community safety, violence prevention and response • public health aspects of local initiatives to tackle social exclusion • Local initiatives that reduce public health impacts of environmental risks. • NHS Health Check assessments

The local authority public health role in Health Protection and Emergencies

5.6. This role has three elements:

i. **Planning for and responding to Public Health disasters and emergencies** e.g. outbreaks of infectious disease, pandemics, dirty bombs, terrorist incidents, natural disasters and emergencies. This includes bringing to the Council a new 24/7 out of hours public health emergency response service.

ii. **One Local Authority in Thames Valley to take a lead role in public health input to the Local Resilience Forum (LRF)** - this is the senior co-ordinating group for all emergency services across a geographical area, in our case covering Thames Valley.

iii. **A new 'watchdog' role for the Director of Public Health** through which the local authority ensures that other organisations have the necessary plans in place to protect the population

5.7. E.g.

- Ensuring NHS Commissioning Board plans are adequate for screening and immunisation.
- Ensuring that the emergency plans of other organisations are adequate to protect the Public Health.
- Ensuring that the plans of providers of health care e.g. the Oxford University hospitals, are sufficient to protect the population from infectious disease.

Adding Value across the Local Authority and 'blending' complementary Public Health services with other Local Authority Services.

5.8. Many public health programmes add value to existing Local Authority services. For example there is a clear benefit in putting childhood obesity initiatives together with existing LA work centred on families. Many other examples are set out in the companion document, detailing the complementary work between Public Health and LAs.

Mandatory advice and support to Clinical Commissioning Groups from public health

5.9. Local Authorities will be required by law to provide Public Health advice and support to Clinical Commissioning Groups.

5.10. This amounts to the local authority being mandated to assist Clinical Commissioning Groups with all aspects of their commissioning.

5.11. The public health team will bring skills such as needs assessment, knowledge of evidence-based medicine, priority setting techniques, expertise in tackling health inequalities and skills in interpreting a wide range of local and national health data to the day-to-day work of Clinical Commissioning Groups.

5.12. To achieve this it will be necessary to co-locate part of the public health team in the Clinical Commissioning Group so as to work in close partnership with them.

5.13. This implies a direction of travel in which the work of public health, social care and NHS commissioning are increasingly part of a seamless whole.

5.14. The detail of how this will look will be decided locally during the next year. Work has begun with the Clinical Commissioning Group to shadow this arrangement as a learning exercise and this will be completed during the next three months.

6. The role of services for children and young people

6.1. The Local Authority role in securing the health and well-being of children and young people is already well understood. This can be summarised as:

a) A leadership and oversight role.

b) Commissioning and providing a range of services to give children a healthy start in life including for example the family intervention service, and the troubled families initiative. Providing services to meet the needs of the most vulnerable groups.

c) Providing a safety net for those who cannot help themselves e.g. looked after children and safeguarding arrangements.

d) Recent government policy documents enhance these roles and strengthen further the County Council leadership role in monitoring and maintaining standards for children's health well-being and education across the County, as well as holding others to account for improving those standards.

6.2. In addition there will be synergies to be gained through integrated working between children and young peoples' services and public health, and between children and young peoples' services and Clinical Commissioning Groups.

6.3. The Children and Young Peoples' Partnership Board will be well-placed to take these opportunities forward.

7. Integration and the future of health and social care for adults

7.1. In recent weeks this has emerged as a major theme for the Government and other commentators. The latest report from the NHS Future Forum highlights this, influenced by work commissioned by them from the leading “think tanks” the King’s Fund and the Nuffield Trust. Recommendations to support integration are;

a) To integrate around the patient, not the system;

b) To make it easier for patients and carers to coordinate and navigate;

c) To see Information as a key enabler of integration so that improvement can be measured;

d) H&WBs must become the crucible of health and social care integration;

e) Providers need to be able to work with each other to improve care;

f) The need to clarify the rules on choice, competition and integration;

g) Giving local areas the freedom and flexibility to “get on and do”;

h) Allowing the funding to follow the patient;

i) National level support for local leadership is seen as essential;

j) Sharing best practice and breaking down barriers.

7.2. All of these recommendations have been accepted by Andrew Lansley. His response states that “we will encourage joined-up commissioning and integrated provision, through the Government’s mandate to the (NHS Commissioning) Board”. We are well placed in Oxfordshire to lead developments.

8. Developments in Adult Social Care

8.1. As Councillors will be aware, John Jackson is currently spending two days a week working alongside Oxfordshire's Clinical Commissioning Group. This is beneficial in a number of ways. Relationships with GPs are being developed; there is improved understanding of the County Council’s perspective on one hand and that of the NHS on the other. There is also now widespread agreement that there should be a much larger and genuine older people's pooled budget which brings in significant additional elements of health spending. Work is now underway on the details of what might be included and how risks will be managed.

8.2. Supporting the development of this overall approach, there is good joint working on the development of new services such as the Crisis Support service commissioned by Adult Social care (which has been well received by GPs) and the implementation of NHS early intervention services such as Hospital at Home and the Emergency Multi-Disciplinary Unit which are all designed to keep people out of hospital.

8.3. There is commitment across all relevant organisations to set up Integrated Community Service Teams by the end of May. These teams will bring together GPs, community health resources and adult social care teams within localities.

