Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 11 March 2010 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Richard Langridge

Councillors:	Tim Hallchurch MBE	Ray Jelf	Don Seale
	Jenny Hannaby	John Sanders	Lawrie Stratford
District Councillors:	Susanna Pressel	Jane Hanna	
	Christopher Hood	Rose Stratford	
Co-optees:	Ann Tomline	Dr Harry Dickinson	Mrs A. Wilkinson

Notes: ***There will be a pre-meeting for members of the Committee only at 9.00am on 11 March.***
Date of next meeting: 20 May 2010

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

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

Committee Officer - *Julie Dean, Tel: (01985) 815322*
julie.dean@oxfordshire.gov.uk

Tony Cloke
Assistant Head of Legal & Democratic Services

3 March 2010

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes

To approve the minutes of the meeting held on 21 January 2010 (**JHO3**) and to note for information any matters arising on them.

4. Speaking to or Petitioning the Committee

5. Oxfordshire LINk Group – Information Share

10.10 am

There will be a verbal report on the Oxfordshire LINk activities to date.

6. Public Health

10.20 am

Report by the Director of Public Health on matters of relevance and interest.

7. Oxford Drug Rehabilitation Project

10.40 am

At the last meeting of this Committee the Oxfordshire Local Involvement Network (LINk) made reference to the closure in 2007 of the Oxford Drug Recovery Project (DRP). Members of the OJHOSC were concerned by what they heard from the LINk particularly as it appeared that there had been no consultation when the closure of the DRP had taken place. Furthermore, undertakings had been given to reopen the DRP but , to date, there had been no action.

Members decided to defer full consideration of the report until this meeting so that additional contributors could be invited to enable a rounded picture to be developed.

Richard Lohman and Adrian Chant from the LINk will attend again for this item. In addition the following people will attend the meeting to provide background to the past and future of the DRP:

- Jo Melling, DAAT Director;
- Alan Webb, PCT Director of Service Redesign;
- Darren Worthington, Chief Executive of SMART, a charity working to reduce drug and alcohol use in Oxfordshire;
- Glenda Daniels, service user involvement coordinator of an independent charity that represents drug and alcohol service users; and
- Dr Angela Jones who is a GP who worked from 1999 – 2007 in the Luther Street Medical Centre in Oxford providing drug and alcohol services for people experiencing homelessness in Oxford.

A copy of the LINk report from the January meeting is attached at **JHO7(a)** together with a report from the DAAT **(JHO7(b))**.

8. The Demographic Challenge

11.40 am

Members will recall the work that was done on the subject of the “demographic challenge” a joint working group comprising members from the HOSC and the Social and Community Services Scrutiny Committee. Their work resulted in a report that contained a number of "red flags" and members would be interested to know what progress has been made in dealing with the concerns raised in the report. The summary of the report that was accepted by the Cabinet in January last year is attached for your information at **JHO8(a).**

Furthermore, and closely related to the above, the papers "Successful Ageing in Oxfordshire: a high level strategy" **JHO8(b)** and the associated "Proposal for Integrated Planning and Commissioning Arrangements for Ageing Successfully" are attached at **JHO8(c).**

The following people will attend for this item in order to provide a report on progress and also to inform the Committee about how they intend to come together in order to contribute to the work on the demographic challenge:

Councillor Jim Couchman, Joint Chairman of the Health and Wellbeing Partnership Board;
John Jackson, Director of Social & Community Services;
Alan Webb, PCT Director of Service Redesign;
Marie Seaton, Head of Joint Commissioning (Older People);
Nick Welch, Head of Major Programmes in Social & Community Services; and
Jonathan McWilliam, Director of Public Health.

9. Access to primary physical health care for people with mental health problems living in rural areas

12.40 pm

At the 21 January meeting this Committee agreed to proceed with this project and to convene a working group to undertake the task. A progress report will be given.

10. Chairman's Report

12.45 pm

The Chairman will report on meetings he has attended with representatives from:

- Community Health Oxfordshire (CHO);
- The Nuffield Orthopaedic Centre NHS Trust; and
- The Ridgeway Trust.

11. Information Share

12.55 pm

No items have been received to date.

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 Section DD of the Constitution for a fuller description.

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

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

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

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

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

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

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

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

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

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

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 January 2010 commencing at 10.00 am and finishing at 12.40 pm

Present:

Voting Members: District Councillor Richard Langridge – in the Chair

Councillor Tim Hallchurch MBE
Councillor Jenny Hannaby
Councillor Ray Jelf
Councillor John Sanders
Councillor Don Seale
Councillor Lawrie Stratford
Councillor Susanna Pressel
District Councillor Dr Christopher Hood
District Councillor Jane Hanna
District Councillor Rose Stratford

Co-opted Members: Dr Harry Dickinson and Mrs Ann Tomline

Officers:

Whole of meeting Julie Dean and Roger Edwards (Corporate Core)

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

1/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Dr Peter Skolar and from Mrs Anne Wilkinson.

2/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

3/10 MINUTES

(Agenda No. 3)

The Minutes of the last meeting held on 19 November 2009 were approved and signed.

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

There were no speakers or petitioners.

5/10 OXFORDSHIRE LINK GROUP
(Agenda No. 5)

The Committee had before them a report (JHO5(a)) which had been prepared by a LINk Drug Recovery Project (DRP) group. Also before them was a written update on the LINKs latest activities (JHO5(b)). A member of the DRP project group, together with Adrian Chant, Locality Manager for the Oxfordshire LINk, were available to answer any questions from the Committee.

Members thanked Richard Lohman and Adrian Chant for attending the meeting.

The Committee **AGREED** to

(a) thank the LINk for the update on their activities and for their very detailed DRP report; and
(b) in view of concerns that there might be a major service change requiring full consultation, to defer full consideration of the report until the next meeting of this Committee on 11 March 2010; and to request the PCT and Jo Melling, Director of the Drug and Alcohol Action Team, to prepare a report on the changes made to the service.

6/10 PUBLIC HEALTH
(Agenda No. 6)

Dr McWilliam introduced his deputy, Dr Shakiba Habibula to the meeting. He reported three areas of interest which had arisen since his last report:

- The Demographic Challenge – Some good work had been done by the Health & Well Being Partnership. Moreover a multi agency, Healthy Ageing Strategy would be produced by March this year which would give some guidance on how to prevent a problem if it should arise;
- A new Bowel Screening Service was due to start the following week at the Horton General Hospital. Eventually the service would roll out to the whole of the county and would have positive outcomes; and
- A new community breast feeding service had been started which aimed at getting more children breast fed within the more deprived communities.

There were no new major areas of concern which had arisen since the last meeting. However, he did raise the following, together with a request for vigilance on the part of the Committee:

- Unease with regard to funding for Public Health, both within this county and nationally, as part of the aim to reduce overall NHS management budgets by 30%;

- The major opposition draft political manifesto on Health issues aimed to turn the Department of Health into a Department of Public Health nationally. While that would not be a problem, it would be important to ensure that prevention continued to be moved further up the agenda.

There followed a discussion on the above issues, together with a question and answer session with regard to the following:

- The proposal by Surrey PCT to no longer treat people with morbid obesity;
- Proposal by Government for free care for older people in the future, together with the possibility of free domiciliary care;
- The 'poor' accommodation and staffing quota given to breast feeding clinics by the ORH in the John Radcliffe Hospital;
- The policing of the use of antiseptic gel at the John Radcliffe Hospital, despite MRSA rates falling within the count; and

The Director and Deputy Director of Public Health were thanked for their valuable input to the meeting.

It was **AGREED** that Councillor Couchman be invited to the next meeting on 11 March 2010 to give an update on measures taken within Oxfordshire, post scrutiny review, to address the demographic challenge relating to older people.

7/10 PAEDIATRIC TRAINING ACCREDITATION AT THE HORTON GENERAL HOSPITAL

(Agenda No. 7)

At the November meeting, the Committee had agreed the following:

'The OJHOSC urges that discussions should continue with the Oxford Deanery aimed at achieving training accreditation for middle grade paediatric posts at the Horton General Hospital (HGH). He report from the Deanery visit to the HGH on 13 November should be made public as soon as possible'. This referred to the Deanery visit, led by Mr Tony Jefferis, Acting Postgraduate Dean, that evaluated the possibility of reinstating training accreditation for middle grade paediatricians.

The report had now been published and a copy was attached to the Agenda at JHO7. The outcome of the visit had been that, due to insufficient workload, accreditation could not be given for training middle grade paediatricians.

Mr Jefferis had been invited, and had agreed, to attend this meeting in order to explain the reasons for that decision.

Mr Jefferis was invited by the Chairman to give a brief presentation of his report. Julia Cartwright, Chair, Community Partnership Forum and Andrew Stevens, ORH, were also invited up to the table with a view to forming a Panel, together with Mr Jefferis, to respond to questions from the Committee.

Members asked a number of questions, a selection of which are included below:

Q How can the service be kept open?
R (Mr Jefferis) There needs to be a radical rethink in the way in which the service is delivered. The world has changed since the European Working Directive was introduced in August 2009. Nobody wants their children to have a lesser service but nationally we are having to adapt to a shrinking, not an expanding service. Training can be offered at the HGH during the working day but it is what is happening at night which is the problem. We would be able to pick up the little problems which occur, but we would not be in a position to solve them all.

We were asked if we could look at the Portland Hospital model and this we did. However, we had some misgivings about it as it is run as a fully serving procedure. Infrequent, emergency occurrences are dealt with on a case by case basis.

Q Have you considered the implications for Maternity in relation to the distances for patient travel?
R (Mr Jefferis) We did consider it, but in the report we focused on the training aspect of it.

(Julia Cartwright) In the Portland model there is a 24/7 consultant delivered service in obstetrics and no middle grade tier. With regard to paediatrics in Banbury, we are continuing the dialogue with the Deanery. There is a need to be at the forefront with regard to training and a little creativity is needed on the part of the Deanery so that everybody can access the services.

Q How can a hospital improve if there is not the appropriate training available?
R (Andrew Stevens) There are a number of problems, one of the European Working Time Directive coupled with equality issues. A number of patients are seen at the HGH, but the way the rotas are, the junior doctors are not seeing enough patients to get the training recognised. An option put forward by the BHCP has been rather than focus on training, to explain how to get a clinically and financially stable model to sustain it.
Q What are the range of consultant –led models within the country as a whole?
R (Tony Jefferis) Most consultant-led models have not been sustainable and middle grade doctors have been brought in. Most of the models do not have 24 hour cover in their hospital. The Weston-Super-Mare model, for example, is a 16 hour service locally and then the team go to the Bristol Children's Hospital to provide the service there. Where the models work well there is strong clinical leadership. The rota is developed to best fit the service and the community. We are working with consultants at the Royal Free Hospital, London, to see how their consultant –led model works there, but it is a different sized hospital to the Horton. We want to be creative with our ideas too.

(Andrew Stevens) We are looking at a number of other hospitals with consultants and other graded staff working on a rota basis.

Q This is quite a critical report – there is no training for middle grade doctors, no appraisal structure, no study leave etc. What is your view on this?
R (Andrew Stevens) This is legitimate criticism. We have to be creative. It is currently a balancing act with regard to the clinical service at the Horton. To date we have supported and maintained the service at the Horton using a series of short term

locums, who, along with the consultants, have worked over and above their call of duty to keep the service going.

Q Is there any reason why the Weston Super Mare model would not work for Oxfordshire?
R (Andrew Stevens) This model is similar to the model originally proposed by the Trust, but which was turned down by the Independent Review Panel; ie an external, community based service, but with no in-patient facilities overnight.

Dr McWilliam commented that every part of the Oxfordshire population was in receipt of a high quality paediatric service, which enjoyed high investment and a significant amount of clinical 'willingness'. Given this, it was his view that there could be a model found to provide a service for both sites using middle grade doctors. Andrew Stevens agreed adding that it was the role of the PCT to decide what was the best service which could be provided for all children across the county. Currently they were looking at where paediatrics was going as a profession and also working with GPs to keep as many robust community based services to enable children to be treated at home. Research indicated that children recovered better. This role needed to be married up with the objectives of the BHCP.

Q Isn't there more to it than whether the PCT can pay or not? If there is clinical willingness – shouldn't that be explored?
R (Andrew Stevens) Yes. The clinicians want to do what is best for the children of Oxfordshire. There is a national move towards community based services and, in the light of this, we need to think about what is the most appropriate service we can afford to get the best clinical outcomes for children and their families.

Julia Cartwright pointed out that the Community Partnership Forum were an independent body who saw their role as bringing all the parties together and keeping the dialogue going. They encouraged 'thinking outside the box' and liaised on A nationa basis. She added that there were very different kinds of issues affecting the two strands of the profession(the acute and the community sector) in the future. For example, the clinicians needed to think about child protection issues in light of the two areas of deprivation in Banbury. The service was undergoing continuous change and there was a need to talk to the public, and to use the skills of the community services to ensure that Banbury was seen as a training of excellence.
Members of the Committee thanked Tony Jefferis, Andrew Stevens and Julia Cartwright for attending the meeting and for their valuable input.

It was **AGREED** to request Mr Edwards to write to the Deanery giving the views of the Committee as expressed in the meeting (a full note will be included in the Minutes); in particular recommending that more clinical willingness and creative thinking be applied to any deliberations on a possible solution.

8/10 STROKE - COMMISSIONED CARE PATHWAY FOR OXFORDSHIRE
(Agenda No. 8)

Members of the Committee welcomed Sylvie Thorn, Mary Barrett and Suzanne Jones, Oxfordshire PCT; and Dr James Kennedy, Consultant in Stroke Medicine, Oxfordshire Radcliffe Hospitals NHS Trust to the meeting. They gave a presentation

to the Committee and afterwards responded to questions. There follows a selection of those that were asked and the responses received:

Q To have a stroke is a very frightening experience, what kind of information is available to patients and their families and friends afterwards?
R (Sylvie Thorn) We have tried to address this by setting up a one year pilot scheme whereby a Stroke Co-ordinator is based at the ORH Stroke Unit. That person will work with the patients, on a face to face basis, who have been admitted. The Co-ordinator will give them the advice and information they require and signpost them to other services, if needed. S/he will also contact patients at home and signpost them back into services if this is so required.

Q Will services such as physiotherapy and speech therapy be available for patients in their home?
R (Suzanne Jones) The PCT has put in some investment into this service. They have concentrated on the acute side first, then it will be the turn of the rehabilitation side.

Q Will everybody be called in for some kind of screening for stroke?
R (James Kennedy) We are not investing in it – there are no risk factors for stroke. Dr McWilliam and his deputy reported that currently there is in situ one clinic in Oxford City and two in Banbury who are offering the service for one year for targeted patients. We invited GP practices in the area to identify screened patients from the 43 – 47 age group, who might be offered intervention or treatment. The programme plan is to eventually expand across Oxfordshire.

Q At what stage does the County Council's Adult Services take over? How does funding work out with the PCT?
R (Suzanne Jones) In respect of the first question, the decision is made on a clinical basis. When somebody has a long term care need, any decision is made by the people looking after that person. In respect of the funding, at the moment it is carried out via a handover from Health to Social Care. The Stroke Association have a return to work programme on the voluntary side.

