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Notice of a Meeting

Adult Services Scrutiny Committee
Tuesday, 6 March 2012 at 10.00 am
County Hall

Membership

Chairman - Councillor Don Seale
Deputy Chairman - Councillor Mrs Anda Fitzgerald-O'Connor

Councillors:	Jenny Hannaby	Larry Sanders	Alan Thompson
	Ian Hudspeth	Dr Peter Skolar	David Wilmshurst
	Peter Jones	Richard Stevens	

Notes:

Date of next meeting: *24 April 2012*

What does this Committee review or scrutinise?
- Adult social services; health issues;

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 Don Seale E.Mail: don.seale@oxfordshire.gov.uk
Committee Officer	-	*Simon Grove-White, Tel: (01865) 323628* *simon.grove-white@oxfordshire.gov.uk*

Peter G. Clark.

Peter G. Clark
County Solicitor

February 2012

About the County Council

The Oxfordshire County Council is made up of 74 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 630,000 residents. These include:

schools	social & health care	libraries and museums
the fire service	roads	trading standards
land use	transport planning	waste management

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

About Scrutiny

Scrutiny is about:

- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:

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

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. 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

3. Minutes (Pages 1 - 6)

To approve the minutes of the meeting held on January 17th 2012 (**AS3**) and to receive information arising from them.

4. Speaking to or petitioning the Committee

5. Director's Update

10:00

The Director for Social & Community Services will give a verbal update on key issues.

6. The new agenda for "Health social care and wellbeing in local government" (Pages 7 - 34)

10:30

Jonathan McWilliam, Director of Public Health, will present to the committee in the new agenda for Health and Social Care in local governement

7. Waiting lists in Adult Social Care (Pages 35 - 38)

11:00

John Dixon will update the committee on waiting lists in Adult Social Care.

8. Day Services - Tier 3 Services and Transport (Pages 39 - 48)

11:30

Simon Kearey, Head of Strategy and Transformation, will give an update on current progress within the day services programme. The key areas covered will be Tier 3 services and Transport.

9. Quality Assurance and Monitoring (Pages 49 - 54)

12:15

Sara Livadeas, Deputy Director for Joint Commissioning, will present proposals to the committee on ensuring quality and developing a robust monitoring framework for commissioned services.

10. LINk Update (Pages 55 - 56)

12:45

The committee will receive an update on the local involvement network.

11. Forward Plan

12:55

The Committee is asked to suggest items from the current Forward Plan on which it may wish to have an opportunity to offer advice to the Cabinet before any decision is taken, together with details of what it thinks could be achieved by looking at any items.

12. Close of Meeting

13:00

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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ADULT SERVICES SCRUTINY COMMITTEE

MINUTES of the meeting held on Tuesday, 17 January 2012 commencing at 10.00 am and finishing at Time Not Specified

Present:

Voting Members:	Councillor Don Seale – in the Chair
	Councillor Mrs Anda Fitzgerald-O'Connor (Deputy Chairman) Councillor Jenny Hannaby Councillor Ian Hudspeth Councillor Larry Sanders Councillor Dr Peter Skolar Councillor Richard Stevens Councillor Alan Thompson Councillor David Wilmshurst Councillor Hilary Hibbert-Biles (As substitute for Councillor Peter Jones)
Other Members in Attendance:	Councillor Arash Fatemian
By Invitation:	
Officers:	
Whole of meeting	John Jackson Sue Scane Nick Graham Christian Smith Simon Grove-White (minutes)
Part of meeting	

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.

188/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Peter Jones sent apologies. Councillor Hilary Hibbert-Biles attended as a substitute.

189/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE
(Agenda No. 2)

The Chairman declared an interest as the cabinet member when the partnership was founded.

Councillor Jenny Hannaby declared an interest as a trustee of the Wantage Care Home.

190/12 MINUTES
(Agenda No. 3)

The minutes of the meetings of December 6th and December 15th were approved and signed.

191/12 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

192/12 DEVELOPMENT IN THE OXFORDSHIRE CARE PARTNERSHIP AGREEMENT
(Agenda No. 5)

EXEMPT INFORMATION

It was resolved that the public be excluded for the duration of item 5 (since it is likely that if they were present during that item there would be disclosure of exempt information as defined in Part I of Schedule 12A to the Local Government Act 1972 (as amended) and specified below in relation to that item and since it is considered that, in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information on the grounds set out in that item.