8.4. Improving information is seen locally as a key requirement. It is also highlighted in the Future Forum work. We are launching an Information Hub in February to help address this. The Clinical Commissioning Group is also doing work on Practice Information Packs which will improve the information available to individual GP practices including their relative performance compared with other practices in the county.

8.5. The Care and Support White Paper is still due to be published by the end of March. There is uncertainty about its contents although it is likely to include acceptance that the Law Commission's proposals to change the law on adult social care will be enacted (although progress will depend on decisions about what legislation will be included in the next session of Parliament). There are concerns about whether the White Paper will address the recommendations of the Dilnot Commission about the funding of adult social care.

9. The new NHS architecture: Clinical Commissioning Groups, the NHS Commissioning Board and NHS Commissioning Support Services

9.1. The NHS is changing rapidly. The changes that will affect County Council business directly are summarised here:

Clinical Commissioning Groups (CCGs)

9.2. Oxfordshire's Clinical Commissioning Group will increasingly take over the reins of local NHS commissioning during 2012, controlling about 80% of the former PCT spend, and will be responsible for local NHS decision-making.

9.3. The Clinical Commissioning Group will 'go live' in April 2013 following a process of authorisation which includes sign-off by the H&WB.

9.4. Essentially the Clinical Commissioning Group is led by local GPs who wish to build much of their work bottom-up from 6 localities with central coordination. (These map approximately to District council boundaries with Banbury and Bicester being separate.)

9.5. One of the practices in Thame has recently come into the Oxon group which more or less restores co-terminosity with the County Council (with the exception of Shrivenham).

The Oxfordshire-Buckinghamshire NHS cluster (the former PCTs)

9.6. This organisation will oversee the current changes and will cease to function at the end of 2012/13. Its functions in overseeing Clinical Commissioning Groups and in running the contracts with local GPs, dentists, pharmacists and optometrists will pass to a new organisation which will be known as the local office of the NHS National Commissioning Board.

9.7. There will be 50 of these organisations across the county. The footprint of the present Oxfordshire-Buckinghamshire NHS cluster will be retained.

Commissioning Support Services

9.8. Clinical Commissioning Groups will buy their support functions (finance, contracting, informatics, HR etc) from new organisations called Commissioning Support Services. To be efficient these are expected to work across multiple counties. Negotiations are ongoing, but ours is likely to comprise Oxon, Bucks, Berks, Swindon and Gloucestershire.

9.9. These organisations will go live in April 2013.

9.10. Clinical Commissioning Groups are obliged to use them at first, but from April 2013 they can purchase these services from the market rather than the Commissioning Support Service.

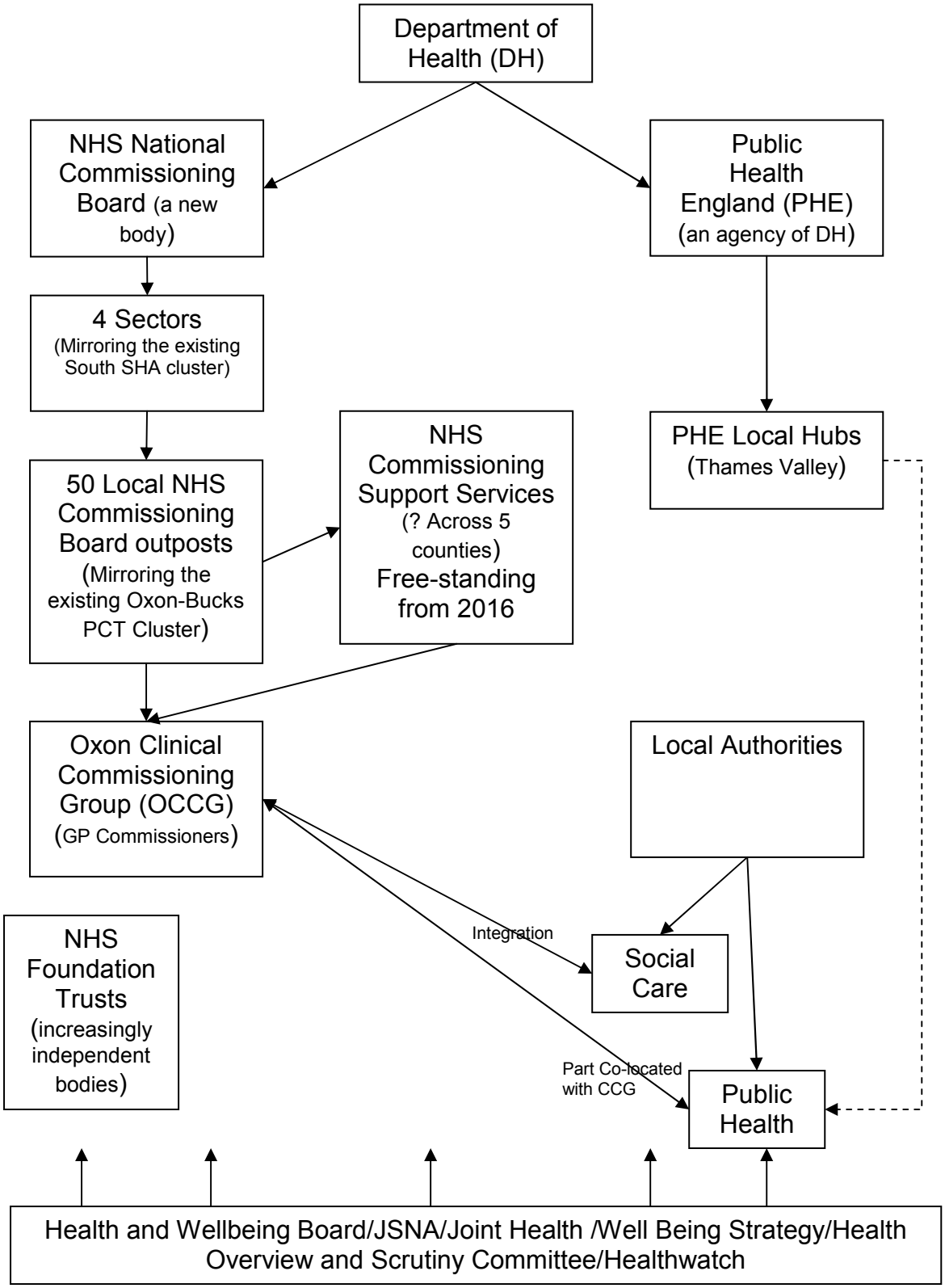
9.11. Commissioning Support Services will become increasingly commercialised and are expected to be freestanding bodies in the marketplace from 2016 at the latest.