Sylvia Thorn commented that funding goes through the normal process integrating the additional services that have been developed since the Strategy started. We use the grant to try to develop services. At the end of the pilot scheme.

James Kennedy further commented that the Strategy is the paradigm of necessity for Health and Social Care to work together. Formerly the intensive acute model could not be matched with social Care. Now we are trying to run with Social Care in at the beginning of the process in order to manage people's expectations and in order to smooth out the pathway and make it seamless. Our job is to get the maximum recovery possible.

The Committee **AGREED** to note the progress report and also to note that Health and Social Care may be required to take action to maintain coordination once pump priming monies are put in place, as it was possible that funding might not be included within the next service review.

Dr McWilliam commented that it was good to now have prevention in at the start of a patient's pathway. He asked James Kennedy if the funding for the prevention programme in the right place. Dr Kennedy responded in the past, funding had focussed only on acute care, but this was now changing. The SHA and the Clinical Stroke Network were taking the preventative aspect very seriously and they would be performance managing the PCT and the section managers, He added that the United Kingdom had a very bad record for unhealthy life styles.

Q Unfortunately there does not appear, so far, to be 'joined up' thinking in terms of life style and awareness training. Many people do not see their GPs very often and therefore are under the 'radar'. Is there sufficient publicity for it?
R (Dr Kennedy) Yes. People have a clear idea of what a heart attack entails, but it is a different picture for stroke. The Stroke Association will only achieve persistent media coverage of issues such as the signs appertaining to mini strokes, in television 'soaps'. The Stroke Association are given a total of 130 minutes of public awareness media time. It has chosen to select opportunities to highlight the prevention agenda, such as targeting the television programme 'Top Gear ' for screening its message, which attracts a targeted audience of middle aged males.

Dr McWilliam pointed out that Public Health were also carrying out outreach. For example, information had been given out and Health Checks performed at two football matches in a bid to get people, particularly middle aged men, into screening earlier.

Q Do you do work with the younger generation?
R (Dr McWilliam) Yes prevention is part of the promotion of a healthy lifestyle, ie. Healthy eating, weight control and exercise.

Q How are you addressing the challenge to get the Oxfordshire public more involved?
R (Dr McWilliam) We are starting a Stroke Community Forum, the first meeting of which is on 17 February. It will include a number of stroke survivors and their carers and will highlight and discuss a number of communication problems. A web site is also being set up where members of the public can pose questions to be answered if they are not able to come along to the Forum.

(Dr Kennedy) This is indeed a major challenge and the targets will have huge outcomes and be of enduring benefit. Stroke has had its moment in the sun with these new initiatives. This Committee could assist in this by keeping up the pressure on Health and Social Care to maintain the co-ordination between them once the pump priming money is put in place. The danger might be that it may not feature in the next service review.

The Committee thanked Sylvie Thorn, Mary Barrett, Suzanne Jones and James Kennedy for responding to questions and for taking part in the discussion. It was **AGREED** to note the progress report and also to note that Health and Social Care may be required to take action to maintain co-ordination once the pump priming monies are put in place, as it was possible that funding might not be included within the next service review.

9/10 CENTRE FOR PUBLIC SCRUTINY - SCRUTINY DEVELOPMENT AREA BID - ACCESS TO PRIMARY PHYSICAL HEALTH CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS LIVING IN RURAL AREAS

(Agenda No. 9)

The Centre for Public Scrutiny (CfPS) had announced in November 2009 a two year programme aimed at raising the profile of overview & scrutiny as a tool to promote community well-being and help councils and their partners to address health inequalities within their local communities. As part of this the CfPS sought applications from scrutiny committees seeking to become what are to be called 'Scrutiny Development Areas (SDA's)'. SDA's would share learning with other scrutiny committees via 'action learning meetings' throughout 2010 and a national conference would be held in 2011.

The chosen scrutiny committees would undertake a project during 2010 that would be used to form part of a national resource kit aimed at developing the role of overview and scrutiny in tackling health inequalities. They would be expected to use 'innovative approaches to undertaking scrutiny reviews' and to work in partnership with one or more district council scrutiny groups as well as other partners such as community groups and NHS colleagues. There would be only four of these across the country and each would receive a small amount of funding (up to £5,000) to help with the project.

The OJHOSC put in a bid to become an SDA, based around a project to review access to primary physical health care for people with mental health problems who find it more difficult to gain access to primary health services. This is compounded for people living in rural areas where access generally is more difficult. The project would seek to identify the evidence most relevant to developing future policy and action and attempt to describe how the evidence could be used to develop practical improvements that would reduce these health inequalities. Unfortunately the bid had been rejected by the CfPS and, as a consequence, members were asked to consider how to proceed with this piece of work.

Following a brief debate, it was **AGREED t**o to proceed with the project, on the terms expressed above, despite the bid having been unsuccessful and to convene a working group comprising Councillor Rose Stratford, Councillor Jenny Hannaby, Councillor Richard Langridge and Dr Harry Dickinson.

10/10 JOINT OXFORDSHIRE, HAMPSHIRE AND BUCKINGHAMSHIRE REVIEW OF THE PERFORMANCE OF THE SOUTH CENTRAL AMBULANCE TRUST (SCAS) IN RURAL AREAS

(Agenda No. 10)

This joint review had been instigated by this Committee following meetings with managers from SCAS. Members had been concerned that the performance of the Trust was much worse in rural localities than in urban areas. This situation had corresponded to that in other counties in the SCAS region and it had been considered that it would be beneficial to undertake a joint project. Two select committee style sessions had taken place with a number of witnesses which had

included some members of the public, the Cabinet Member for Health from West Oxfordshire District Council, ambulance crew members, commissioners, first and co-responders, SCS managers and the Trust Board Chairman.

It had been anticipated that a report would be available for public distribution prior to the meeting. Mr Edwards reported that unfortunately this had not proved possible. It was currently with stakeholders for factual checking. He added that there had already been a significant amount of public interest in it.

It was **AGREED** to note the report and to look forward to its consideration at a future meeting.

11/10 JOINT OJHOSC/CHILDREN'S SERVICES SCRUTINY COMMITTEE TEENAGE PREGNANCY WORKING GROUP
(Agenda No. 11)

The joint OJHOSC/Children's Services Scrutiny Committee Working Group had been set up some months ago to examine progress on developing an improved strategy for reducing levels of teenage conception across Oxfordshire. The Working Group had reviewed a joint County Council/PCT self assessment of progress and produced a number of recommendations for inclusion in the new strategy. These recommendations had all been accepted, as could be seen in the attached letter (JHO11).

It was noted that the strategy would be presented to the Children's Trust Board in January. The Working Group planned to review progress nine months after the implementation of the strategy.

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

In the Chairman's absence, Dr Dickinson reported on an informal meeting with the Chief Executive and other senior managers of the Oxfordshire & Buckinghamshire Mental Health Foundation Trust. The meeting was with regard to the reconfiguration of Mental Health day services provided by the voluntary sector. It had been decided to apply the 'tool kit' to determine whether the changes should be subject to full public consultation.

The report was noted.

13/10 INFORMATION SHARE
(Agenda No. 13)

There were no information items shared.

..... in the Chair

Date of signing .....

NHS
Oxfordshire

Oxfordshire Primary Care Trust
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford OX4 2LH

Telephone: 01865 336700
Fax: 01865 337094
Website: www.oxfordshirepct.nhs.uk
Email: andrea.young@oxfordshirepct.nhs.uk

Rt Hon Andrew Smith MP
House of Commons
London
SW1A 0AA

14 APR 2009

Your ref: EOT/LO4001/01091215

7 April 2009

Dear Andrew

Drug Recovery Project

Oxfordshire DAAT has commissioned a residential detoxification facility to replace what was the 'Drug Recovery Project' as the old premises were no longer available and the projects performance needed to be improved.

The opening of the new facility was delayed due to the search for appropriate premises and relevant permissions. New premises have now been sourced with formal arrangements currently being finalized, the expected opening of the new 'Howard House Project' is anticipated for September 2009. 'During the closure period no clients have been disadvantaged and additional funding has been made available for out of county placements while the new Oxfordshire facility was under development.'

This exciting new project will see 8 dedicated beds for Oxfordshire being available for entrenched drug and alcohol users to undertake detoxification with intensive aftercare support and move on accommodation now being in place to aid sustained recovery.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Catherine Mountford

Catherine Mountford
Director of Planning and System Reform
Signed on behalf of Andrea Young, Chief Executive

Your voice on local health and social care

Oxfordshire LINk
Bourton House
18 Thorney Leys Business Park
Witney, Oxfordshire
OX28 4GE

Tel: 01993 862855 (local office)
0300 111 0102 (information line)
oxfordshirelink@makesachange.org.uk
www.makesachange.org.uk

Drug Recovery Project

an Oxford City based health and housing solution providing detoxification and residential treatment for vulnerably housed and rough sleeping addicts

A report prepared by Oxfordshire Local Involvement Network (LINk) Drug Recovery Project Group

January 2010

Oxfordshire LINk is hosted by help&care

The Pokesdown Centre
896 Christchurch Road
Bournemouth BH7 6DL

Help and Care is a Company limited by guarantee

Registered in England and Wales
Registered Company No. 3187574
Registered Charity No. 1055056

Contents:

Oxfordshire LINk Drug Recovery Project (DRP) Group report for the Oxfordshire Joint Health Overview and Scrutiny Committee meeting on 21st January 2010.

Introduction

Dear Overview and Scrutiny Committee Chair and Members,
Whilst Oxfordshire LINk acknowledges the good work undertaken by commissioners, partners and providers in the county's drug and alcohol area it is not the remit of this report to highlight this, rather to bring to attention areas of public concern. This report requests that the HOSC scrutinise the process of the DRP closure and clarify why replacement provision is still not in place. It is hoped, by the committee undertaking this piece of work, that publicly funded, well functioning drug and alcohol services within the county will in future not be closed without consultation or appropriate replacement provision being in place.

This report is informed by the November 2009 'Oxfordshire LINk DRP, Project Group Statement and Recommendation for the LINk Stewardship Group' which is included below and forms an integral part of the report.

Oxfordshire LINk DRP Project Group Statement and Recommendation for the LINk Stewardship Group meeting November 2009.

Abbreviations:
DRP – Drug Recovery Project: an Oxford City based health and housing solution providing detoxification and residential treatment for vulnerably housed and rough sleeping addicts.
NTA – the National Treatment Agency: a branch of the NHS set up ten years ago to implement, administer and regulate the government's Ten Year Drug and Alcohol Treatment Strategy.
DAAT – the Drug and Alcohol Action Team: the commissioner of county wide drug and alcohol treatments. A public funded arm's length organisation hosted by a public body, NHS Oxfordshire, formerly Oxfordshire Primary Care Trust.
SMART - Substance Misuse Arrest Referral Team: a local provider of drug treatment services who won the tender to run the replacement unit to the DRP
Ley Community – a local residential drug and alcohol treatment centre.
OBMH – Oxfordshire and Buckinghamshire Mental Health Care Trust, responsible for:
SCAS – Social and Community Addiction Service: the part of OBMH which assesses and funds people for detoxification and residential drug treatment programmes and also prescribes methadone, an opiate substitute. SCAS provided previous clinical cover for the DRP.
OUT – Oxfordshire User Team: a charity run by drug service users which runs workshops and also represents the service users voice to both commissioners and providers.
OJHOSC – Oxfordshire Joint Health Overview and Scrutiny Committee: has more powers than the LINk and both are expected to work closely together and complement each others' work.
LINks – Local Involvement Networks: the public's voice on health and social care services.
LINk SG – LINk Stewardship Group: a governance group of ten elected representatives.
ECHG – English Churches Housing Group: the provider of the Drug Recovery Project previously located at 170 Walton Street, Oxford from 2002 until the closure in 2007.

Brief history/background:

The DRP was a unique service for vulnerably housed addicts including rough sleepers and people experiencing homelessness. It was set up in Oxford because the City has the highest proportion of people experiencing homelessness per head of population outside of London and it had been acknowledged that the drugs service provision did not satisfy the needs of this vulnerable minority group. It was open from 2002 – 2007. Oxford still has the highest proportion of people experiencing homelessness per head of population outside of the capital.

DRP project group:

A project group was set up after the LINk organised meeting on 29th September 2009 which was well attended by a variety of different stakeholders within the homelessness sector as well as homeless and Drugs Services clients, the Rt. Hon Andrew Smith MP, Nicola Blackwood conservative Prospective Parliamentary Candidate, the chief executives of the Ley Community and SMART, the director of the DAAT, a representative from Oxfordshire User Team, the practice manager of Luther Street Medical Centre, a specialist community addiction nurse and other concerned citizens. An informed letter written to Oxfordshire LINKs for this meeting from Dr. Angela Jones is included at the beginning of '*Appendix 1*: *LINK notes from September 2009 meeting'* for information.

The DRP project group has met once per week since the meeting and has gathered signatures from the close neighbours of the former project who attest to not experiencing any problems during the five years that the project was in existence; *(copy available on request)*. This information was gathered to support the DAAT and SMART in their process of setting up a replacement unit – the main function of the Group. Darren Worthington, Chief Executive of SMART expressed his thanks for this valuable information. To gather background information, the Project Group also engaged with OUT, SCAS senior management, the City and County councils, former DRP employees and others including DAAT.

Over the course of these meeting and after thoroughly discussing and reviewing the information obtained, the Project Group **made a request to the LINk SG for a decision on whether the discrepancies and LINk non-compliance listed below warranted referring to OJHOSC in the form of a report.** This was agreed at the SG meeting of 25th November 2009

The Project Group came to this recommendation on account of the following:

1. The answers to a series of questions from the LINk to DAAT have often been answered evasively and on one occasion late.

2. The DRP closed in October 2007; the reason for the closure provided at the time was the Oxford City council owned property was no longer available and that performance needed to be improved. Freedom of Information requests to the City and County council have revealed that the closure of the project was not property related. This information is at variance with the reason given at the time of the closure by DAAT to Nicola Blackwood (Prospective Parliamentary Candidate) and to the response given to Andrew Smith MP in his request for information made to Oxfordshire Primary Care Trust earlier this year. Nicola and Andrew have been informed of the FOI request responses, as has the PCT. An independent 60 page report into the DRP in 2005 previously provided to the LINk Stewardship Group stated in the conclusions that 'Overall, the evaluators were impressed with the Drug Recovery Project, describing it in feedback to commissioners as "…a cracking little project". In terms of both qualitative outcomes for service users, and value for money, on a 'unit cost' basis, the evaluators were unable to identify any other initiatives able to challenge the DRP. However it is measured, the 'success rate' for the DRP is to be particularly applauded given the often entrenched and multiple needs of its target client group'; *Appendix 2.*

3. Evidence has been found by the Project Group that a consultation on the closure did not take place; *Appendix 3.*

4. The replacement unit cannot open without clinical cover. Darren Worthington, the chief executive of SMART explained in emails to the project group that responsibility for clinical cover for the new unit is with the DAAT and would be provided by a SCAS addictions nurse specialist, *Appendix 4.* In communications with the previous and present SCAS service managers, *Appendix 5*, it is noted that previous negotiations between SCAS and DAAT took place seven to eight months ago and finished without agreement due to governance and financial concerns raised by SCAS and that these remained. Previous negotiations in mid 2009 with the Ley Community to provide property for the 'Howard House Project' replacement unit also broke

down due to governance concerns they raised. This information conflicts with repeated statements that providing a replacement unit has remained a priority over the past 27 months.