THE REPORT RELATING TO THE EXEMPT ITEM HAS NOT BEEN MADE PUBLIC AND SHOULD BE REGARDED AS STRICTLY PRIVATE TO MEMBERS AND OFFICERS ENTITLED TO RECEIVE IT.

The committee were invited to examine the principles for developing the Partnership Agreement with the Oxfordshire Care Partnership and specific service developments to achieve service and financial objectives of the Council and the Oxfordshire Care Partnership.

The information in this case is exempt in that it falls within the following prescribed categories:

3. Information relating to the financial or business affairs of any particular person (including the authority holding that information)

and it is considered that, in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information, in that otherwise commercially sensitive information would be disclosed to the detriment of the companies involved.

Councillor Stevens **AGREED** to submit his concerns to the Monitoring Officer for a response. This correspondence has been shared with members of the committee, who will be updated on the progress of negotiations at the next meeting of the committee.

A vote was taken to accept the principles of the report. The committee voted in favour by margin of 6 to 2.

193/12 CLOSE OF MEETING
(Agenda No. 6)

..... in the Chair

Date of signing .....

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

Document is Restricted

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Adult Services Scrutiny Committee

6th March 2012

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

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

1. Introduction

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

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

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

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

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

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

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

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

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

Purpose of this Report

1.10. This paper has 3 purposes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The particular opportunities open to Oxfordshire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

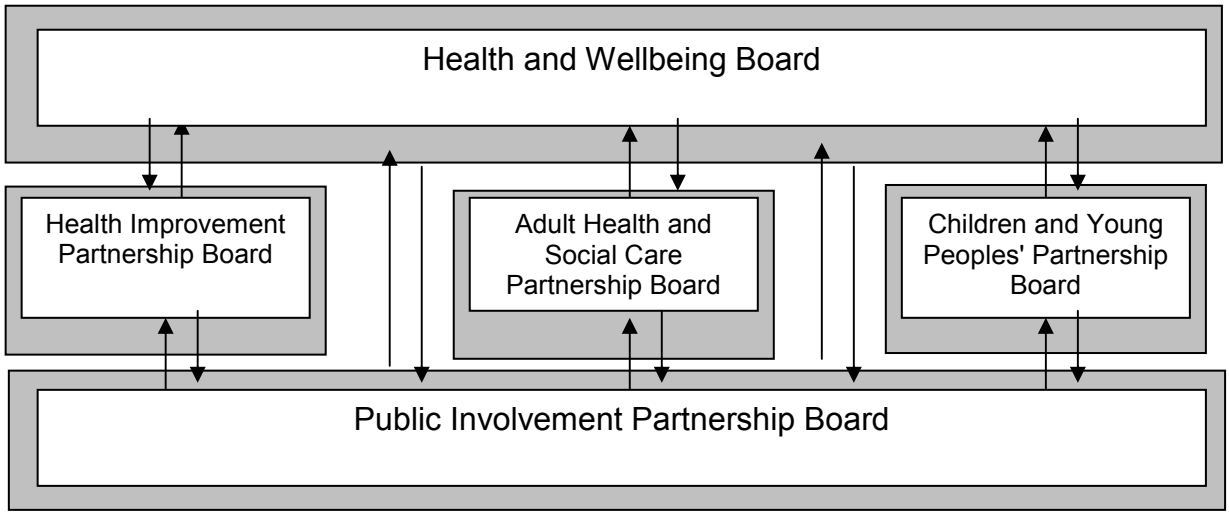
- The H&WB is also accountable for producing a joint health and well-being strategy. This is again a joint effort between local government and Clinical Commissioning Groups. Priority setting for a first health and well-being strategy for Oxfordshire is currently underway and the first strategy will be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

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

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

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

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



5. The new remit public health remit for local government

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

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

The public health role in leadership and strategic Influence

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

The direct commissioning role of public health

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

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

Public Health Services Proposed for commissioning by Local Authorities

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

The local authority public health role in Health Protection and Emergencies

5.6. This role has three elements:

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

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

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

5.7. E.g.

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

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

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

Mandatory advice and support to Clinical Commissioning Groups from public health

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

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

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

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

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

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

6. The role of services for children and young people

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

a) A leadership and oversight role.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h) Allowing the funding to follow the patient;

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

j) Sharing best practice and breaking down barriers.