9.12. The challenge for Commissioning Support Services will be to provide GPs with a locally sensitive service from such a large footprint.

9.13. It is possible that Local Authorities may ultimately supply Clinical Commissioning Groups with some of these services - a parallel to the situation between LAs and schools.

9.14. The diagram overleaf sets out the expected organisational structure from April 2013:

NHS and Local Authorities: Architecture from April 2013



10. Implications for the scrutiny function

10.1. The Health Overview and Scrutiny Committee (HOSC) retains its overview of health, wellbeing and NHS scrutiny role. Government clearly sees the value of the HOSC function. For this reason Its independence from H&WBs will be enshrined in legislation so that its scrutiny role is not compromised. It will retain its composition as a partnership between County, City and District Councils.

10.2. Other Scrutiny committees along with HOSC will now also scrutinise public health as a new County Council function.

10.3. The HOSC role will include holding the H&WB to account along with individual organisations including Clinical Commissioning Groups and NHS Foundation Trusts.

11. The role of District Councils

11.1. District councils have a major role to play in the new architecture, particularly in ensuring the well-being of the population. Many District council functions underpin the broader determinants of health and it will be important to be able to work closely with housing, leisure, recreation, environmental health and district planning functions.

11.2. The new Health Improvement Partnership Board has been established particularly with this purpose in mind. It is chaired and vice-chaired by district councillors, both of whom have seats on the H&WB.

11.3. The District council role in the Health Overview and Scrutiny Committee is another important contribution to the new arrangements.

11.4. District councils will also be represented on the Children and Young People's Partnership Board and the Health and Social Care Partnership Board.

11.5. The public health team will work closely with district councils on issues such as promotion of exercise, the prevention of obesity and environmental health.

11.6. The new national guidance and the return of public health to local government gives the County Council the opportunity to integrate services and service planning more closely between the two tiers of local government.

12. Implications for Public Involvement, and Localism

12.1. The views of the public will be vital in making the new system work. Oxfordshire has a strong track record in involving the public. In addition to existing mechanisms for obtaining public views, the new architecture will include:

a) the Democratic representational role of local councillors
b) the H&WB's Public Involvement Partnership Board which will be a portal through which all strands of public views can be accessed. This will secure the involvement of the public, service users, carers, advocacy groups and the advocacy role of the voluntary sector in health planning. This is innovative work and will take time to develop. The new model should be up and running by the end of 2012/13.
c) During this time further guidance will be received about the design of the Local Authority hosted HealthWatch service which will have a watchdog role over health services. This represents a new take on services such as LINks and the old Community Health Councils.
d) Opportunities for meeting the needs of local people and local groups will also be enhanced by the locality structure of the Clinical Commissioning Group.
e) Opportunities to join up County Council work in localities with the work of District Councils, Clinical Commissioning Groups and local communities.

13. Implications, opportunities and possible direction of travel for the County Council

Implications for the New Roles of Upper Tier Local Authorities

13.1. Local authorities have a new, major role to play in health, well-being and social care. This has not yet been recognised by the majority of Local Authorities. The time is opportune, should the Council wish, to set a new direction of travel.

13.2. Health and well-being now becomes one of the main planks of County Council policy, alongside its evolving role education and the economy.

13.3. A major part of this new role is holding others to account for their responsibility to deliver improvements in healthcare. This responsibility lies with H&WB, HOSC and the new DPH powers. These could be used in a coordinated manner to bring about focussed change where it is most needed.

13.4. To be effective, the new role in health and well-being requires coordination. Because these changes affect a wide range of council activity, this coordination will need to be carried out across traditional directorate structures

13.5. The public health function brings new services and a new financial allocation to the Council. This increases the Council's commissioning

responsibilities as well as its influence across a wide range of organisations on health matters.