In the light of these discrepancies and considering the remit of the LINk and what is in the present and future best interest of the public, the Project Group agreed to ask the LINk SG to take a decision on whether these issues are best served by being referred to OJHOSC so the Project Group can focus future work on supporting the process of setting up a replacement unit.

Oxfordshire LINk report to OJHOSC continued:

This report requests the OJHOSC scrutinise the process of the DRP closure and clarify why replacement provision is still not in place. It is hoped that by the committee undertaking this piece of work that publicly funded, well functioning drug and alcohol services within the county will in future not be closed without consultation or replacement provision being in place as commissioners will have been told by the committee that this is unacceptable.
We would also request that a clear message is given to commissioners that full co-operation with Oxfordshire LINk is required, specifically that requests for information are to be answered clearly, to the point and on time. We further request the committee to instruct commissioners to ensure that sufficient funding is provided for appropriate clinical cover for the required replacement unit as it strongly appears that this has been the cause on at least one previous occasion as to why no replacement unit is still in place after a 27 month gap.

Closure due to commissioning a replacement service is now illegal within the NHS (Lord Darzi's final report); closure is to occur when the newly commissioned unit is ready to take over. Commissioners are often far removed from the 'coal face' and, as in this case, a major service review and commissioning decision has been made without consultation, resulting in a highly vulnerable and minority group losing out on a unique and highly valued service for far too long.

Concern and shock was expressed around the time of the DRP closure to the DAAT director Jo Melling by the 2 main groups of organisations working within the homelessness sector, specifically the single homelessness group by its chair Leslie Dewhurst; *Appendix 6*, and the Network Meeting group by its representative Victoria Mort via Nicola Blackwood. Responses to both parties explained the closure was due to the property being no longer available. FOI requests, *Appendix 7*, to both city and county councils clarify the closure was due to a replacement unit being commissioned after a strategic review and was not property related. A later explanation to Oxford MP Andrew Smith from Oxfordshire PCT added that the project's performance needed to be improved, *Appendix 10.*

The Committee are aware that locally Oxfordshire PCT allowed the previous Oxford community hospital (OXCOMM) get to a stage whereby closure was inevitable and it was only with the committee's robust intervention that the interim provision was questioned and the replacement unit given the emphasis it required, so that Oxford now has an improved community hospital serving its growing number of vulnerable older citizens. Similarly it would appear in this instance that commissioners allowed tenders and leases, rather than bricks and mortar, to expire so their ending could be used to warrant closure.

It is the opinion of the LINk Stewardship Group that justification for the lack of a consultation on the closure of the DRP is repugnant; *Appendix 3,* (that it only served a small number of overall clients 'in treatment'). It is important to note the differences in treatment provision available within the county and that a high proportion of those 'in treatment' are not receiving detoxification and residential treatment such as the DRP provided, but rather maintenance and harm minimisation prescribing and other community-based treatments. Consultations are imperative because realities on the ground (in this instance that it will be very difficult to find a suitable replacement building) often come to light when they are carried out, thus informing commissioning decisions.

We request the Committee clarify with the City Council whether, if requested, they would have had a problem with the property continuing to be used until a replacement unit was up and

running and likewise with the previous provider ECHG. Over the past twenty seven months, whilst potential DRP clients have not had access to an often life-saving and life changing service, significantly higher financial savings have been made by both former DRP funding organisations (Oxfordshire DAAT and Supporting People) than those allocated (and unused) to 'fill the gap' (£40,000 DAAT), *Appendix 8*. Papers at the meeting of the Supporting People Commissioning Body held 11/12/09 confirm Supporting People reduction in spending last year being £83,000 due to there being no DRP service. It has been confirmed by SCAS senior management; *Appendix 5*, that previous negotiation for clinical cover at a new unit broke down due to governance concerns and because there was not enough money on the table to pay for what was needed. LINk request the Committee obtain assurance from commissioners to ensure that sufficient funding is provided for appropriate clinical cover for the required replacement unit.

We should also report that concerns were raised at the LINk organised meeting on 29th September that commissioners seemed to be favouring one provider, SMART, and that in the case of the DRP some considered it unwise that the tender had been given to them, a provider with no experience of providing housing and residential detoxification. These were part of wider concerns expressed regarding a monopoly of non NHS drug and alcohol service provision within the county. As the saying goes, 'one size/approach does not fit all', and this certainly applies within substance misuse treatment services whereby choice of different providers using different styles of approach is imperative to suit service users different needs. It is the LINk view that near monopoly of provision is not in clients' best interests. *Appendix 9* lists part of the series of questions LINk has asked the DAAT and the responses it has received. It is because of the nature of these responses that the following recommendations are put forward.

Recommendations to OJHOSC:

1. HOSC scrutinise the DRP closure and clarify why replacement provision is still not in place.

2. HOSC instructs commissioners: to ensure sufficient funding is provided for appropriate clinical cover for the required replacement unit; that it is not acceptable that well functioning drug and alcohol services are closed without consultation and replacement provision being in place: that any replacement unit continues to also serve entrenched Oxfordshire substance misusers who are vulnerably housed, homeless or rough sleeping; that full co-operation with Oxfordshire LINk is required, specifically that requests for information are to be answered clearly, to the point and on time.

3. HOSC clarifies with the City Council whether, if requested, they would have had any concerns with the property continuing to be used until another building had been found to locate the replacement unit and what the City Council have done with the property at 170 Walton Street, Jericho, Oxford since the closure.

4. HOSC notes the widespread concerns of which the LINk has been made aware around near monopoly of non-NHS service provision and informs commissioners of the probable detrimental impact this approach will have, as evidenced by the DRP case. It is generally accepted that monopoly often stifles competition which in turn stifles innovation. One size does not fit all.

Conclusion:

Whilst LINk has no doubt that commissioners, their host, funding and other partners wish to provide an improved version of the former DRP (an already highly acclaimed unit) and that this desire is to be applauded, we note with accompanying sadness of how vulnerable people suffer due to an apparent lack of foresight. Consultations are important, hence their status in law (regardless of how many people they serve). Lord Darzi's decision for the NHS in regard to commissioning new services closed loopholes that often left people without appropriate services for years. Where instructed by Oxfordshire citizens, as in this case, we will continue to advocate that Lord Darzi's decision be replicated across the county within well functioning health and social care services, thus helping to ensure continuity of appropriate provision.

Report ends

This content of this report was checked by the LINk DRP Project Group including the project leader and LINk steering group member Barrie Finch and the LINk locality manager Adrian Chant on 6th January 2010.

Appendices:

1: Letter to LINk and abbreviated notes from LINk meeting 29/09/09.

2: Extract from the 2005 independent report into the DRP commissioned by the DAAT.

3: Shortened response to letter from MP Andrew Smith 09/07.

4: SMART email response to LINk DRP project group.

5: SCAS service managers' emails to LINk DRP project group.

6: Letter to LINK/JHOSC from Leslie Dewhurst.

7: County and City council FOI responses.

8: DAAT email confirming 'unspent, fill the gap' funding allocation.

9: LINk questions to DAAT and responses.

10: Oxfordshire PCT response 07/04/09 to the Rt Hon Andrew Smith MP.

***Appendix 1**: Informed letter to LINk followed by edited notes from LINk meeting 29/09/09.*

Dear Oxfordshire LINKs,

My name is Dr Angela Jones and I am an NHS GP. I am writing to present my concerns regarding the closure of the Drug Recovery Project (DRP) to the meeting which I gather will be held on 29th September 2009. I am sorry that I cannot attend this meeting, but I will be away on a course which has been booked for several months. My own history and justification for having an opinion on this matter is as follows. I was a principal in general practice for 10 years in South Wales before returning to Oxford and joining Luther Street Medical Centre, the homelessness practice, where I was employed from 1999-2007 as, at various times, a salaried GP, joint Medical Director, clinical lead and shared care GP providing drug and alcohol services for people experiencing homelessness in Oxford. During that time, I set up a Postgraduate Course on the Provision of Health Care to People Experiencing Homelessness with the University of Oxford and ran 3 annual international conferences on Health and Homelessness which attracted over 100 delegates from all over the world.

For the last two years of my employment (and for a further year after leaving the employ of Oxfordshire PCT), I was seconded to the Office of the Deputy Prime Minister, later Communities and Local Government as their specialist adviser on Health and Homelessness and worked alongside Department of Health colleagues on a number of initiatives, culminating in the publication of the most recent rough sleeper strategy, "No One Left Out". I now work in Oxfordshire as a GP in the Didcot Resource Centre, a drug treatment centre for more hard to reach clients in South Oxfordshire, in the out of hours primary care service in Oxford City and as a GP for homeless people in Westminster. I am Chair of the Health Inequalities Standing Committee of the Royal College of General Practitioners and recently co-founded a small social enterprise, Inclusive Health, which aims to improve health care for socially excluded groups. I was part of the Management Team at Luther Street Medical Centre when the Drug Recovery

Project was set up and responsible for the clinical management of the clients and the supervision of the clinical staff working there. The model was that of a pre-rehab, in other words, it was a facility where rough sleepers, in particular, had the opportunity to exit the streets, to stabilise their drug use, to select a rehab facility and to gradually reduce their substitute medication in readiness for admission to their chosen rehabilitation facility.
During their three to four month stay at the DRP, they engaged in health promotion activity as well as participating in the life of the house, sharing in tasks etc and attending one to one and group sessions, all excellent preparation for rehabilitation, and designed to maximise the chances of successfully completing rehab. During this time, they were cared for by their usual GP who could monitor their mental and physical health and offer a unique level of continuity during this difficult phase.

The DRP was designed to enable rough sleepers with addiction problems and who wished to aim for abstinence to make a step change in their lives, one that was linked to addressing their substance misuse. It was felt to be necessary because the relentless pressures of the life of a rough sleeping drug user allow very little, if any, space for undertaking the necessary actions needed for change. Safe accommodation and structure are vital to foster change and although the direct access hostels within the city worked for some people, for many rough sleepers, there was not sufficient structure or support to provide for their needs. Many of the clients of the DRP had revolved in and out of the shelter / hostel accommodation, without making any ongoing progress and clearly needed different input: The DRP was one method of providing this more intensive structure and support and definitely filled a gap. (I would also have liked to see a similar model made available for those who for whatever reason did not feel able to aim for abstinence and wished to intensively address their issues in the context of maintenance.) I was no longer working at Luther Street when the DRP closed. My understanding is that some additional funding for residential detoxification was provided but it is clear from the above that a brief (5 to 7 days) admission in no way replaces the stabilisation and therapeutic value of the DRP. Thus, this very vulnerable group of clients have lost a vital element in their options for care and Oxfordshire lost a facility which had been recognised as best practice nationally.

The new Rough Sleeper Strategy stresses the link between complex trauma and rough sleeping. It is increasingly recognised that severe and enduring mental health and psychological problems related to childhood trauma frequently underpin many experiences of homelessness and this is the subject of ongoing work within CLG and several areas of the Department of Health. I strongly urge commissioners to ensure that a service, such as the DRP, providing a 'safe haven' for people who have become so marginalised as to find themselves sleeping on the streets, is once again developed and fostered, so that we can be seen to provide a humane and effective response to their situation and to enable them to leave the streets and find and maintain a home of their own.

I am grateful for this opportunity to share my thoughts on this issue.
Yours sincerely

Angela Jones

Dr A M Jones
MA BM BCh DCH DRCOG DFFP MRCGP

Meeting notes from 29/09/09: ***of particular note for report numbers 3, 4, 6 and on page 9 the 2nd paragraph highlighted in italics.***

1. Welcome & introductions
Anita Higham (AH) in the Chair, welcomed all to the meeting and introduced Jo Melling (JM), Director of Oxfordshire Drug & Alcohol Action Team (DAAT), Richard Lohman (RL) from the LINk Stewardship Group and Adrian Chant (AC), Locality Manager,

Oxfordshire LINk. AH provided a brief outline of the meeting's content, and informed people that LINk hopes to set up a small Project Group of 3 or 4 people following this meeting, to follow up any issues raised. A further meeting will then be organised for this group to report back to on progress.

2. What is the Oxfordshire LINk?
Adrian Chant gave a brief introduction to Oxfordshire LINk and explained what its statutory powers are, including the ability to request information about a service and receive a response within 20 days and visiting rights to view services as they are being provided. This is not an inspection, but a way of obtaining further information about a specific service. He encouraged people to register to receive future information and become involved.

3. Drug Recovery Project: update on the new service
AH asked Jo Melling to provide an update on the progress of a replacement service for the Drug Recovery Project (DRP): The DRP was set up as a housing-based project for Oxfordshire rough sleepers and homeless people requiring an in patient detox program. This project came to an end two years ago and the DAAT tendered for a new provider for an Oxfordshire based detox facility. SMART (a registered charity working with clients who have substance misuse issues) won the tender. They have had difficulty in finding suitable premises however report ongoing negotiations with housing providers. JM explained more about her role and the DAATs work in general:
JM is the Director of the DAAT for the whole of Oxfordshire. The DAAT is hosted by the PCT. The DAAT designs and tenders for services, it also performance manages, commissions and purchases services on behalf of its partners.

4. Questions to Jo Melling from the audience

Q – Wouldn't it have been better to keep the DRP open until somewhere new was found?
The City Council needed to sell the premises where it was located. There were a lot of things that we did not have a choice about when it came to closing the DRP. We did not think there would be a two year gap before the service was up and running again.

Q – There is a massive need for the service that the DRP used to provide. What is being done to re-provide this service?
The difficulty with the DRP is that is was a very unique service. We are continually trying to find new premises. We are going out to tender for a residential re-hab and looking at other options elsewhere. There is a lot of bureaucracy to wade through and a legal framework to adhere to. We hope to get a new DRP set up by the end of the year. There is a problem with people not wanting this facility on their doorstep and with this type of premises not obtaining planning permission. If a Project Group was set up, it could help lobby for the DRP.

General comments made
People need proper direction and help. Surely the Council could help find a place?
The people that are not visible need to be reached. People could come into the DRP for a short time and then go back to normal life. The DRP functioned very well.

Q – How can we move this issue forward for this group of vulnerable people?
We need a group of committed people to support the DAAT.

Q – Does the DRP have to be located in the City Centre?
No, it can be anywhere.

Q – Is this service just for people in Oxfordshire?
Yes. Homeless people come to Oxford for the service it offers, but can't use this service because they have to have a 'local connection'. There is a problem with services being inundated and they do not want to deny Oxfordshire residents the chance to use the service. The 'local connection' criteria is that you have to have an Oxford based GP.