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

8. Developments in Adult Social Care

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

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

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

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

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

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

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

Clinical Commissioning Groups (CCGs)

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

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

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

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

The Oxfordshire-Buckinghamshire NHS cluster (the former PCTs)

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

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

Commissioning Support Services

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

9.9. These organisations will go live in April 2013.

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

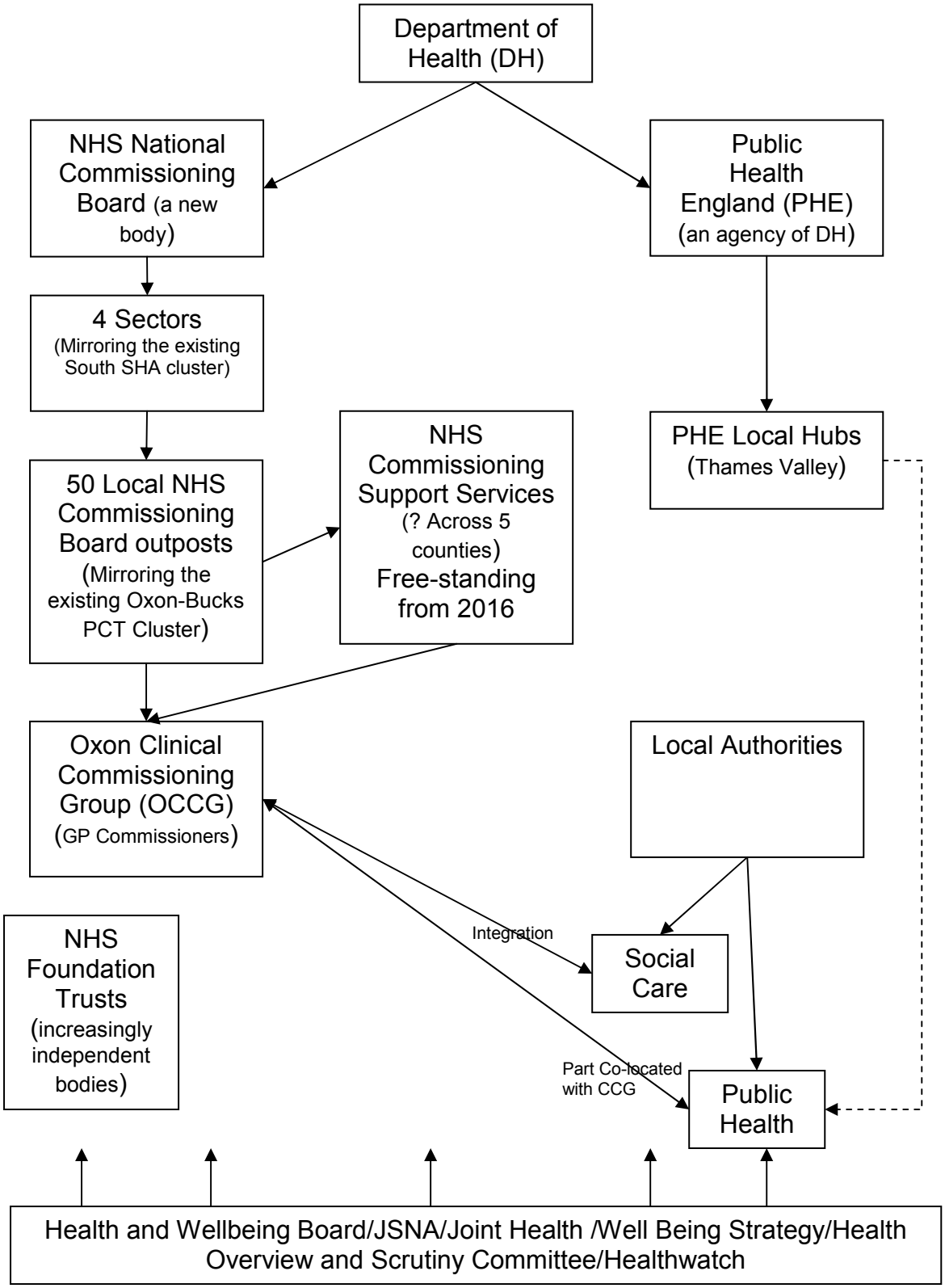
9.11. Commissioning Support Services will become increasingly commercialised and are expected to be freestanding bodies in the marketplace from 2016 at the latest.