Implications for the day to day work of the County Council

13.6. The development of the H&WB, the JSNA and the health and well-being strategy are important tools to be developed in exerting this influencing role. Developing these to a high standard will be a high priority.

13.7. Deriving high quality intelligence from health data through careful analysis will be vital. The Council will need to use this data to set priorities for what it wants to achieve in terms of health and well-being, and will then need to use these priorities to influence other organisations. Developing a high-quality JSNA will be necessary to carry out this task.

13.8. To facilitate the County Council's role in holding itself and other organisations to account, a more proactive approach to health performance indicators and benchmarking data will be needed. An annual cycle of analysing key benchmarking data could be used to identify problems and gaps which the H&WB and scrutiny committees could then use proactively to expose problems and seek assurance that remedial action is taken.

13.9. Taken together, the new national guidance provides six levers for bringing about change and improvement. These are the H&WB; the JSNA ; the joint health and well-being strategy; scrutiny arrangements; DPH powers and the degree to which councils choose to integrate health and social care.

13.10. Making full use of these new opportunities implies the need for the County Council to understand better the detailed NHS rules and regulations governing the annual financial cycle, the setting of tariffs, NHS contracting rules and the national requirements governing NHS priorities and annual targets.

13.11. Social care and NHS care will be increasingly integrated and planned as a single service. The national drive to increase integration of social care and NHS services is to be welcomed. As long as risks can be managed, this will again increase Local Authority input into the local health agenda. As part of this there is an opportunity to extend financial pooling arrangements between the NHS and social care.

13.12. There is an opportunity to align more closely the priority setting and planning cycles of the County Council and NHS. Working jointly on a JSNA and health and well-being strategy should improve the alignment of priorities and investment across the County. There is the further opportunity to more closely align the Clinical Commissioning Group annual planning cycle and the County Council's Star chamber process.

13.13. Co-locating part of the public health function within the Clinical Commissioning Group will greatly increase the Council's input to NHS policy and priorities within the County. This is an important opportunity for the Council.

13.14. These developments contain an opportunity to strengthen localism and local determination. Developing a more locally orientated JSNA and working with Clinical Commissioning Groups in 6 localities has potential to increase the depth and quality of locality planning and to engage the public and communities in new ways.

13.15. the power of local government to devolve roles and budgets to the H&WB could be used to encourage and stimulate closer working between the two tiers of local government with the Clinical Commissioning Group, providing risks can be managed

13.16. There is an opportunity to use the new Health Improvement Partnership Board as the Council's vehicle for tackling the broader determinants of health and engaging more closely with District Councils and a wide range of organisations within a countywide strategic framework.

13.17. The existing Community Safety Partnership is another important body with a role in tackling the broader determinants of health, particularly with regard to crime, the criminal justice system the Fire and Rescue Service. Aligning the work of the Community Safety Partnership and the Health Improvement Board will enable us to make a greater impact on the population. This may also provide a practical interface for working with the incoming Police and Crime Commissioner.

13.18. There is an opportunity to strengthen work for children and young people by aligning existing council functions with the new public health services. If commissioning of the health visiting service returns to local authority control in 2015 as planned, County Council work to secure a good start in life for children will be improved.

13.19. There may be a future option to achieve economies of scale by providing some support services to Clinical Commissioning Groups in due course. In parallel with the debate on schools, the Council will need to decide whether this is an opportunity they wish to explore.

Implications for the County Council workforce of the future

13.20. The emerging new roles of Local Authorities have implications for the workforce and working practices of staff in the County Council of the future. The environment we are in is fast moving, dynamic and politically sensitive. There will also continue to be an increasing emphasis on commissioning services rather than direct provision. The ability to influence and make change within a wide range of other organisations will also be required. Levering-in the efforts of local communities, the private sector and local philanthropists will also be essential. Successful senior managers in local government will be required to have these skills.

13.21. Senior managers will need to be supported by expert commissioning staff whose success will be based on a thorough knowledge of the sectors within which they are commissioning.

13.22. Staff will increasingly work flexibly across a number of partnering organisations within which they may be embedded.

13.23. Seeking market opportunities through integrated commissioning with other organisations will be vital, as will the ability to reconcile the need to make real change at the local level while following countywide priorities and policies.

14. Conclusions

14.1. The architecture of health, well-being and social care is changing rapidly .

14.2. Oxfordshire County Council is well placed to respond to these changes and to capitalize on them.

14.3. The new County Council role as a community leader, which sets standards and holds others to account, as well as commissioning services itself, is underlined in these developments.

14.4. This document sets out a wide range of profound implications for the day-to-day working of the Council and for the future workforce it will need to train, develop and recruit.

14.5. The health service architecture is incredibly fluid at the moment but will begin to settle in a few months' time. A natural window of opportunity for repositioning the County Council is therefore upon us. This will require decisions to be made regarding the new direction of travel For the County Council on health issues.

14.6. This paper sets out the current state of play and describes what the elements of the new direction of travel might be.

Joanna Simons, Chief Executive
Jonathan McWilliam, Director for Public Health
John Jackson, Director for Social & Community Services
Jim Leivers, Interim Director for Children Education and Families

February 2012

Annex 1 – National policy documents referred to and summarised in this paper.