JM observed that all the comments people made were very useful. She also said the following: The DAAT is committed to having a local DRP. Approx 140 people went through the DRP when it was running. They are not in a crisis situation, but they are taking this very seriously. The DAAT are sending people outside of Oxford to get the treatment they need. There are only a handful of other such facilities across the Country. We need to look to the future, not dwell on the past.

Further audience comments:
The tender for the new project was won within 6 months of the old one being closed. How could they have won the tender when they had no new building in place? The DRP was developed in Oxfordshire because there is a need for it. The DRP gave people the time they needed in a safe environment. It's difficult for some people to travel outside of the County. The DRP is really missed.

5. What are the countywide drug and alcohol support services?
JM gave an update on the services DAAT offers across the County. They have recently re-commissioned all their services and have separated out the Drug and Alcohol services. The provider of these is SMART. They are developing Family Support Services – setting up and developing family champions, 1:1 support and support groups. They are doing research into any unmet need there still is. They have a new Centre opening at the Banbury Health Centre. They are extending their premises in Witney. They have a new Mobile Treatment Centre that will be going out to rural villages. It will be a drop-in service, with treatment being facilitated from this

6. Questions

Q – All these services have been taken over by SMART. A lot of users aren't comfortable with them and don't want to access services provided by them. They won't be able to go anywhere else because they run everything. Where can they go? Can SMART answer some of our questions?

The representative from SMART had left, but it was suggested that some of these questions could be brought to the meeting in January.

7. How the LINk can help
People were asked if they would like to be part of the Project Group, looking at next steps and practical outcomes. This will be an informal group. Five people expressed interest.

8. Closing remarks and next steps
AH thanked everyone for coming, and extended her thanks to JM in particular.

Website: www.makesachange.org.uk
Email: OxfordshireLink@makesachange.org.uk
LINk Office Tel: 01993 862855

Anita Higham – Member of Oxfordshire LINk Steering Group, chair of meeting
Richard Lohman - Member of Oxfordshire LINk Steering Group, work programme group leader
Jo Melling – Director, Oxfordshire DAAT
Adrian Chant – Locality Manager, Oxfordshire LINk

The Project Group has met every Wednesday evening since 29/9/09. It consists of 2 service users, 2 LINk steering group members and a homelessness housing provider member of staff. Discussions with the chief executive of SMART during a break in the meeting of 29/9/09 revealed that the main impediments to the new unit had been public opinion and planning committees. In order to address these issues and support DAAT and SMART the project group agreed to try and gather signatures from neighbours of the former DRP attesting that they had experienced no problems whilst the unit was in place. If necessary this petition will be presented

at future planning committee meetings by the project group leader who would also give a brief 5 minute presentation. The project group has also agreed to formally approach the LINK for support in setting up a public meeting for the neighbours of the future unit should the neighbours express anxieties. This meeting would provide a forum for any questions to be answered, showcase the petition from previous neighbours of the DRP and allow the sharing of personal stories by ex-addicts who are now productive members of society.

A snapshot survey in mid October has revealed 22 people experiencing homelessness in the city fulfilling the criteria for the DRP and showing motivation for treatment provided by such a specialist unit. This figure consists of thirteen residents in Lucy Faithful House hostel, seven in O'Hanlon House (Oxford Night Shelter) and a few rough sleepers (Street Services Team). A countywide survey was not undertaken.

28/10/09 – All the close neighbours of the former DRP signed a statement saying that they experienced no problems whilst the unit was in place.

Appendix 2*: Extracts from the 60 page Independent 2005 report into the DRP.*

An evaluation of the
Drug Recovery Project

July 2005
Consultants
Andy and Lynn Horwood

Conclusions
'Overall, the evaluators were impressed with the Drug Recovery Project, describing it in feedback to commissioners as 'a cracking little project'. In terms of both qualitative outcomes for service users, and value for money, on a 'unit cost' basis, the evaluators were unable to identify any other initiatives able to challenge the DRP. However it is measured, the 'success rate' for the DRP is to be particularly applauded given the often entrenched and multiple needs of its target client group'.

Appendix 3*: Shortened copy of reply letter dated 09/07 to Andrew Smith MP (of particular note for this report – 3rd sentence and last paragraph)*

Dear Andrew,

Thanks for sending the reply from Ox PCT regarding the imminent closure of the Drugs Recovery Project. The DRP is specifically designed for rough sleepers as a needed stepping stone treatment prior to accessing residential rehabilitation; it is the only service of its kind. The reply from the DAAT via the PCT seems to say that as the DRP only treats 15-20 people a year and this is a minority of overall Oxon people in treatment there was no need for a consultation, this negates the status of rough sleepers as a minority group: it's like saying we wont bother consulting on black peoples views because they only make up a small percentage overall. The closure of the DRP has a significant impact on the rough sleeping population it was designed to serve and it will not be available for at least 5 months, therefore it surely required a wider consultation (wider than members of the commissioning group - I have spoken to OUT who informed me that they did not consult with users regarding this prior to the decision being taken).
The DAAT have informed me that they did not know that the lease of the property was ending! I find this hard to understand; surely as main purchaser of the service they would be aware.
The PCT/DAAT response states that during the tender process the council decided to take the property back (was there no contractual timeframe then?) I am aware that due to the lack of information regarding the closure being disclosed to DRP staff, that staff anxiety and staff

sickness levels rose. I would be grateful if you could raise the issue of why it would have been appropriate to have a consultation.

One last point, it seems that DAATs' across the country are not subject to the FOI Act despite being funded by public monies, could they be included within the current framework or would it need amending? My FOI request for details of any consultation was refused by the DAAT. Thanks for the swift response

Warm regards,

Richard Lohman.

Appendix 4: *SMART email to DRP project group (of particular note for the report is the 1st sentence).*

From: DWorthington@smartcjs.org.uk
To: richardntlohman@hotmail.com; adrian.chant@helpandcare.org.uk
Hello Richard,

Re: Details of the programme:

Clinical input/management is being provided by a dedicated SCAS nurse who will oversee all prescribing needs.

The therapeutic activities, programme design and auditing processes are aligned to NICE, Models of Care and Clinical Governance expectations respectively.

The programme is structured across 7 days and provides a range of support functions including; dedicated one-to-one sessions, support groups, education workshops and complementary therapies. All of this set against the backdrop of needing to support the longer-term housing needs of the majority of our service users, and developing the skills they need to live independently. When designing the programme we remained mindful that the unit is not intended as a 'residential rehabilitation centre'.

Re: Negotiations so far: As referenced in my previous mail, negotiations so far have broken down as a result of problems with actual and potential planning applications. Public opinion was the key obstacle during our application to Cherwell District Council whilst all other Councils, bar the West, have voiced concerns over a project of this type in their locale prior to going to planning.

Where partnership proposals have been in place with housing providers, the sourcing of suitable premises has been the main obstacle.

Thank you once again for the support.

Darren Worthington

CEO
SMART CJS

Appendix 5: *SCAS service managers' email response. Of particular note for the report the response on the bottom of page 11.*

From: Richard Lohman
To: steve.thwaites@obmh.nhs.uk
29/10/09
Dear Steve, please see attached as per our discussion this morning. I will contact Pauline Scully to see if things have moved on and note that when you were involved around 6 months ago that

nothing had been confirmed in regard to a dedicated scas nurse due to the concerns you had.

The LINks website is www.makesachange.org.uk and you will be able to access the local Oxfordshire LINks office tel nr and other details there

warm regards,

Richard Lohman.
Oxfordshire LINks steering group member.
LINks: your voice on local health and social care.

From: RICHARD LOHMAN
Sent: 29 October 2009 10:13
To: Scully Pauline (RNU) OBMH

Dear Pauline,

my name is Richard Lohman and I sit on the Oxfordshire LINks steering group. LINks replaced patient and public involvement forums however also covers social care. Oxfordshire LINks has been up and running with an elected steering group in place since March of this year, more details can be found at the website www.makesachange.org.uk including contact details of the Oxfordshire office in Witney.

The Steering Group is focussing on several areas raised by the public and one of these is the replacement of the former DRP which as you are probably aware was shut down 2 years ago. The unit provided residential detox and therapy for especially vulnerable substance misusers, particularly rough sleepers and people experiencing homelessness.

I was given your name by Steven Thwaites after we had a chat this morning and I am seeking clarification on whether it has now been confirmed by scas that a dedicated scas nurse would be overseeing all prescribing needs (see email below from Darren Worthington) in the new unit or whether this is still being looked at due to the concerns that Steven had raised circa 6 months ago.

I understand that you must be extremely busy and yet I would be grateful if you could respond as soon as you are able

With kind regards

Richard Lohman.
Oxfordshire LINk steering group member.
LINks: your voice on local health and social care.

From: Pauline.Scully@obmh.nhs.uk
To: richardntlohman@hotmail.com
29/10/09

Dear Richard,

Steve has informed me of your conversation this morning. *I can confirm that there has been no agreement at this point that SCAS will provide a dedicated nurse for this service. The concerns raised by Steve earlier stand, we have had no recent discussions with the DAAT about this.* We do remain open to discussing this with the DAAT in the future.

Best wishes
Pauline
Pauline Scully, Service Manager

Appendix 6: *Letter to LINK/OJHOSC from Leslie Dewhurst.*

January 2010

Drugs Recovery Project

I am writing in support of the LINKS Project Group's request to the County Council Health and Overview Scrutiny Committee to look into the closure of the DRP in Walton Street.

As chair of Single Homeless Group, I wrote to Supporting People and the DAAT back in early 2008, to express concern about the lengthy interim period between the closure of the DRP in Walton Street and the new contract being awarded in April 2008. It was with dismay that we then heard that the new service was not likely to be up and running until autumn 2008. It seemed unfortunate planning to close one service before the replacement service was ready to commence.

Of course, the expected opening of SMART's new service in autumn 2008 was then delayed and has still not opened. Though I appreciate the problems of securing appropriate premises and the relevant planning consents, this does seem to be an unacceptable length of time to go without a service which has been deemed both necessary and strategically relevant.

I do hope that you can do whatever is necessary to help bring this sorry situation to a speedy and satisfactory conclusion.

Yours faithfully,

Lesley Dewhurst
Chief Executive, Oxford Homeless Pathways
Chair, Single Homeless Group

Appendix 7 and 7a: *County and City council FOI responses (of note for this report the last 2 sentences in italics of appendix 7 and the 2nd paragraph in appendix 7a).*

Date: Mon, 16 Nov 2009
From: Grace.Mayo@Oxfordshire.gov.uk
To: richardntlohman@hotmail.com

Dear Mr Lohman

Thank you for your recent enquiry regarding the closure of the Drugs Recovery Project at 170 Walton Street, Jericho, Oxford.
I can confirm that yes, the Drug Recovery Project was provided at this address by English Churches Housing Group. From 1 April 2003 until the end of September 2007 the housing related support service provided to residents was funded by Oxfordshire County Council under the Supporting People programme.

This service was subject to a strategic review and was re-commissioned following a competitive process, to be provided by a difference provider and at different premises. Therefore the closure of the service at this address was not property related.

With Best Wishes
Grace Mayo
Quality & Performance Officer
Social & Community Services
Oxfordshire Supporting People Team

Appendix 7a
Subject: 1734 FOI - Drug Recovery Project
Date: Tue, 8 Dec 2009
From: James.Willoughby@Oxfordshire.gov.uk
To: richardntlohman@hotmail.com

Dear Mr Lohman

Thank you for your request of 30 November 2009 in which you asked for the following information: I would like to make a freedom of information request regarding the closure of the Drug Recovery Project at Walton Street, Oxford in 2007. The request is for the details of any consultation on the closure which took place, either with Oxford organisations working with the homeless and/or with service users.

Further to our telephone conversation of 4 December regarding your request, I have contacted the Supporting People Team as you suggested. However, after consulting this and several other teams within the County Council, I must inform you that no information regarding a consultation is held by the council.

However, this does not mean that a consultation did or did not take place, only that the council holds no information about it.
Please let me know if you have further enquiries. I would be grateful if you could use the reference number given at the top of this email.
Yours sincerely,
James Willoughby
Complaints and FOI Manager
Oxfordshire County Council

Appendix 8: *extract from 16/11/09 DAAT email confirming 'unspent, fill the gap' funding allocation.*

"… We increased the budget available to the residential rehabilitation placement team by £40K as an initial buffer after the project closed, this was not spent …"

Appendix 9: *LINk questions to DAAT and responses. The pertinent aspects are in italics.*

The following email was sent from Adrian Chant to Jo Melling on 4th September – both of the following questions were not answered as requested for or at the meeting 29/09/09.

1. How many rough sleepers accessed the DRP in the final two years of its operation?
2. Of the additional monies set aside after the closure to fill the gap in services how much has been spent on people who were rough sleeping?

The questions were not answered at the meeting or subsequently as needed within the 20 working day timeframe. A reminder email of the same was sent 12/10 repeating both questions. A reply was received on the same day which again did not answer the question or provide a reasonably helpful response, i.e. provide the numbers of No Fixed Abode clients for which figures are held.

04/09/09

Dear Jo,

We have received a request from the Steering Group if the following 2 questions could be prepared for discussion at the 29 September meeting (or supplied in advance as appropriate):

1. How many rough sleepers accessed the DRP in the final two years of its operation?
2. Of the additional monies set aside after the closure to fill the gap in services how much has been spent on people who were rough sleeping?

If it would help to discuss further I will be available in the office next week or on the mobile number below. Many thanks.

Kind regards,

Adrian

12/10

Dear Adrian

Regarding your questions below, The DAAT commission Drug and alcohol treatment we are not commissioners of housing, therefore the data we collect relates directly to an individual's treatment and treatment outcomes. *The national data requirements on the national database for treatment services (NDTMS) collects the following fields related to housing*

NFA (No Fixed Abode), Housing Problem, No Housing Problem

Therefore we did not collect data on rough sleepers. The project was not commissioned by us as a rough sleeper project as it would be inappropriate for us to commission a project on this basis as we are commissioners for treatment. So in brief I cannot give you the statistics you are asking for. Negotiations for new premises are well underway and we hope to make an announcement within the mouth.

Regards

Jo

The following letter was sent 22/10/09, a reminder email sent of the same was sent 5/11, a further request for response 12/11, a response was received 16/11.

Dear Jo,

The project group would like to be informed as to:

How much funding was set aside to fill the gap and was it ring fenced, and if so, how much of that funding was allocated and spent on what services?
If not ring fenced, again how much was allocated and spent, and on what services?

Your email of 12th October stated "Negotiations for new premises are well underway and we hope to make an announcement within the month". Please can you advise if this is still on target for announcement by the middle of November?

The LINK would like to be in a position to report back to Oxfordshire Joint Health Overview and Scrutiny Committee as part of the LINK update for their next meeting on 19th November and I would therefore be appreciative of a reply within the normal timescale of 20 working days under the LINKs legislation.

Thank you for your help.