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

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

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

NHS and Local Authorities: Architecture from April 2013



10. Implications for the scrutiny function

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

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

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

11. The role of District Councils

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

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

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

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

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

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

12. Implications for Public Involvement, and Localism

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

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

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

Implications for the New Roles of Upper Tier Local Authorities

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

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

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

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

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

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

Implications for the day to day work of the County Council

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implications for the County Council workforce of the future

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

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

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

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

14. Conclusions

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

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

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

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

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

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

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

February 2012

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

The Health and Social Care Bill

Factsheets about the health and social care bill

The Future Forum

Summary of future forum report

Government response to future forum

Overview of all Public Health Services

Public Health Services in England

Letter - Public Health in England

Public Health in Local Authority

Public Health in Local Authority

Public Health Outcomes Framework

Workforce - public health staff transferring to LA

Public Health England

Public Health England operating model

A new service to get people healthy

Public health England - timeline

Social Care Papers

Caring for our future

Improving Health Outcomes for Children

NHS Commissioning Board

Developing the NHS commissioning board

Developing the NHS Commissioning Board - update

Clinical Commissioning Groups

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

Health and Well Being Board

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

Health and Well Being Strategy/Joint Strategic Needs Assessment

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

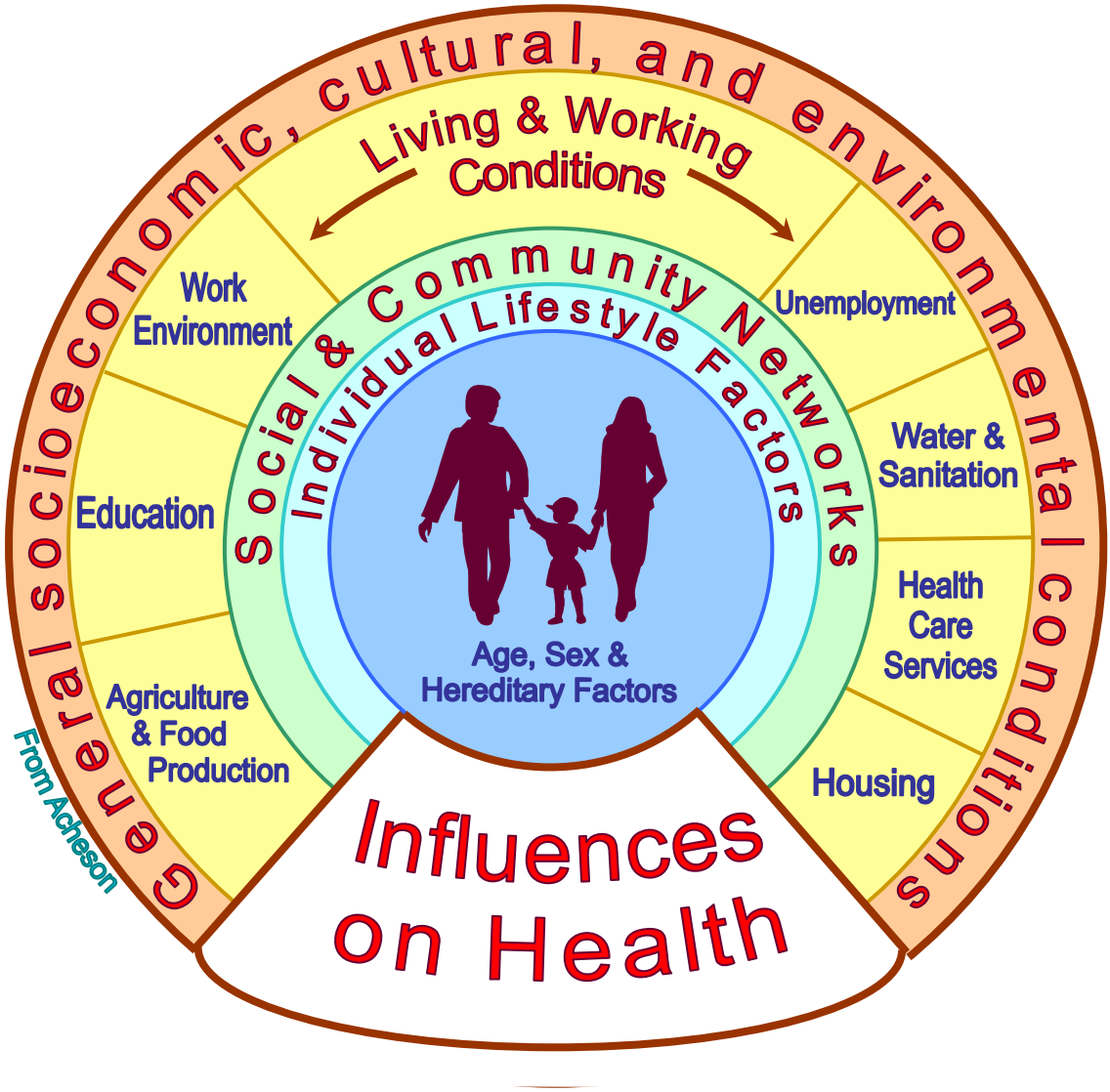
Healthwatch

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

NHS Workforce development

- Liberating the NHS workforce

Annex 2 – Broader Determinants of Health diagram.



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

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

Summary of responsibilities

1. **Health and Wellbeing Boards**

Establishment of the H&WB Board

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

Functions of Board

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

Associated functions

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

Ensuring alignment of commissioning plans

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

2. **Clinical Commissioning Group**

Establishment of H&WB Board

- Duty to send representative to H&WB Board

Functions of H&WB Board

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

Other associated functions

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

Ensuring alignment of commissioning plans

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

Other duties, contributed through JSNA and JHWS

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

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

Establishment of H&WB Board

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

Functions of H&WB Board