The Health and Social Care Bill

Factsheets about the health and social care bill

The Future Forum

Summary of future forum report

Government response to future forum

Overview of all Public Health Services

Public Health Services in England

Letter - Public Health in England

Public Health in Local Authority

Public Health in Local Authority

Public Health Outcomes Framework

Workforce - public health staff transferring to LA

Public Health England

Public Health England operating model

A new service to get people healthy

Public health England - timeline

Social Care Papers

Caring for our future

Improving Health Outcomes for Children

NHS Commissioning Board

Developing the NHS commissioning board

Developing the NHS Commissioning Board - update

Clinical Commissioning Groups

- Pathfinder learning network
- Patient and public involvement - case studies

Health and Well Being Board

- Health and Wellbeing boards
- Operating Principles for Health and Wellbeing Boards

Health and Well Being Strategy/Joint Strategic Needs Assessment

- JSNA/JHWS Explained
- Draft Guidance on health and wellbeing strategies and the JSNA

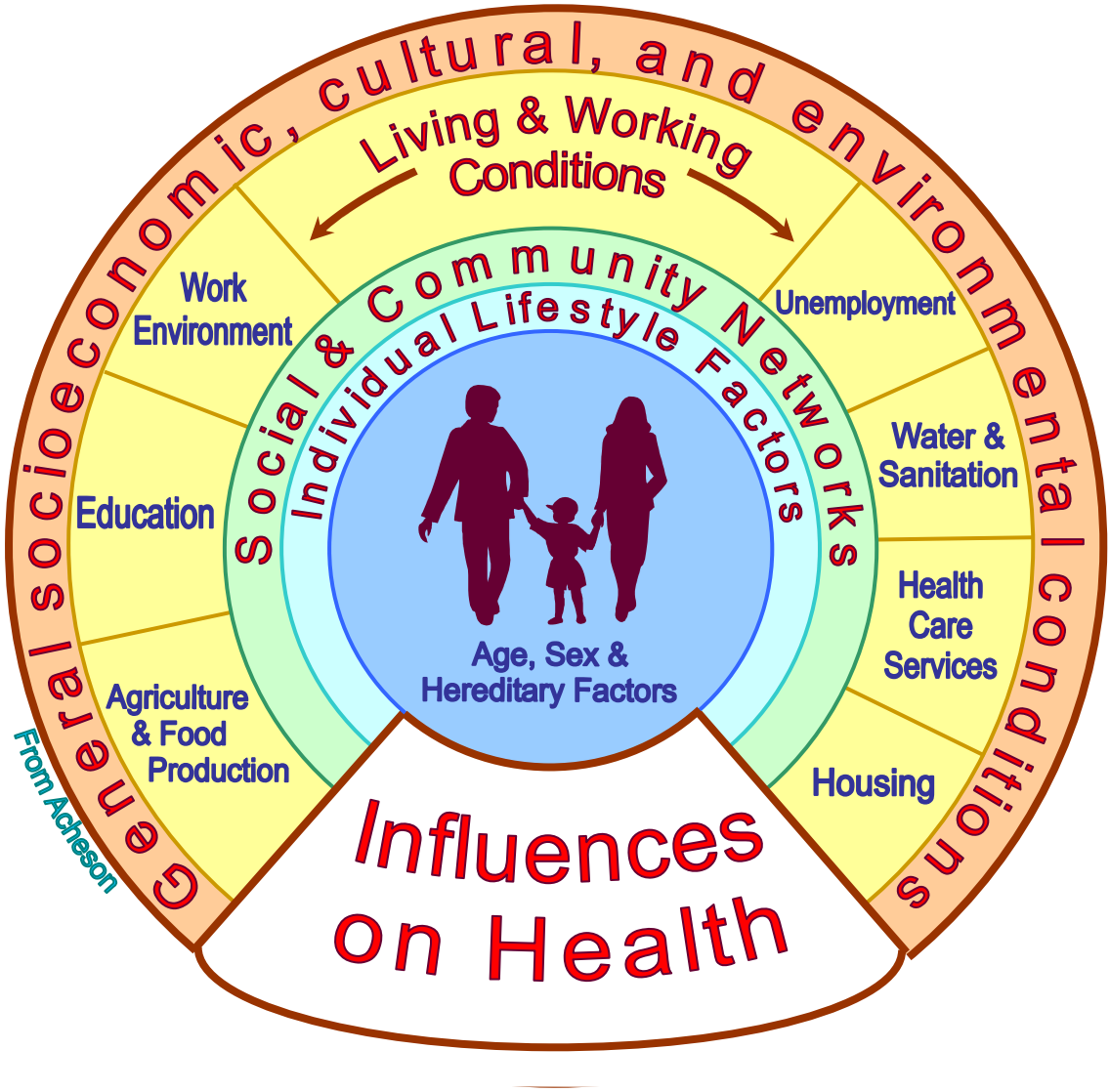
Healthwatch

- What is Healthwatch?
- Healthwatch in Local Authorities
- Current consultation on Healthwatch

NHS Workforce development

- Liberating the NHS workforce

Annex 2 – Broader Determinants of Health diagram.