Yours sincerely,

Adrian Chant,

12/11/09
Dear Jo,

I would be grateful to receive a response to my previous email. The LINk will be providing an update to the next meeting of Oxfordshire Joint Health Overview and Scrutiny Committee on 19th November and wish to be able to do this on current information received many thanks.

Kind regards,

Adrian

16/11/09

Adrian

My understanding was that the project group that LINKs set up was to work with providers in moving forward, does the group have terms of reference? Therefore I am not sure how productive it is to keep going over old information that is no longer relevant. I have sent over a large amount of information over that last few months on *a project which closed over two years ago and in its entire life span saw just over 100 people*, when the overall treatment system treats over Two Thousand Three Hundred Individuals per year. I appreciate that this is an emotive subject to some people, at the meeting and during all the correspondence we have stated that we continue to look for premises to develop a local residential detoxification facility. Something that others areas do not have, so Oxfordshire is not being denied a service that is everywhere else, quite the opposite. We have clearly indicated we are always happy to work with people to move forward and would welcome a more positive approach to this piece of work.

As far as funding is concerned what we do not and cannot do is have money sat unspent. *We increased the budget available to the residential rehabilitation placement team by £40K as an initial buffer after the project closed; this was not spent* and was used to offset the county councils decrease in the residential rehabilitation funding. Budgets in this form as not ‘ring fenced’ but allocated as described above. The money available for residential rehabilitation is part DAAT funding and part county council funding; the budget is management by the county council. Residential Rehabilitation placements are county council contracts.

We are progressing with the premises agenda and have meetings in place to discuss the move forward with a third party. We hope to have some information within the next 2

weeks; I cannot risk the process of negotiation by informing people of discussions when no agreement has yet been made. I am as keen as everyone to be able to make the announcement that we have premises and that a new project will soon be opening. In short I do hope that this will be forthcoming in November.

Kind regards,

Jo

The following email was sent 7/12/09 for which a response was received on 23/12/09.

Dear Jo,

I provide below information from the LINk project group:

As you are probably aware the DRP project group formed after the LINks initiated meeting has gathered signatures from the close neighbours of the former project attesting that they experienced no problems over the duration of the project and that this information has been passed onto Darren Worthington, where it is hoped it will be of use in the process of setting up the replacement unit. *If you have ideas on anything further the project group could do to support the process during this phase please do let us know.*

At the last meeting of the Oxfordshire LINk Stewardship Group, in order for the project group to focus solely on supporting the process of setting up the replacement unit, it was unanimously agreed that the information gathered by the project group in regard to the former DRP be forwarded to Oxfordshire Joint Health Overview and Scrutiny Committee for their attention. This is the normal referral process for LINk projects, the OJHOSC having requested reports of current activities from all LINk projects for their next meeting on 21st January 2010. Part of the report from the DRP project group will cover some discrepancies in information received in the course of the group's inquiries into the former DRP and its closure.

In order to complete our report I would be grateful if you can confirm whether any public consultation on the closure of the DRP took place at the time and if so, can we be provided with details of the type and scope of this?

Please do not hesitate to contact the group via the LINKs office with any work which the project group may be able to undertake in supporting the process of setting up the replacement unit to the DRP or should you require any further information/clarification.
Many thanks for your continued help.
Yours sincerely,

Adrian Chant,

23/12/09.

Dear Adrian, Thank you for your letter, it is great news this is going to the Oxfordshire Joint Health Overview and Scrutiny Committee, can I please have a copy of your report.

To confirm, there was no public consultation regarding the end of the contract that ECHG had for the DRP.

Regards
Jo

NHS
Oxfordshire

Oxfordshire Primary Care Trust
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford OX4 2LH

Telephone: 01865 336700
Fax: 01865 337094
Website: www.oxfordshirepct.nhs.uk
Email: andrea.young@oxfordshirepct.nhs.uk

Rt Hon Andrew Smith MP
House of Commons
London
SW1A 0AA

14 APR 2009

Your ref: EOT/LO4001/01091215

7 April 2009

Dear Andrew

Drug Recovery Project

Oxfordshire DAAT has commissioned a residential detoxification facility to replace what was the 'Drug Recovery Project' as the old premises were no longer available and the projects performance needed to be improved.

The opening of the new facility was delayed due to the search for appropriate premises and relevant permissions. New premises have now been sourced with formal arrangements currently being finalized, the expected opening of the new 'Howard House Project' is anticipated for September 2009. 'During the closure period no clients have been disadvantaged and additional funding has been made available for out of county placements while the new Oxfordshire facility was under development.'

This exciting new project will see 8 dedicated beds for Oxfordshire being available for entrenched drug and alcohol users to undertake detoxification with intensive aftercare support and move on accommodation now being in place to aid sustained recovery.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Catherine Mountford

Catherine Mountford
Director of Planning and System Reform
Signed on behalf of Andrea Young, Chief Executive

Report for the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC)

Date of Meeting: 11th March 2010	**Paper No:**

Title of Report: Oxfordshire Drug Recovery Project (DRP).

Purpose of Report:

To present the committee with the facts regarding the closure of the Drug Recovery Project (DRP) and delays in the opening of a new residential detoxification facility.

Background:

Who are Oxfordshire DAAT:
Oxfordshire DAAT is the partnership commissioner of drug and alcohol treatment services and drug and alcohol criminal justice treatment interventions, hosted by Oxfordshire PCT. We are governed by a specialist authority the National Treatment Agency (NTA), which is an arm of the Department of Health. Our budget is made up of Department of Health finance through the NTA and Home Office funding for criminal justice interventions. We are currently ranked fifth in the country for both treatment effectiveness and the number of drug users in treatment against the prevalence of drug use in Oxfordshire. We are the best performing DAAT in the South East.

The Drug Recovery Project:
Was originally an Oxford City supported housing project which subsequently became an Oxfordshire based initiative aimed at providing individuals who where on Opiate Substitution Therapy with the opportunity of detoxification in a local residential setting over a period of up to six months.
The project's main funders were the County Council (Supporting People) with some grant funding from the City Council, with the DAAT providing the funding for the drug treatment elements of the project.

Actions taken by DAAT and reasons:

Due to Supporting People cost pressures and funding formulas, reductions of 50% (30% in the first year) were required, as Supporting People were the main funders of the project this would have a significant impact. The City Council cost pressures meant that they were unlikely to sustain their grant to the project. As a temporary measure the DAAT agreed to fund some of the deficit whilst joint commissioning arrangements could be made. All contracts and the lease on the building had expired, however the DAAT worked with Supporting People and the City Council to commit to the development of a new project due to the cost effectiveness of the model, although significant clinical governance concerns had to be addressed for a new service to be effective and as such the new specification was treatment and not housing focussed.

The new specification requested a 5–8 bed project as a rise in the number of beds would increase cost effectiveness. At the time of going out to tender, it was assumed that the premises in Walton Street, even though it was only five beds, would be available for the provision to act as a buffer until alternative premises where identified through the tender process. It was anticipated that there would be a three- six month delay in the new project opening to allow for refurbishment of premises to meet new regulations and for the appointment of clinical staff. Due to the condition of Walton Street, closure would need to occur for refurbishment of the existing premises regardless of the

tender, therefore to ensure patient safety and continuity of care for existing clients ECHG were requested not to admit any new clients as closure for refurbishment would mean a disruption in their detoxification.

Midway through the tender process (after the Pre-Qualification Questionnaire stage) the DAAT received a copy of a letter sent to Judith Taylor (ECHG) from Graham Stratford (Oxford City Council). This letter stated that as the tender specification was for 8 beds the property was no longer suitable for the project and as such the City Council would regain possession of the property. Mr Stratford was contacted immediately by e mail to clarify that the specification was for 5-8 beds and the DAAT requested confirmation that the property would be available. We were informed that the property was no longer available and would be returned to housing stock. The property was subsequently sold. The tender process continued with Supporting People and the DAAT.

The tender was awarded to SMART who had identified a partnership with Dominion Housing for the provision of premises. Unfortunately attempts at securing accommodation failed and due to the economic downturn Dominion Housing felt they could not continue with the partnership as they wanted to consolidate their core business.

SMART then explored a partnership with the Ley Community to lease a property on their site. During this process the DAAT secured £150,000 capital grant from the Department of Health (NTA) to refurbish any premises. Negotiations broke down due to the length of term of the lease. The Ley Community requested an initial one year lease with a three month notice period, it was felt that £150,000 capital investment could not be made on a one year lease and a three month notice period was too short for a programme length of up to six months as clients would be left vulnerable.

Current Situation

SMART have formed a partnership with St Mungo's a housing provider currently providing two supported housing projects for drug and alcohol users in Oxford. The partnership will see SMART providing the psychosocial treatment services and management, with St Mungo's providing the premises, resettlement, housing management. Premises on the Iffley Road in Oxford are in the process of being secured and work on refurbishment is anticipated to commence by the end of March 2010. All parties will be working closely with the city council to facilitate any planning requirements.

SMART and St Mungo's are currently drawing up a full project management plan for the refurbishment of the premises and the Care Quality Commission registration.

There has always been adequate funding for the medical input into this project, which could not be sourced until premises where secured.

Where any users disadvantaged?

Oxfordshire User Team (OUT) is an independent charity which represents drug and alcohol users. Amongst their services, they offer independent advocacy for service users requiring treatment or in treatment. There have been no advocacy cases for any clients who feel their drug treatment has been compromised as a result of this service closure. There is no evidence at all that any individual's treatment for drug addiction has been impacted in any way. Oxfordshire's drug treatment system is one of the best in the country.

Oxfordshire DAAT made available an additional £40,000.00 for residential detoxification to ensure that additional placements could be made during the period of closure. There was no increase in placements. Due to the County Council cutting their contribution to the residential rehabilitation budget some of this money was required to offset these cuts, in order to sustain the partnership investment in residential placements.

The national figures of those individuals in treatment in Oxfordshire over the last three years is:-

2006/2007	2007/2008	2008/2009
1937 individual people	**2213 individual people**	**2271 individual people**

The number of individuals treated within the DRP was on average 20 per year. In the entire life of the project only 89 people completed their treatment:

DRP	Up to 31 March 2005	2005-6	2006-7	2007-8	Total over the entire life of the project
Starts	90	20	24	6	140
Left	84	21	20	11	136
Left Planned	58	13	11	7	**89**
Left Unplanned	26	8	9	4	47

Community detoxification is available to every drug user. However, we have continued to seek premises and work with supporting people in developing this provision to maximise opportunities in a cost effective manner for individuals on Opiate Substitution Therapy to become drug free. It is essential that the model is treatment focussed and not housing focussed to maximise the clients opportunity to achieve abstinence.

Service User Involvement?

As Commissioners of one of the best treatment systems in the country for many years we have led the field in service user consultation. Every year we have a robust process of consultations with current, past and potential service users, with Oxfordshire User team conducting over 300 one to one interviews to ascertain individual's views and opinions of treatment and treatment accessibility. We have service user representation on every level of commissioning including the Board. Service users are an integral part of every recruitment and tender process, the most recent being the joint Oxfordshire County Council/DAAT residential detoxification and/or rehabilitation framework tender. Service users have worked alongside commissioners to undertake site visits and interviews at establishments across the county.

OUT have stated that although they welcome the new treatment project to broaden the opportunities for detoxification no service user in Oxfordshire has been disadvantaged by this process.

Recommendation

That the Health Overview Scrutiny Committee support the partnership in taking forward this initiative and notes the measures taken to avoid any patients being disadvantaged.

Report Author: Jo Melling

This page is intentionally left blank

CABINET – 20 JANUARY 2009

THE DEMOGRAPHIC CHALLENGE IN OXFORDSHIRE

Report by the Oxfordshire Joint Health Overview & Scrutiny Committee and the Social & Community Services Scrutiny Committee

1 Introduction

1.1 Oxfordshire, like the rest of the UK is going through a period of profound demographic change. The population of the County is growing, and it is also growing older. In twenty years time there will be more people living in the County, the proportion of those people who are aged over sixty-five will be considerable larger than it is now and that there will be a particularly large increase in those aged over eighty-five.

1.2 This is good news: people are living longer, and many can now look forward to a considerable number of years of active life beyond the current age of retirement. Moreover, as friends, neighbours, carers, active citizens, and simply as individuals in their own right, older people make a tremendous contribution to society; an increase in their number is to be welcomed.

1.3 But this also presents challenges; a higher proportion of older people in the population, particularly people who can be numbered amongst the 'oldest old,' will put a strain on those services that are most frequently used by older people – most notably those statutory health and care services provided or commissioned by Oxfordshire County Council and Oxfordshire Primary Care Trust. It also means that the ratio between those of retirement age, and those of working-age, will be different from what it is now.

1.4 It is appropriate then to think about the impact of demographic change on the various services provided in the county – including the impact on community and volunteering initiatives – and to start to plan, collectively, for this change. The challenge is by no means insurmountable, but it does demand that all stakeholders engage in a serious dialogue about demographic change; consideration of how well prepared the County is to deal with the challenges that change presents; to think about what can be done to anticipate it, and to start

planning now for what is needed to be done to meet the challenge of demographic change effectively.

2 Background

2.1 The population of Oxfordshire is growing; on current trends, the population of the county could increase by 20% by 2031, from 685,600 to 758,000 people.

2.2 The population of the county is also ageing. On present trends, there will be 154,200 people aged over 65 in 2031 (66% more than in 2006); numbers of the very elderly (85 years plus) are projected to increase by almost 40% by 2016, and by 143% by 2031. This means that the proportion of older people in the population will increase from just under 15% in 2006 to just over 20% in 2031, while a decrease is projected in the proportion of the population of working age, from 54% in 2006 to 48% in 2031.

2.3 Demographic change will have a significant impact on services for older people and on service-provision in general: in 2005/06, for example, just under 50% of Oxfordshire's total personal social services expenditure was spent on older people, which amounted to just under £1,000 per head of population aged 65 and over.

2.4 It should be noted in passing, however, that this is not the only change afoot; up to 2017, Central Government expects positive net migration to account for half of UK population growth, and expects this trend to remain positive in the longer term. Migrants are overwhelmingly of working-age, and this should be taken as a corrective to viewing the phenomenon of population ageing outside of the broader demographic context.

3 Emerging Themes

3.1 In general, the panel of members examining this issue found that there was, throughout the various relevant agencies and their partners, a significant degree of awareness of the issues around demographic change, and it was clear that much work is already being done to account and plan for it.

3.2 The single biggest theme to emerge from the review process was the importance of partnership-working *in*, and joining-up *of*, services for older people; where it existed, the benefits of partnership working were consistently lauded by review participants, although there were suggestions that partnership could be emphasised more at a grassroots level. Members also saw a need to join up strategies in a way that is not always intuitive – for example, harnessing the Local Transport Plan (LTP) to the Oxfordshire Primary Care Trust (PCT) Strategy.

3.3 The need to promote and support independence and choice among older people by, for example, moving to deliver various services in, or close to, the home was the second theme to consistently emerge. The ethic of home-delivery cuts across services provided by health and social care, but should also be borne in mind as an element of housing and planning strategy.