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

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

Other associated functions

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

4. **NHS Commissioning Board**

Establishment of H&WB Board

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

Functions of H&WB Board

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

Other associated functions

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

5. **Local Healthwatch**

Establishment of H&WB Board

- Duty to send representative to H&WB Board

Functions of H&WB Board

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

Ensuring alignment of commissioning plans

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

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People waiting for Adult Social Care in Oxfordshire

Introduction

1. The council aims to help people remain as independent as possible by supporting a range of services in local communities which are open to all (such as lunch clubs) and services targeted to specific individuals to help them remain independent or gain independence following an incident (e.g. fall) or period of ill health. However some people will need on-going support.

2. The process by which a person receives on-going support is known as 'self directed support' (SDS) and is shown diagrammatically in annex 1. When a person approaches the council for help we will provide information on local services that may be able to help people remain independent. If a person needs more targeted support we will organise short term services such as therapy or helping people become able to undertake daily living tasks, such as dressing, feeding and washing. These services are offered to all people. If a person needs on-going support, their needs will be assessed and if the needs they have meet the criteria for providing care, a budget will be provided for the person to purchase this care. At the same time the person will be financially assessed to determine how much they need to contribute to their care. The budget provided is called a personal budget. The person can then choose to take this as cash and organise the care for themselves, or ask the council or other person to organise this care. However this care is organised, a support plan will be produced with the person agreeing how the services purchased will meet their needs. This will be regularly reviewed and the result of the review could change the level of the budget e.g. as a person gets better the budget may reduce or stop completely.

3. There are currently around 5,500 people in Oxfordshire receiving on-going support from the council. Between April 2010 and January 2011
    - 5,825 new people were assessed (132 people per week)
    - 1,466 people started long term services (33 people per week)
    - 4,675 people were reviewed (106 people per week).

4. Nationally there has been significant demographic pressure on adult social care, with a growing elderly population and advances in health that mean people with a disability live for longer. The population estimates for Oxfordshire show that between 2008 and 2033, the population of people over 65 will increase by 75,000 or 77%; the population of people over 85 will increase by 265% and the population of people over 90 will increase by 367%. This is shown in table 1 In addition to this in 2011/12 we have seen increased referrals for services over and above that which would be expected by the simple increase in population.

Forecast population change in Oxfordshire 2008 - 2033

	2008	2033	Difference	% difference
People aged over 65	96,600	171,200	74,600	177
People aged Over 85	14,200	37,600	23,400	265
People aged Over 90	4,600	16,900	12,300	367

Recent Service Changes

5. The last 18 months have been a time of significant change in adult social care. The process of SDS described above was implemented across Oxfordshire in 2010/11. This led to the decision to close the internal home care service last year and the re-organisation of social work teams. During these changes we were concerned that it would take some people longer to get services than had previously been the case.

6. The process of SDS originally implemented needs to be simplified, work on this has begun, but further work is still needed.. Some significant changes have already been made e.g. devolving budgets for care to a team level to remove unnecessary processes. This has seen the number of people waiting for care in their own home drop by over 60% since June. Options for further change were presented to senior managers in February, and proposals for improvement are included in paragraph 13 below.