Annex 3 - roles and responsibilities for local government, clinical commissioning groups and other agencies in delivering health and well-being boards, JSNAs and health and well-being strategies

Taken from 'JSNAs and joint Health and Wellbeing Strategies – draft guidance' (Published January 2012)

Summary of responsibilities

1. **Health and Wellbeing Boards**

Establishment of the H&WB Board

- Power to appoint additional Board members
- Power to exercise functions jointly with other H&WB Board(s)

Functions of Board

- Power to request information to enable or assist its functions, from the Local Authority or any H&WB Board members or representatives
- Duty to prepare JSNA
- Duty to involve third parties in preparation of JSNA and JHWS – Healthwatch, people living or working in the area, District councils
- Power to consult anyone appropriate in producing JSNA
- Duty to prepare JHWS
- Duty go consider NHS Commissioning Board mandate and statutory guidance in developing JSNA and JHWS
- Duty to consider Health Act flexibilities in producing JHWS
- Power to state views on how commissioning of Health and Social Care services, and wider health related services could be more closely integrated (within JHWS)

Associated functions

- Duty to promote integrated working between commissioners and using health act flexibilities (like pooled budgets and lead commissioning)
- Power to encourage integrated working across wider determinants of health

Ensuring alignment of commissioning plans

- Duty to be involved in preparing or revising CCG commissioning plan
- Duty to provide an opinion on whether it has taken account of the JHWS.
- Power to write to NHS Commissioning Board (NHSCB) with that opinion on CCG commissioning plan (copy to CCG).
- Power to give an opinion to NHS CB on final published plan
- Duty to review how well the CCG commissioning plan has contributed to the delivery of the JHWS
- Duty to give a view on how well the CCG has contributed to the delivery of the JHWS as part of annual performance assessment of CCG

2. **Clinical Commissioning Group**

Establishment of H&WB Board

- Duty to send representative to H&WB Board

Functions of H&WB Board

- Duty to cooperate with H&WB Board in exercise of its functions
- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to prepare JSNA for local authority area (equal duty of all partners)
- Duty to prepare JHWS for local authority area

Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions

Ensuring alignment of commissioning plans

- Duty to involve H&WB Board in preparing or revising the commissioning plan, including consulting on whether it has taken proper account of JHWS
- Duty to include statement of the final opinion of the H&WB Board in the published commissioning plan
- Duty to review how well the commissioning plan has contributed to the delivery of the JHWS and to seek opinion of H&WB Board on this.

Other duties, contributed through JSNA and JHWS

- Duty to exercise functions with a view to scrutinising continuous improvement in quality of services
- Duty to act with a view to secure continuous improvement in outcomes achieved
- Duty to exercise functions with regard to need to reduce inequalities between patients in outcomes and access to services
- Duty to promote the involvement of patients, their carers and reps in decisions about provision of health services
- Duty to promote innovation in the provision of health services
- Duty to exercise functions with a view to securing integration in the provision of health services, H&SC services, to improve quality of patient services or reduce inequalities between patients in outcomes or access to services

3. **<u>Local Authorities</u>**

Establishment of H&WB Board

- Duty to send representative to H&WB Board
- Power to appoint additional members to the Board as appropriate (in initial set up only)

Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to prepare JSNA for local authority area (equal duty of all partners)

- Duty to prepare JHWS for local authority area
- Duty to publish JSNA
- Duty to publish JHWS

Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions
- Power to delegate any local authority function (except scrutiny) to he H&WB Board

4. **NHS Commissioning Board**

Establishment of H&WB Board

- Duty to send representative to H&WB Board when requested (not a permanent member)

Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to participate in preparation of JSNA for local authority area (equal duty of all partners)
- Duty to participate in preparation of JHWS for local authority area

Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions

5. **Local Healthwatch**

Establishment of H&WB Board

- Duty to send representative to H&WB Board

Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions

Ensuring alignment of commissioning plans

- Duty to get a view on how well the CCG has contributed to the delivery of the JHWS as part of annual performance assessment of CCG

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South Central Ambulance Service performance update report for Oxfordshire Health Overview and Scrutiny Committee meeting March 8th 2012

Response time performance

The following information shows response time performance for Oxfordshire broken down into District areas.

The following commentary supports the information:

- Overall 999 and Urgent demand continues to trend upwards approximately 16.3% in January compared to last January.
- Red Call (the most urgent) performance has held well and shows improvement over the last year – remaining above the national standard for the PCT/Oxfordshire area.
- Red 8 minute performance remains well within national performance standard despite relocation of resources into West Oxfordshire which has shown a 10% improvement. However there has been a decline of 6% in South Oxfordshire and the Vale of the White Horse performance has also seen a very slight reduction. Work continues in all areas to improve performance.
- Following a reorganisation Bicester EOC (call centre) will shortly assume additional responsibility in the South Oxfordshire(Henley area). To date this area has been controlled by our Berkshire EOC. Our expectation is that performance improvements will follow.
- Emergency Control room computer system (CAD) was introduced into Bicester. This is the final phase across SCAS and now means that all three of our control rooms operate on the same CAD, allowing true integration and resilience across the whole of SCAS. The impact on performance was very well mitigated enabling SCAS to recover more quickly to 77% by September which has remained above national standard to date.