3.4 The importance of prevention was the third recurring theme. As the number of older people grows, costs to various services can be reduced by taking steps to decrease morbidity – for instance, by taking simple preventative measures in health, and also by trying to attend to moderate, as well as critical, need in care service provision.

3.5 The fourth theme to emerge consistently was inclusion; older people are not a homogenous group, and there are different sectors of older people who will either have different or greater needs, who will be harder to reach for service-providers, or who do not always avail themselves of the services available to them – be they older people living in rural areas, older members of black and minority ethnic communities, or older people living with a physical or learning disability.

4 Caveats

4.1 With all of this said, it should be noted that the situation is subject to re-appraisal; future-proofing is an inexact science, and future ageing will not occur without other changes, such as significant technological or medical developments, or a change in cultural or social practices. Therefore, this review should be conceived of as a 'living process,' or one incident in an ongoing process that would need reviewing on a regular basis.

4.2 Furthermore, the panel strove to retain focus on the bigger picture of demographic change insofar as this was possible, and thereby to create a review that was self-consciously strategic in outlook. In producing this report therefore the Panel was striving to use the wealth of data obtained to *identify* and deepen awareness of areas and issues that require detailed examination, and not to seek to fully engage in that examination itself.

4.3 Hence, what follows should be seen as a series of 'red flags' that are intended to raise awareness of the major issues identified by the review rather than a series of specific recommendations.

4.4 However there is one specific recommendation and that is to undertake a conference in Oxfordshire, in the spring of 2009. The conference would take the major themes of this review as its point of departure, and would be an opportunity for all relevant agencies and bodies – both statutory and voluntary – to come together to hear influential speakers, to discuss the issues in greater detail and to begin to further develop begin the serious work of planning for the future.

5 Red Flags

5.1 As pointed out above, the following are intended to raise awareness of major issues of importance recognised by the panel that will need attention if the response to the demographic challenge is to continue to be positive and effective.

5.2 The Contribution of Older People

5.2.1 Efforts should be made to ensure that all communities are aware of the services that are available to older people and the importance of understanding the needs of older people and, perhaps more importantly, the contribution that they can make to society.

5.3 The Contribution of Informal Carers

5.3.1 Informal carers make a tremendous contribution to the wellbeing of their families, friends, neighbourhoods and communities and in fact this is the main level of care for most people. There are a variety of forms of informal care

and it will be important to encourage, support and develop all of them– whether it be family caring, simple neighbourliness, or a more structured idea of volunteering. Support from the statutory authorities working together is vital to maintaining this level of informal support.

5.4 Maintaining Independent Living

5.4.1 In order to help people to continue to live for as long as possible in their own homes both social care and the local NHS should give particular attention to:

- Continuing to develop the preventative agenda by promoting positive lifestyle change and reviewing the barriers to older people's activity
- Attending to critical needs in social care, but also attending to those needs that are less obviously acute
- Continuing, and spreading more widely, investment in specific preventative services – including, but not limited to, the falls prevention service
- Developing, and increasing, the use of assistive technology

5.4.2 Independence, choice and dignity of older people should be promoted and maintained by taking steps to increase the take-up of direct payments and personal budgets, with the appropriate support and advice.

5.4.3 The move towards lifetime homes and neighbourhoods will have a significant part to play in enabling people to continue living at home and careful thought should be given towards how this could best be developed in Oxfordshire.

5.4.4 Extra care housing is part of the support which is available to more frail older people to enable them to continue living independently for as long as possible and, as such, the development and implementation of the extra care housing strategy should be pursued.

5.4.5 Deteriorating mental health is often a barrier to people managing to live independently, particularly in old age. A significant increase in dementia and depression should be anticipated, although this could be ameliorated by the promotion of good mental health and by working against social isolation.

5.4.6 A model of choice and independent living for older people with learning and physical disabilities needs to be promoted and sustained.

5.5 Partnership Working

5.5.1 Partnership working between health and social care, and between other agencies (statutory and voluntary), has developed well and is ahead of many other parts of the country. However it will be important to ensure that effective partnership working takes place between all agencies at the level of frontline services as well as at the institutional level.

5.5.2 Joined-up planning will be vital to the development of strategies for responding to the demographic challenge. This is particularly relevant to housing and to transport; for example, housing plans could and should be linked with relevant plans from other agencies – such as the PCT Health Strategy, the Local Transport Plan, District Council Community Plans and others.

5.5.3 Consideration should also be given to broader modes of partnership and linking-in; for example, the County Council could conceivably forge links with organisations such as the SPARC (Strategic Promotion of Ageing Research Capacity) initiative, a showcase for, and a funder of, 'the latest research findings from design, engineering and biology to all stakeholders in older people's issues.'

5.6 Access to Services

5.6.1 Access to services is obviously limited if people do not know about them; unmet need could be addressed to a major degree by ensuring that older people are made aware of, and have access to, all of the services and benefits that are available to them.

5.6.2 Specialist advice and advocacy services for older people would be of great benefit in helping older people to access services, and to claim those benefits to which they are entitled. Imaginative provision of such services, for example

by using GP surgeries as sites or signposts, could bring them to the attention of a wider group of people.

5.6.3 With regard to access, particular note must be made of older people living in rural areas, and older members of Black and Minority Ethnic (BME) communities.

5.7 Continuing the Work – A Conference on the Demographic Challenge

5.7.1 To carry the spirit of this document forward, it is proposed that a conference take place, on this topic, in Oxfordshire, in the spring of 2009. The conference would take the major themes of this review as its point of departure, and would be an opportunity for all relevant agencies and bodies – both statutory and voluntary – to come together to hear influential speakers, to discuss the issues in greater detail and to begin to further develop begin the serious work of planning for the future.

This page is intentionally left blank

Successful Ageing in Oxfordshire: a high level strategy

Introduction

1. 'Successful Ageing in Oxfordshire' is a high level overarching document that sets out the overall aims and objectives for services for people in Oxfordshire as they age. It provides the framework for service development across local government and the NHS.

2. At present the statutory agencies in Oxfordshire do not have an agreed, robust and overarching vision of what services for older people in the county should be, what the priorities, objectives, the vision and the underlying principles are. This has led to a lack of clarity and focus for the provision and development of services. There has not been a clear enough framework within which the voluntary, independent and for profit sectors can develop their own services, confident in their understanding of what service commissioners wish to see. It has also hampered the involvement of service users and carers in the development and delivery of services.

3. The implications of this are very significant. There are increasingly tight financial limits within which services have to be developed and provided, and there are a number of very significant policy changes that are being implemented across social and health care services. The demographic pressures are well documented and will give rise to major challenges in how to meet the care needs of increasing numbers of older people, particularly those with dementia. These realities will have a major impact across all aspects of the NHS and local government, and, most significantly, for older people and their families.

4. This high level strategy will provide the overall direction for the development and delivery of a very broad range of services to support successful ageing. It will:
    - describe the scope of services that should be considered;
    - propose the high level aims and objectives for service development;
    - identify the underlying principles for the development and delivery of services and the role of local government and the NHS;
    - outline the key policy developments that are driving service development.

5. This will give the framework within which a range of commissioning strategies will be prepared or, where there are already strategies, reviewed.

6. The preparation of the commissioning strategies should be done jointly across at least social care and NHS commissioning staff, older people and their carers, and much preferably on a broader basis involving the district and city councils for them to be effective, working strategic planning documents. An overall approach to partnership and joint working across the PCT and local government, and involving the voluntary sector, will be outlined. It will also require a careful examination of the formal and

informal joint commissioning and planning arrangements, and the structure of planning and commissioning teams across the county council's Social & Community Service and the PCT.

Aims and Objectives

7. An overarching statement of intent for successful ageing in Oxfordshire is proposed. It is: "*We celebrate the fact of our ageing population. We want all people as they age to lead lives that are healthy and personally and socially fulfilling. Our mission will be to achieve significant and measured improvement in how we plan and deliver services so that our community will be supported to age successfully*."

8. To achieve the mission statement the following overarching aims and objectives for services across Oxfordshire are proposed to ensure that:
   - the increased years of life are quality years, with people being as independent and as healthy as possible;
   - there is a significant reduction in health inequalities;
   - there is a greater range of high quality and effective preventative approaches;
   - more people with complex needs are able to live in their communities;
   - there is an increase in the restoration of independence following illness and injury;
   - there is greater choice and control by people who use services over service provision;
   - services are effective, efficient and high quality.

9. These aims and objectives will be delivered through a range of commissioning and other strategies and service plans, and underpinned by specific indicators and targets. These will support judgements about the effectiveness of the arrangements to reach the aims and objectives, and enable local government and the NHS to achieve their objectives in their community strategies, Local Area Agreements and other key performance management requirements.

10. These aims and objectives cover a very broad range of services from acute and emergency services, specialist healthy and social care services, to those that are not directly or specifically for older people. This includes activities and developments such as supporting and influencing the approaches that other agencies may take to their services. It will also inform the community development and community building work that the statutory agencies undertake or support. A key element in this is supporting citizens to take personal responsibility for their own health and care needs.

Scope

11. This high level strategy is not predicated on a single definition of what constitutes old age. The imposition of 65 years old as a definition of old age will ignore the reality of the aspirations and ambitions of people who

anticipate many years of active and fulfilling lives after their 60th year and the wish of many to extend their useful working lives; the evidence of the benefits of a range of preventative and health promotion services to people as they age through their 50's and 60's; and the reality of increasing frailty that has an impact on many people as they age beyond 75. There are also a number of benefits and provisions that come into effect at 60 and 65. Moving away from a fixed, single definition of what constitutes old age to one that is based on the needs of people as they age will give a better basis for realising the interconnectedness of a very broad range of services in improving and maintaining the quality of people's lives.

12. The evidence-base for commissioning strategies and plans that this high level strategy will drive is the evidence and experience that demonstrates success in meeting the needs of people as they age. For planning purposes three different age definitions will be used:

    - the age(s) at which age related benefits apply;
    - the age ranges regarding the incidence and prevalence of conditions associated with the ageing process. At present this will mean that 75 plus will be a working definition of old age for many health and social care services and possibly for housing authorities in considering the needs for sheltered and extra care housing;
    - the 50 plus population for preventative and early intervention services.

13. However the term older people will be used in this document and in other plans to refer to services for people aged 65 and above as a general description.

The Drivers (1) – needs and expectations in Oxfordshire

14. The overall demographic pressures are well documented. The key facts are as follows:

    - projecting an increase in over 65s of 12.9% between 2007-2012;
    - projected over 85's to increase by 15.6%;
    - greater increase is in the more rural district councils (15.3% for over 65's) compared with Oxford City (1.1%).

15. The JSNA contains a considerable amount of data on the issues facing people as they age. A detailed and thorough analysis of this and the data on needs, service provision and the gaps will be an essential part of the specific commissioning strategies. It suggests that there is likely to be an increase in the population of over 75's over the next few years. This increase in the older population will be uneven across the county, with the southern half of the county expected to show the largest increase in numbers. This area already has higher proportions of older people than average. The over 65's amount to more than 17% of the current population in West Oxfordshire and growth in the over 65's over the next 5 years is set to be highest in this district.

16. Although growth across Oxfordshire in the over 75 age group from 2007 to 2016 will be 13% this disguises large variations, with many localities

showing increases of over 40%, which represents a significant ageing of their local population. In some wards the over 75 age group is increasing at a much higher than average rate (more than 30%) and is also increasing as a proportion of the population (more than 27%).

17. The needs, wishes and expectations of older people and those in their 50's and 60's are clearly and strongly articulated. This is expressed through consultation processes and evidenced in research. This is an increasingly important driver of service developments.

The Drivers (2) – the Policy Framework

18. The policy framework for the development of health and social care services is extensive and is being actively pursued by the government. These developments have been clearly placed in the broader context of the reform of public services, including the requirement for strong and effective partnership arrangements, a strong enabling role for local government and facilitating community development. The implementation of choice and control for service users is seen as a one of the fundamental drivers for changes in service delivery.

19. The approach set out in this high level strategy is intended to give the basis of for the full and effective involvement of the district and city councils in the joint planning and commissioning arrangements. 'Strong and Prosperous Communities' and 'Lifetime Homes Lifetime Neighbourhoods' both emphasise the broader enabling role of the tiers in local government. Housing is very significant in this and the role of the district councils as strategic authorities is critical, and the contribution extends beyond this.

20. The national policy drivers are summarised in Annex 1.

Financial Resources

21. The overall investment in a preventative approach to secure successful ageing across the county council's Social & Community Services and the PCT is summarised in Annex 2. The overall expenditure is shown and then broken down in to the various expenditure blocks.

Implementation

22. This high level strategy will be taken forward through the preparation of commissioning strategies that set out the medium to long term objectives (15 years) and the short term action plans (3 years). This in turn will inform and drive the annual business plans of the agencies involved. A detailed timetable is being prepared which will cover the final work on this high level strategy and the specific commissioning strategies (outlined below) that will drive the implementation of the high level strategy.

23. A commissioning strategy is seen as being a formal statement of plans for securing, specifying and monitoring delivery of provision to meet people's needs at a strategic level. It applies to activities promoted and services provided by the local authorities, the NHS and the private and voluntary sectors. Its purpose is to effect change in the overall configuration and nature of provision across a broad range of actions to meet the needs of all those who fall within its scope. It is not a plan developed by providers of specific interventions but by those agencies with commissioning or enabling responsibilities.

24. The commissioning strategies for people as they age will cover:
    - all service requirements for the support, care and treatment services for older people in their own homes and community settings that are commissioned by the county council, district and city councils and the PCT;
    - the development of a broad range of preventative approaches and early intervention services;
    - NHS acute services that interface with provision for people in their own homes and community settings, to ensure and good quality hospital discharges, and to maximise the opportunities for rehabilitation and maintaining independent living.

25. The aims and objectives will therefore drive the planning, development and delivery of activities ranging from community-based preventative initiatives to the services of the acute sector.

26. The county council and the PCT are already committed to, or have produced, strategies or service development plans. The PCT's Operational Plan outlines its 'Better Deal for Older People' which will include work on:
    - integrated care pathway for fractured neck of femur;
    - community equipment retail model;
    - integrated care pathway for stroke;
    - a service specification for foot care for older people;
    - a service specification for continence services;
    - review of complex medication in care homes;
    - community-based Gerontology service;
    - continuing care.

27. The county council's Social & Community Services have or are developing plans for:
    - alternatives to residential care;
    - Extra Care Housing;
    - increasing specialist Older People with Mental Health (OPMH) needs residential provision and specialist OPMH support in people's homes;
    - developing alternatives to non-intensive home support services and increase the number of people accessing universal services;
    - improve access to appropriate levels of assessment;
    - developing preventative work/ support that delays or avoids the need for more traditional services;
    - the implementation self directed support in social care.

28. The county council and the PCT are both committed to increasing the support for carers and the development of a strategy for dementia services.

29. Effective strategic commissioning must also be based on achieving clearly articulated outcomes for the population and groups, and have a sound performance management framework through which progress will be driven. The strategies and development plans listed above should all be reviewed and written on this basis, and this approach should underpin the development of all future strategies.