7. The original restructure of teams has been reviewed. In order to ensure people are reviewed in a timely manner we have introduced additional specialist reviewing officers. This will allow more specialist staff to have smaller caseloads of around 25 people with a much quicker turnover of work. Significant training is being provided to non-specialist staff, which, while reducing the time these staff have to spend with clients at present, does mean that their skills will improve and timeliness increase.

8. The closure of the internal home care service is now complete. All recipients of service have now moved to new providers. The council has also retendered its external home care contracts and has purchased significantly more home care this year. We are now purchasing over 20% more home care hours for older people than the same time last year at 18% lower cost per hour than this time last year, with new providers who need to staff up appropriately for the new demand.

Timeliness of Services

9. Last year the council took part in a national survey on social care. 90% of the people in Oxfordshire who responded to the survey (over 550 people) were satisfied with services, with 59% being very satisfied. Locally in Oxfordshire we wished to check how happy people were with the speed of our response, so we asked extra local questions including a question on timeliness. Most people were happy with the time taken to receive a service, 53% saying it was received as quickly as possible, and another 33% citing minor understandable delays. However only 15% of people said at least one part of the process took longer than expected, with just 4% saying everything took longer.

10. When people are waiting to receive the most appropriate care, they will still be supported as appropriately by the council. Locality teams work a prioritisation system of urgent, high, medium and low priority cases. Urgent cases are allocated immediately and not put onto the waiting list. This includes any safeguarding cases and work under the Police and Criminal Evidence Act. High priority cases identified as next to be seen should be picked up within 14 days,

and where they cannot are managed within the duty system (i.e. the social workers taking urgent calls). The duty team will ensure any urgent care needs are addressed, or if appropriate a person can be started or fast tracked for equipment. Other high priority cases may wait. Medium priority cases identified as next to be seen should be seen within 28 days. Most people waiting for care at home or in a care home are currently in receipt of services, but need a more appropriate service.

11. We are currently reviewing whether an interim payment can be made at the end of the assessment as the support plan is being drawn up, so that people can receive immediate financial help which would be reviewed when the assessment is made.

Delayed Transfers of Care

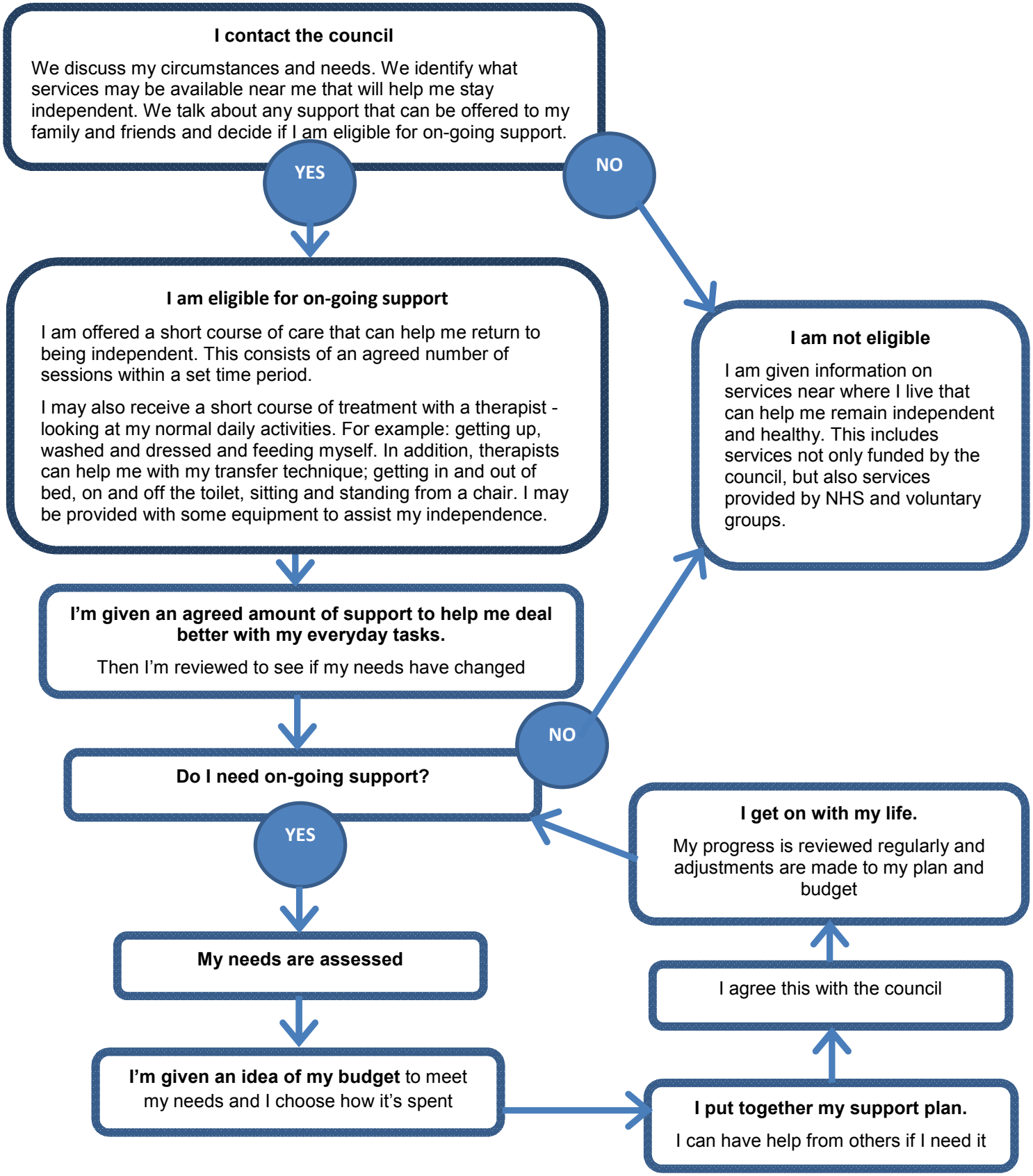
12. People who are classed as delayed transfers of care are people who are in a hospital bed when it is not the most appropriate setting for their care. They could be waiting for on-going social care or on-going health care. Those waiting for on-going social care will be included above. The most recent published figures for delayed transfers of care are for the end of January and show that in Oxfordshire 176 people were delayed transfers of care on the last relevant snapshot day of that month. Of these 39 were due to social services (27 waiting for care homes, 7 for assessment, and 5 for care at home). A further 43 were waiting for both social care and health care of who 34 were waiting for reablement, 5 for care homes and 4 for assessment.