Chipping Norton First Aid Unit Update

The PCT in partnership with SCAS have taken the decision to extend the FAU (first aid unit) service for another two years until 2014. Since a recent publicity drive in partnership with the PCT and the Hospital League of Friends, we have seen increasing numbers attending the FAU. Over the coming months we will be undertaking further publicity and strengthening links with local GP services.

Other Developments

Misuse Costs Lives campaign
SCAS has launched a public awareness campaign to discourage misuse of the ambulance service. Responding to your stories of people misusing the service and the audit run earlier this year, the campaign has been designed to highlight all major types of ambulance misuse. The campaign has gone live with a short hard-hitting film. The campaign launch received extensive positive coverage. The campaign has been well received by the public and our partners across our four counties.

The film has been seen by 65,000 people so far and we plan for the campaign to carry on for the foreseeable future. A second film has now been added, called 'crews views'. The two films can be seen via these links.

You Tube:
http://www.youtube.com/watch?v=0de4RQn91Cs&feature=related

Crews Views
http://www.youtube.com/watch?v=KfCTa1KSbh8

Any assistance in promoting this message will be very welcome.

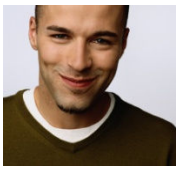
New Area Manager for Oxfordshire
Aubrey Bell has become the Area Manager responsible for Oxfordshire. Aubrey has extensive experience within the health service and is a welcome addition to the Operations Team.

Foundation Trust Status
The Trust's application for Foundation Trust status has been referred by the Department of Health to Monitor. Monitors decision is expected on the1st March 2012.

February 2012

Duncan Burke
Director of Communications & Public Engagement
South Central Ambulance Service

Oxfordshire Clinical Commissioning Group


NEWS RELEASE

9 February 2012

Chipping Norton First Aid Unit pilot is extended

Oxfordshire Clinical Commissioning Group and South Central Ambulance Service NHS Trust (SCAS) have agreed to extend the Chipping Norton First Aid Unit pilot for a further 2 years.

During the first nine months of the pilot, there has been an increase in activity from the numbers attending the old service (on average less than 30 patients per month) to more than 100 per month for the past two months. At the same time, there has also been a small reduction in those attending A&E with minor conditions.

The First Aid Unit will continue to be open Monday to Friday between 5.00pm and 9.00pm and at weekends and on bank holidays between 10.00am and 9.00pm to provide a drop-in service – no appointment necessary.

During the next two year of the pilot, SCAS will look at the potential for increasing the use locally with more publicity, particularly in the neighbouring areas served by GPs in Charlbury, Hook Norton and Deddington. They will also work with the local GPs to consider how more joint working could improve the service provided to patients.

Alan Webb, Director of Transition and Partnerships at Oxfordshire Clinical Commissioning Group said: “We are very pleased to extend this pilot and the initial evaluation is encouraging. We do understand that it is a valued service for local people.

“For the unit to be viable for the long term it will need to be treating more people locally for minor injuries and illnesses rather than them using other urgent care services such as A&E or GP out of hours.

“With the support of local GPs and SCAS, we believe there is potential for the service to be further integrated with other local health services. This could deliver more efficiency for the service.

“The service will continue to be a pilot and will be fully evaluated in February 2014 based on its sustainability for the long term.”

South Central Ambulance Service ECP Manager, Vicky Holliday said: “We are delighted to have extended this innovative pilot scheme in Chipping Norton until February 2014.”

‘It is staffed by an Emergency Care Practitioner (ECP) from the local ambulance service – a registered healthcare professional such as a paramedic or nurse who has received additional education and training to assess and treat simple injuries and minor illness which cannot be treated at home with a first aid kit. The ECP is also available during opening hours to respond to life threatening emergencies in and around Chipping Norton.”

“Since the unit opened in April 2011 we have seen a steady increase in the number of patients from Chipping Norton and the surrounding villages being treated here for a wide and diverse range of conditions including wounds which require closing or dressing and infections that require antibiotics. We have been able to recognise serious health conditions in some patients presenting with minor injury or illness - conditions that these patients were not previously aware of.”

- **ENDS –**

For more information contact NHS Oxfordshire’s media office on tel: 01865 334640 or email: media.office@oxfordshirepct.nhs.uk

Notes for editors:

1. The Chipping Norton First Aid Unit pilot started in April 2011.
2. Staffed by an emergency care practitioner the FAU treats the following types of injuries:

- Simple injuries that cannot be treated / managed with a home first aid kit.
- Cleaning and simple stitching of wounds.
- Insect bites and stings.
- Minor burns and scalds (not involving the face, neck, feet, hands and genital areas).
- A foreign body in the eye.
- Bumps to the head where there has been no loss of consciousness.
- Bruises.
- Sprains (if the emergency care practitioner thinks that you have broken a bone you will be referred onto a minor injuries unit or an A & E department)

Opening times:
Monday to Friday (excluding bank holidays) from 5pm to 9pm.
Weekends and bank holidays from 10am to 9pm.
You do not need to make an appointment, the FAU is a drop-in service.