Partnerships and Joint Working

30. The policy framework expects and assumes that commissioning, planning and development will be done through effective partnerships and other joint working arrangements. Important though the national framework is, such working arrangements are what people in Oxfordshire tell us they want to see happening.

31. The planning work summarised above would be significantly enhanced if there were stronger and more inclusive joint working and partnership arrangements in place with the district and city councils. Some of the objectives can only be achieved with this significant enhancement. The voluntary sector also has a crucial role in the development of strategies and the proper involvement of the voluntary sector must be established through the development of new arrangements for partnership and joint working.

32. The challenge facing all agencies and organisations is how to make the step change in we work together, to achieve the leap of imagination in how partnerships can be established so they can lead on the necessary changes necessary for outcomes to be reached and services delivered. The following principles should guide the development of partnerships and other joint working arrangements.
    - Commissioning is a joint priority for the PCT, county council and the district and city councils that is led by senior managers with the strategies endorsed at Board level.
    - All services and arrangements within the scope of the strategy, purchasing and contracting activity and in-house services and plans will be based on the priorities identified in the commissioning strategy.
    - The arrangements to develop and implement the commissioning strategy must be as open and transparent as possible, and designed to engage with people who benefit from support, carers, providers, clinicians and professionals as well as the wider community.
    - There will be the right level of skills, expertise and capacity in the commissioning function to support the lead commissioners.
    - Commissioning activities will be coordinated and scrutinised to ensure that policies and strategies meet the overall strategic aims and objectives, are based on evidence and implemented as planned.
    - Commissioning strategies should inform future budget setting forums and drive towards achieving best value.

33. The ambiguity that will arise from partners having both commissioning and provider roles will have to be managed through any partnership and joint working arrangements. This will apply to local government and the voluntary sector. This will be reflected in the governance arrangements and the scope of the commissioning strategies; they should cover and treat all service providers in the same way.

Next Steps

34. A full review of the current partnership and joint working arrangements between the PCT and Social & Community Services will be carried out. Discussions will be held with officers in the district and city councils to prepare proposals on the most effective joint planning arrangements across the PCT and local government in Oxfordshire.

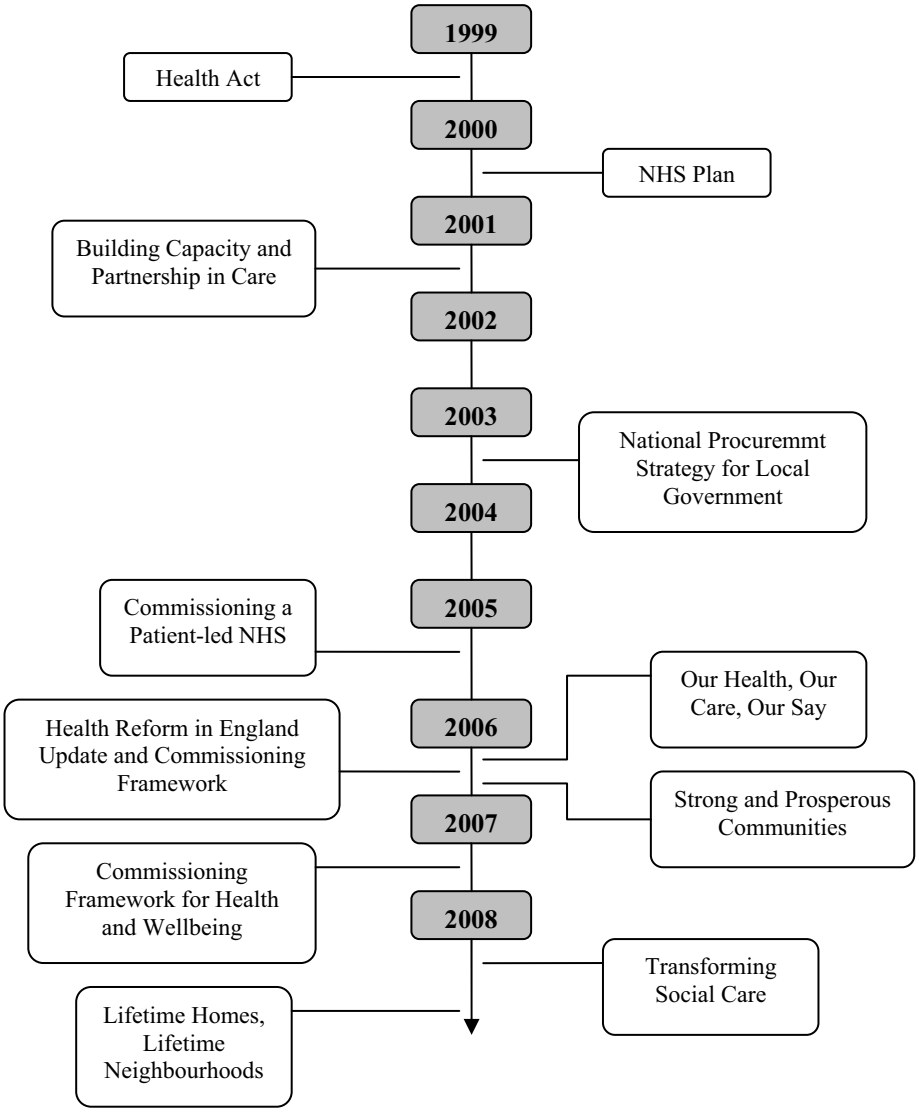
35. It is intended that the principles will inform the development of integrated joint planning arrangements between the PCT and Social & Community Services, and work on this will start now.

Recommendations

36. **The Health & Well Being Partnership Board is recommended to agree to the**:
    - **I. overall aims and objectives for preventative approaches for older people as given in paragraph 7 & 8;**
    - **II. scope of the high level strategy in paragraphs 11 – 13;**
    - **III. approach to implementation in paragraphs 22 – 25;**
    - **IV. principles and approach to joint working in paragraphs 30 – 33;**
    - **V. next steps in paragraphs 34 – 35.**

Annex 1

Summary of national policy drivers

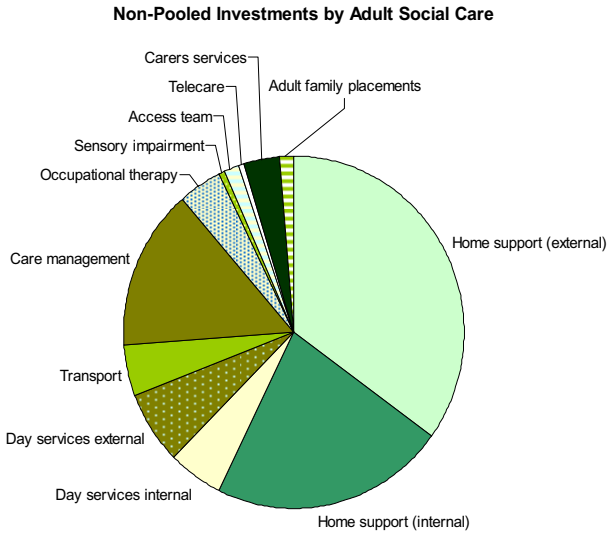


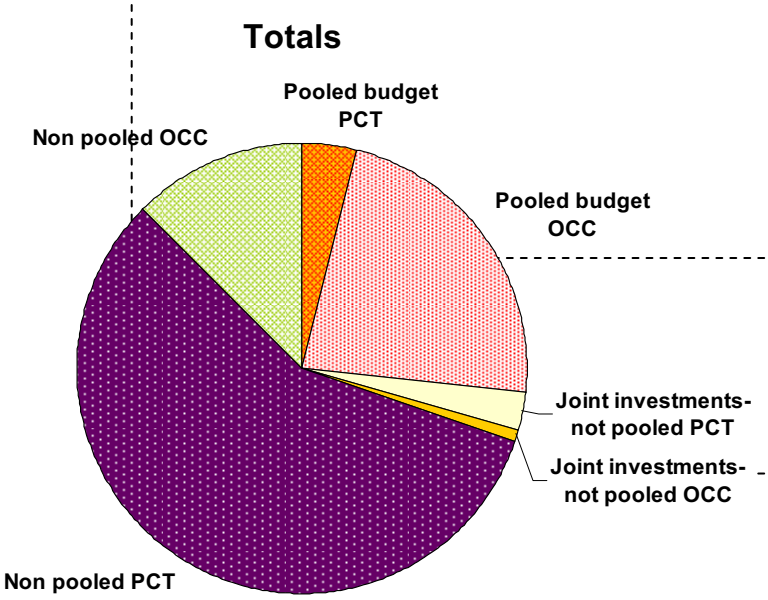
Annex 2

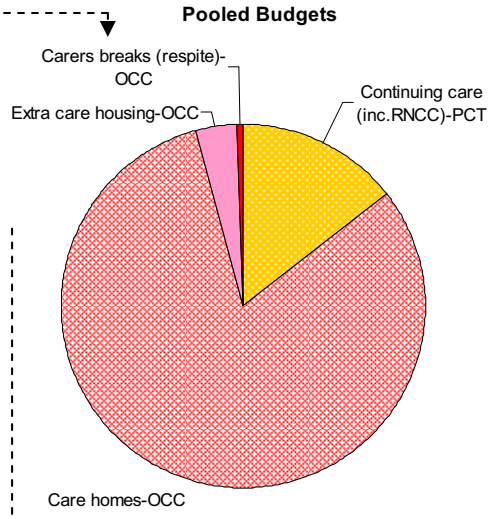
Financial Allocations

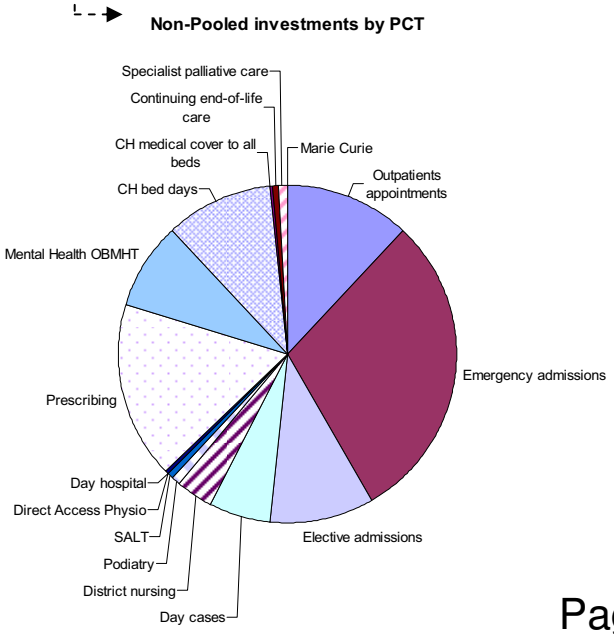
Health & Social Care spending pattern for 2007/2008

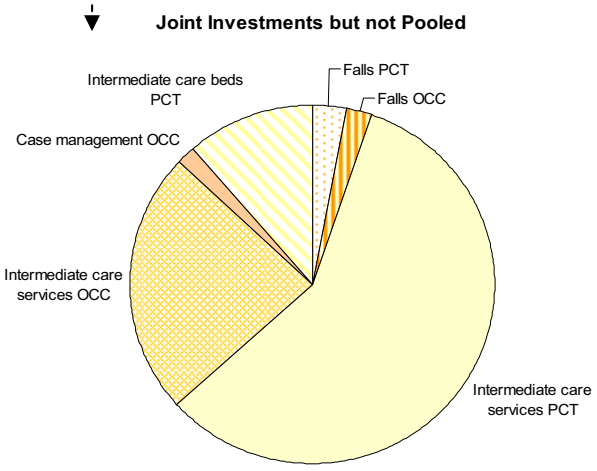
	Service area	OCC Expenditure	Activity	Health Expenditure	Health Activity	Total Expenditure
		£000		£000		£000
Pooled Budgets	Continuing care (including RNCC)			11,035		11,035
	Care homes	61,731				61,731
	Integrated Community Equipment					-
	Extra care housing	2,758				2,758
	Carers breaks (respite)	322				322
	Total	**64,811**		**11,035**		**75,846**
Joint investments but not pooled	Falls	215		330		545
	Intermediate care services	2,476		6,042		8,518
	Intermediate care beds			1,199		
	Case Management	150				150
	Total	**2,841**		**7,571**		**9,213**
Non pooled investments by PCT	**Acute Hospital care**					
	outpatients appointments			19,409		19,409
	emergency admissions			48,082		48,082
	elective admissions			16,136		16,136
	day cases			9,605		9,605
	Community interventions					
	district nursing			6,136		6,136
	podiatry			1,294		1,294
	SALT			627		627
	Direct Access Physio			26		26
	day hospital			551		551
	Prescribing			27,359		27,359
	Mental Health OBMHT specialist services OP			13,711		13,711
	Community Hospitals					
	bed days			16,497		16,497
	Medical cover to all beds			774		774
	End of Life care					
	Contiuing care EoL			739		739
	specialist palliative care			1,241		
	Mrie Curie			94		1,241
	Total	**-**		**162,281**		**162,281**
Non pooled investments by Adult Social care	Home Support (external)	12,518				12,518
	Home support (internal)	7,906				7,906
	Day services Internal	1,907				1,907
	Day services External *	2,358				2,358
	Transport	1,635				1,635
	Care Management	5,328				5,328
	Occupational Therapy	1,425				1,425
	Sensory Impairment	229				229
	Access Team	506				506
	Telecare**	224				224
	Carers services	1,150				1,150
	Adult Family Placements	495				495
	Total	**35,681**		**-**		**35,681**
Total for Health &		**103,333**		**180,887**		**283,021**


Non-Pooled Investments by Adult Social Care
Carers services
Telecare
Access team
Sensory impairment
Occupational therapy
Adult family placements
Home support (external)
Care management
Transport
Day services external
Day services internal
Home support (internal)


Totals
Pooled budget PCT
Non pooled OCC
Pooled budget OCC
Joint investments- not pooled PCT
Joint investments- not pooled OCC
Non pooled PCT


Pooled Budgets
Carers breaks (respite)-OCC
Continuing care (inc.RNCC)-PCT
Extra care housing-OCC
Care homes-OCC


Non-Pooled investments by PCT
Specialist palliative care
Continuing end-of-life care
CH medical cover to all beds
Marie Curie
CH bed days
Outpatients appointments
Mental Health OBMHT
Emergency admissions
Prescribing
Day hospital
Direct Access Physio
SALT
Podiatry
District nursing
Day cases
Elective admissions


Joint Investments but not Pooled
Intermediate care beds PCT
Falls PCT
Falls OCC
Case management OCC
Intermediate care services OCC
Intermediate care services PCT

Oxfordshire County Council & Oxfordshire PCT

Proposal for Integrated Planning and Commissioning Arrangements for Ageing Successfully.