Next steps

13. The key next steps are
    - To continue to work in partnership with the NHS to improve the effectiveness and efficiency of the reablement service run by Oxford Health, this provides time-limited support to help people recover after a period or incident of ill health. We need to ensure more people are seen by the service and that at the end of their time with the service more people have returned to full independence.
    - Within the Appropriate Care for Everyone (ACE) programme ensure we move people away from bed based services to services in their own home where this is appropriate.
    - Redefine the work of locality teams to focus just on people eligible for SDS and diverting single service clients to local community based services, alongside the provision of good quality information and signposting to services for everyone
    - Continue to simplify the SDS process
    - Continue to clean up and reduce the assessment waiting list
    - Implement new locality reports on service recipients and waiting lists
    - Improve case recording and reporting with the implementation of the new Adult Information System
    - Commissioners to work to identify shortages in domiciliary agency capacity in local hot spot areas and work with provider market to incentivise an increase in capacity and quality e.g. reducing the time between notification of a new client and starting to provide them with care.

Annex 1

PROCESS TO RECEIVE CARE



Day Opportunities and Transport Strategy

Introduction

1. This paper provides an update on the Day Opportunities strategy currently being implemented for adults in Oxfordshire. It describes the new position and transport arrangements for day services provided to older people and people with a physical disability (PD). The new strategy is designed to move the focus away from buildings and towards activities people might want to participate in during the day in their local communities.

2. The day opportunities strategy is a response to the relatively recent policies of personalisation and localism. Services should be responsive and tailored to people's needs. They should be able to meet the requirements of people who want to pay for day time activities, whether through a personal budget provided by the Council or with their own funds. In line with Council priorities the strategy allows for increased local decision making and encourages a mixed economy of care and support.

Background to Day Opportunities Strategy

3. Between 2008 and 2010 the Council r day services strategy reflected the results of the Fundamental Service Review of Day Services that was carried out in 2007/8. This envisaged three elements:

   - Resource and Well-Being Centres in the larger towns
   - A variety of contracted services provided in other localities
   - The encouragement of community based activities often without any financial support from the Council

4. This strategy was endorsed by the former Social & Community Services Scrutiny Committee. It was reflected in the capital investments that were being made in developing Resource and Well-Being Centres in Witney, Oxford, Abingdon and Banbury.