Location: Chipping Norton First Aid Unit
Chipping Norton War Memorial Community Hospital
Out-Patient Unit
Russell Way, off London Road
Chipping Norton
OX7 5FA

Health Overview and Scrutiny work programme 2012

Topic	19 January 2012	8 March 2012	5 July 2012	27 September 2012	15 November 2012
Public Health	Director's Annual Report	Director's Update - to include a report on the prevention agenda	Director's Update	Director's Update	Director's Update
LINk	Update	Update	Update	Update	Update
Chairman's report	Update on meetings/activities between main meetings	Update on meetings/activities between main meetings	Update on meetings/activities between main meetings	Update on meetings/activities between main meetings	Update on meetings/activities between main meetings
Community Mental Health teams	Update on progress and future plans (Oxford Health)				
Health aspects of early intervention hubs	How health matters will be handled through the hubs				
Planned care Project - disinvestment proposals and QIPP	Presentation on areas for savings; what, why and how.				
Future work programme		Proposals for the annual work programme			
South Central Ambulance Service		Update on new indicator data			

Topic	19 January 2012	8 March 2012	5 July 2012	27 September 2012	15 November 2012
Maternity provision in Oxfordshire		Update on service position and challenges (LINk/PCT presentation of the issues)			
Oxford Health Update		Progress since the merger; future plans/challenges; patient experience/outcomes etc.			
Dental services			Update (Follows on from July 2011 meeting)		
Accessible Care for Everyone (ACE)			Update (from Nov 2011)		
Commissioning			A review of future commissioning practice in Oxfordshire (who, what, why etc)		
The new health structure					Mapping the new health geography - how the OCCG, the County Council and the PCT cluster will fit together
Alcohol Addiction Services					Select committee style review of issues, challenges and possible means for improvement

Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting 8th March 2012

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. Further Health and Social care issues will be prioritised during this year.
N.B. The following concise update refers to LINk projects which mostly have a Health remit only, unless there is crossover, or joint commissioning, with Social Care services

LINk Core Group

All members are welcome to attend the next Core Group meeting, which will take place at **The People's Church** in **Banbury** on **15th March from 6.30pm (networking) – meeting from 7.00pm until 9.00pm.** One of the agenda topics will be an updated information session about the transition to HealthWatch in April 2013 and new commissioning structures in relation to public engagement. Papers will be available from 8th March.

Ongoing Health projects and engagement:

A draft report from the **Mental Health 'Hearsay'** event which took place on 12th January (as a replacement for the Mental Health 'Sounding Board') has been submitted to Oxford Health and the PCT Commissioners. An action plan and timeline for the year, to be taken forward within the Hearsay model, will be agreed at the beginning of March, together with the formal report completed for circulation to all those who took part. A verbal report of the main issues which came out of the event will be provided for members.

LINk support for a pilot **Patient Participation Group** with Luther Street Medical Centre has been agreed. The first formal meeting with patients will take place in March, facilitated jointly between LINk, the Medical Centre and the Homelessness Chaplain for Oxford.

A new project proposal, supplied to the LINk Priorities and Finance Groups, has been accepted from Oxfordshire ME Group for Action (OMEGA) to carry out a survey of GPs in order to understand:
1. the level of awareness of the guidelines and treatment for CFS/ME in Oxfordshire;
2. whether or not GPs are making use of the agreed referral criteria;
3. whether there have been changes in the GP recorded prevalence of CFS/ME since the previous (2002/03) survey;
4. how best to communicate with GPs – use of paper questionnaire vs email, the role of the practice manager, etc.

The resulting report will be shared locally and nationally.

Other projects

'Enter and View' visits to Care Homes

Following two information and training sessions held in December and February to provide Enter and View' participants with statutory authorisation for newly recruited visitors and an opportunity to review the process with those who carried out visits last year, a second series of visits to 23 Care Homes, selected by provider, size and geography, will take place from March onwards. A report will be agreed once the visits have been completed later in the year.

Self Directed Support (Personal Budgets)

LINk has supported the SDS event on 1st March being run in partnership with Oxfordshire Wheel and Oxfordshire Family Support Network. The aim will be to bring together information obtained from service users and carers from this event, from the earlier LINk research, and LINk involvement with the TASC Reference Group. There are also elements of the Hearsay report which contains actions related to SDS. The various strands of information will be brought together to reflect a wide consensus of views about the effectiveness and implementation of Personal Budgets.

Third Social Care 'Hearsay' engagement event – 9th March 2012 at the Four Pillars Hotel, Witney from 11.00am to 3.00pm

The third annual service user and carer event will cover all recommendations and actions completed, still in progress or incomplete over 2011-12, together with the views of service users and carers as to what has improved, remained the same or become more problematic over the last 12 months as a result of changes to services. At the time of writing the event is fully subscribed (70) with a waiting list of 10. There will be representatives from SCS Leadership Team, Commissioner, PCT/CCG and CQC at the event. Those who are not able to attend will be encouraged to submit their views in writing or by phone and will be signposted to new quarterly update events, which have been proposed to take place in other parts of the county over the course of the year. These smaller events will also provide an opportunity for local commissioners to hear views about Social Care services in their locality. Venues and dates will be promoted once agreed.

HealthWatch / public engagement
An update and further information from ongoing engagement activities with stakeholders, and a revised procurement timetable, will be provided by the LINk lead officer for the County Council.

Adrian Chant (LINk Locality Manager)
01865 883488
Update 24/02/2012