Introduction

This paper sets out proposals for integrated commissioning arrangements between Oxfordshire County Council and Oxfordshire PCT for the implementation of the Ageing Successfully strategy. The Ageing Successfully strategy is a high level strategy that was discussed and agreed by the Health and Well Being Partnership Board in April 2009. The strategy is predicated in close partnership working, and a subsequent paper has been approved by senior managers from the PCT, SCS and the District Councils which set out the options for and the principles underpinning the development of partnerships to take the strategy forward and drive its implementation.

Agreement that the overarching Ageing Successfully strategy will be implemented through four themed commissioning strategies. These are:

- effective prevention and well-being (*Prevention and Well Being strategy*);
- more personalisation and services that are more responsive to each person's needs (*Personal and Responsive Service strategy*);
- greater Levels of independence for people as they age in their own homes, and effective recovery and rehabilitation after illness or injury (*Achieving and Maintaining Independence strategy*);
- making the best use of resources across the health and social care systems (*Resources Strategy*).

These themes will support and facilitate better engagement with partners in the District and City Councils.

It was also agreed that consideration should be given to any new joint integrated arrangements being set out in and supported by a formal agreement under s75 Health Act [date] at least between the County Council and the PCT and possibly with the District and City Councils.

The Ageing Successfully strategy has significant implications for the commissioning, contracting and services for people as they age. The central tenet and the overall approach of the strategy is not to have a single definition of old age, but to focus on the evidence of the impact of medical, personal and social factors on people's live as they age and their ability to live independently. The strategy therefore takes an integrated view of services and arrangements through adult life up to death.

This approach means that the evidence of medical conditions and social and personal circumstances that are age related could be covered by the arrangements for the development and implementation of the Ageing Successfully strategy, irrespective of the age of onset for any particular adult. This will impact on and be reflected in the developments that are proposed for the current pooled budget and s75 arrangements between the County Council and the PCT.

The changes outlined in this paper are potentially very far reaching and substantial. A time line is given that sets out in outline a number of stages. Each of these is seen as being of value and will make an improvement in the arrangements and services for people as they age as well giving a basis for further development. This does envisage an iterative process. It will be important to ensure that there are points in the process for review and deciding on when to take the next step and what the destination is.

Proposals

The proposals cover four areas:
- establishing a single integrated team for commissioning services for older people;
- expanding the scope of the current s75 arrangements;
- structure and governance arrangements involving a high level Policy Board and sub committees to develop and deliver services;
- an option for the integration of contracting and contract management and other support functions.

The starting points for the proposals are the:
- agreement that there should be a new joint strategy for Oxfordshire for services for people as they age;
- decision by the PCT that there should be a new post, joint with the County Council SCS at a senior level for commissioning services for older people and it is assumed that this post will take forward the Ageing Successfully strategy. It is proposed that the title of this post reflects the approach of the Ageing Successfully strategy rather than simply referring to 'older people'. In this paper the post will be referred to as the Joint Post.

Establishing a Single Integrated Team

It is proposed that a single integrated core team is established with a wider number of support teams working on a project or thematic basis made up of colleagues from across the NHS, County Council and District Councils. The core integrated team will oversee and coordinate the work of the support teams and of the sub committees that are proposed below. It is also proposed that the Joint Post heads up and is the senior manager for the single integrated core team.

The rationale for establishing an integrated core team is that it:
- is the most effective way of making the most effective and efficient use of scarce commissioning resources;
- gives the best basis for establishing joint strategies and service development options;
- is an effective way of coordinating and managing the contribution of the wide range of agencies and organisations that are necessary to achieve the implementation of Ageing Successfully;

- the present Comprehensive Spending Review runs until 2011 and it is widely anticipated that the financial settlements that follow on from will be very tight and it is important that there is a sound joint strategy in place that identifies the agreed objectives and priorities for the services and drives the work across the NHS and local government to achieve them.

The four themed commissioning strategies will have to be prepared on the basis of a broad partnership across the PCT, the County Council and the District Councils and in close discussion, and consultation with NHS providers, the voluntary sector, and third sector and for profit sector organisations across social care, health and a range of community services.

The Integrated Core Team

This team should be an integrated, single team under the Joint Post with equal accountability to the County Council and the PCT for the:

- delivery of agreed joint strategies;
- development of services to achieve the objectives of the joint strategy;
- purchasing and arranging of services from provider organizations;
- support for the Policy Board and its sub committees that the Policy Board oversees.

It is proposed that the Core Integrated Team would be made up of people seconded to the team and the organization that takes on responsibility for it. It is to be decided if this would be the County Council or the PCT. Staffing arrangements should be considered in detail during the first year of the team's existence to and proposals for the best longer term arrangements prepared.

The Joint Post and the Integrated Core Team will have overall responsibility for:

- overseeing and coordinating activity across a wide range of work streams delivered through the support teams and sub committees of the Policy Board;
- overseeing the implementation of service and other developments itself and through its partner organizations.

The main responsibilities for the Joint Post and the Integrated Core Team will be to:

- develop the four themed commissioning strategies that between them will deliver the overarching vision of Ageing Successfully;
- oversee and coordinate the activities of the various teams and services across the PCT and the County Council that are necessary for delivering the Ageing Successfully Strategy;
- prepare proposals for the County Council's and the PCT's policy making and budget setting processes;
- work with and support operational management on the preparation of annual business plans;
- oversee and monitor the implementation of developments;
- monitor and review progress against the objectives of the commissioning strategies.

The core integrated team should include:

- The Joint Post;
- Finance support;
- Specialist drawn from staff currently working on the development of or commissioning services for older people;
- Administrative support.

The Support Teams

Because the Ageing Successfully vision and the four thematic commissioning strategies require the involvement of and contributions from people across a wide range of teams or services in the PCT and the County Council, and because there are very few staff across the PCT and SCS who are dedicated to and focused solely on commissioning for services for older people, the integrated core team that will have to call on the support and contributions from a wider network to achieve its objectives. The range of services, teams and organizations that have to be involved is considerable. The initial, headline list includes the following.

County NHS:	All division in SCS; Supporting People (as Administering Authority);
PCT	All divisions across the PCT;
Districts	Housing, well being and leisure services.
Voluntary sector	Age Concern Oxfordshire, Alzheimer's Disease Society.
Provider services in the NHS	ORH, OBMHT, Ridgeway Partnership;

It is considered to be too disruptive to separate out the work and contributions of staff across this wide range of services into discrete posts that could become part of a single extended team, probably impossible to do sufficiently accurately, and ultimately undesirable because of the evolving and wide ranging requirements of the Ageing Successfully strategy.

It is proposed that there should be an agreement between the County Council, the PCT and the District Councils covering the establishing of the Support Teams, which could be included in a S75 agreement. The table above gives an indication of the scope of the arrangements to be covered.

The work for the Support Teams and the arrangements for the involvement of the Integrated Core Team would be set out in an annual work plan prepared by the Joint Post.

Governance Arrangements

The governance arrangements for the Integrated Team will have to be in place at the same time as the team is established. They could be included in the overall s75 arrangements proposed below.

Expanding the s75 Arrangements

The current s75 arrangements establish a pooled budget for services for older people and the arrangements have served the County Council and the PCT well. The pool has been added to considerably since its inception but it has operated without the benefit of an overarching strategy agreed by the two partners to the agreement.

The Ageing Successfully strategy and the four thematic strategies will become the over arching strategic framework. To maximise the potential that this approach will have the following three developments are proposed.

- The s75 arrangements should be developed to formally include commissioning and planning services.
- Commissioning for long term conditions and physical disability services for adults should be covered by an expanded arrangements and s75 agreement.
- There should be pooled budget arrangements that would cover the County Council's and the PCT's spending on the range of services and activities covered by the current s75, funding for long term conditions and physical disability and funding for services for age related conditions.

Governance Arrangements

The arrangements proposed in this paper will involve a very wide range of stakeholders which are summarised in the table below. This table is very much work progress and will require more work to ensure that the range of stakeholders are properly listed and to ensure appropriate involvement in the governance arrangements.

OCC	PCT	Districts	Others
SCS Community Safety E&E Public Health Procurement JMG Pooled budget for older people	Public Health Strategy Commissioning JMG Pooled budge for older people Acute sector commissioning	Well Being Housing	Age Concern Oxfordshire NHS providers Voluntary sector and third sector

The governance arrangements proposed are as follows.

<u>Policy Board</u>

It is important that there is proper high level oversight of these arrangements. This could be through the Health and Well Being Partnership Board or it could be newly constituted Policy Board. This will can be considered in detail later. A Board at this level should be established to oversee and agree the strategic direction for all the joint arrangements for the Ageing Successfully strategy. It will have reporting to it three sub committees, which could be seen as being

Joint Management Groups, and a Management Board for the Joint Integrated Team.

The Board will oversee the work of the Management Board and the Integrated Team and the sub committees. It will agree:

- The objectives and the priorities for the sub committees, the Management Board and the Team annually for the next [3]years on a rolling basis;
- Agree the annual plan for the sub committees Management Board and the Team;
- Receive reports from the Integrated Team Manager on: the team's performance against the objectives and priorities, proposals for the further development of the commissioning strategies for Ageing Successfully and use of the team's resources;
- Receive reports from the sub committees on their progress on establishing and implementing service developments and their use of resources.

If it is a new Policy Board its membership would be:

- OCC Cabinet member and PCT Non-executive Board member;
- Director of SCS and PCT Director of Commissioning;
- OCC and PCT Director of Public Health;
- Representatives of the District Councils;
- Representatives of service users.

The Board would be supported by the Joint Team Manager who would be in attendance and have in attendance the chairs of the sub committees. The Board would also have in attendance the OCC Head of Service for Adult Social Care and other senior officers from the PCT. It would be chaired by the OCC Cabinet member and the PCT Non Executive alternating annually.

The Policy Board would meet quarterly for the fist year of the arrangements which could then be reviewed.

<u>Management Board</u>

The management board will be responsible for the team achieving its objectives and priorities and agreeing what resources will be available to the Team's manager. It will:

- Propose to the Board the team's objectives and priorities;
- Agree the resources for Joint Team Manager;
- Monitor and review the team's performance against agreed objectives;
- Set specific targets for the team's Manager;
- Receive regular reports from the team's Manager;
- Ensure that there are effective arrangements in place for supporting the work of the sub committees.

The Management Board's membership would be:

- The SCS Head of Adult Social Care and the PCT Director of Commissioning;
- Financial advisors
- The Joint Team Manager.
- Representative[s] of the District Councils;

- Representatives of the sub committees.

The Management Board would be supported by the Joint Team Manager.

Structure

The proposed structure in diagram 1 below is intended to support the following key processes and responsibilities.

- The Board has overall oversight and accountability to the County Council Cabinet and the PCT Board.
- The Management Board oversees the work of the sub committees and oversees and the work of the Joint Integrated Team.
- The Joint Team Manager establishes his/her own arrangements for the Team's management. The Manager will oversee and coordinate the work of the Support Teams and ensure that they as well as the core team are properly linked to and work with the sub committees
- The Pooled Budget sub committee will be responsible for the use of the pooled funds.
- The sub committees will be responsible for the preparation and plans and strategies for the development and delivery of services through the four thematic strategies that deliver the overall Ageing Successfully strategy.

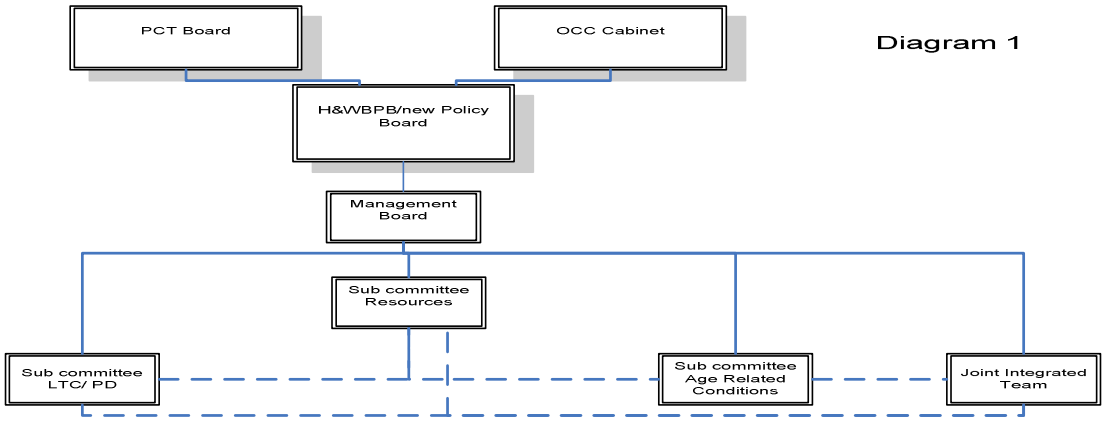


Diagram 1

Contracting and Contract Monitoring and other support functions

Expanding the scope of the s75 arrangements and the size of the pooled funds in the ways proposed in this paper will require different arrangements for financial and activity monitoring.

Contracting and contract monitoring are crucial to the effective implantation of strategies and the delivery of services. If the approaches and arrangements outlined here are implemented agency and service boundaries will change and agency boundaries become blurred. Consideration should be given to joining the contracting and contract management functions across the Social and Community Services and the PCT.

Implementation

The implementation of these proposals will require detailed work to be carried out in a number of areas. These include:

- Agreeing on the age related services and their budgets;
- Agreeing the basis of putting the integrated team in place, and in particular if staff are seconded to transferred and establishing proper consultation arrangements;
- Establishing monitoring and reporting processes;
- Establishing the support groups for the core team;
- Considering the best arrangements for contracting and contract management and procurement;
- Drafting possible s75 agreements.

The above list is not exhaustive.

The implementation of these proposals will be phased, with each phase resulting in improvements in the arrangements as well as laying the basis for further development and implementation. A project plan will be prepared on the basis of the responses to these proposals. A possible timetable is outlined below.

Time table

Phase 1 puts the governance, staffing and work streams in place to deliver the joint Ageing Successfully strategy in April 2010. Phase 2 is given in outline only.

Phases	Completion date	Comments
Phase 1		
Establish and appoint to Joint Post	In post during December 2009	Dependent on advertising before end of July.
Identify core team, consult and establish.	October 2009	Subject to the appointment of the Joint Post, the core team could be assembled and temporarily work under an SCS or PCT senior manager or NW could take on this role.
Preparing the foundations; establish work streams to • finalise governance arrangements and ToR; • identify key staff from across the	July 2009 September 2009	This area of work can be undertaken and coordinated by NW.

partner agencies to take forward wider partnership working; and • establish arrangements for preparing the 4 thematic commissioning arrangements. • identify age-related conditions to be included and their budgets.	October 2009 October 2009	
Thematic commissioning strategies agreed	April 2010	In place to drive and support preparation for 2011 CSR
Phase 2		
Review options for s75 development and implement		
Consider options for integrating contract functions and procurement		
Full involvement in budget setting and financial and activity planning		
Implementation of year 1 plans in the Ageing Successfully strategy		
Monitor and review, update strategy		

Nick Welch
Head of Major Programmes
27/05/09; v2 9/6/09; v3 16/6/09; v4 18/6/06

This page is intentionally left blank