5. The Council runs 7 day centres across Oxfordshire that deliver services to people presenting a higher dependency level of need. A further centre is contracted to the Leonard Cheshire Foundation and provides similar services.

6. In addition to these there were approximately 50 contracted services, all run by small and medium sized voluntary sector organisations that were delivering traditional day centre services. These services are traditionally provided in village halls or community centres and generally were funded to provide service on one or a two of days per week.

7. A high percentage of people who use the day services tend not be eligible for social care support. Services are used by family carers who are seeking respite from caring for those people who are frail or vulnerable but do not necessarily have very high levels of need.

8. The Council spends above the average of comparator authorities on day services - more than twice as high as the average. This reflects the fact that the Council supports twice as many places as other authorities. This is because day services are considered to be preventative – promoting independence and carers support, thus preventing the need for more costly and intensive services.

Revised Commissioning Intentions

9. A proposal was taken to Cabinet on 16 November 2010 to agree a new strategic direction to move away from traditional day services for older people to a concept of offering a range of support and services to be accessible seven day a week during day time and evenings. Cabinet agreed the strategy and the proposal moved to the implementation stage.

10. These developments were to help older people to become better integrated within their communities, reducing social isolation and the maintenance of independence is primary. Universal services should become predominant. Older people need to have information about what is available locally to meet their particular needs. The model is based on three tiers reflecting the range of universal services, specific support, and specialist social and health care provided to individuals and their carers:

    - Tier 1: Community Engagement
    - Tier 2: Community and Low-Level Support
    - Tier 3: Health and Wellbeing Resource Centres

11. A project team was established to manage the implementation.

12. Principles

A number of principles were enshrined in this approach

- Where possible services would be available locally avoiding the need for transport
- Services would need to ensure they were delivered to a sustainable business case

- Where people were eligible for social care support then transport would be provided where it was needed. Where people were not eligible then they

could either use existing Fleet Transport at a reasonable cost or use Community Transport if that existed.

- Providers are encouraged to develop modern, customer focused and innovative services which users are keen to use and which helped to promote independence and Well-being.

- A need for equality of provision and charging for people who are eligible for Social Care support and those who are not who use these services.

Tier 1 - Community Engagement

13. Social & Community Services increased its investment in schemes that link a volunteer to someone needing community support. The Director for Social & Community Services has committed £150,000 to the Big Society Fund and joint working with the Big Society Team has been established. Two rounds of Big Society bids have been evaluated. Officers will continue close working with the Corporate Core team to ensure that sufficient bids from the providers of older people's services are forthcoming. Providers will be supported to develop bids for Tier 1 services.

Tier 2 - Community and Low Level Support

14. Tier 2 is where the vast majority of the traditional day centres, lunch clubs and other providers fit and where there has been a significant amount of development work undertaken. In particular the project:

- Developed a funding formula for use with Tier 2 services

- Remodelled the indicative funding allocation for each of the Council's 14 Locality areas for the period 2012/13 through to 2014/15

- Established an Approved Provider List for day opportunity providers. This has been built on the back of existing systems and processes and will make it simpler for providers to bid for work with the Council in the future. It has also generated an available resource of pre-vetted providers identified against our 14 local areas.

- Increased the number of providers known to the Council in the Day Opportunities category.

- Briefed Locality Boards on the proposed commissioning intentions and procurement process and refined the service specifications for each as required.

- Carried out a competitive procurement exercise to identify the best day services options for each locality.

- Generated a service offer that has ensured a balance between sustaining existing provision and the introduction of new and innovative providers to the localities.

- Shared the outcome of the procurement exercise with Members

- Notified providers of the outcome by the end of December 2011 in readiness for new service contracts from April 2012.

15. The Council awarded 48 contracts to 30 providers to deliver Tier 2 services for contracts to the end of March 2013. (A new procurement round for services after this will commence this summer). The timetable for this will be finalised by the end of April.

16. As part of the procurement process, there was a greater focus by commissioning to ensure providers demonstrated in their bids the quality of service, and that there was greater visibility of cost and business justification to ensure sustainability.

17. Many existing providers used local community transport or their own schemes to provide access to the services and these were laid out in their business case. The charge to users differs between providers, but could include the cost of the service, lunch and/or transport. Some of the large providers such as Age UK and Day Break are currently using Fleet Transport. The intention is to continue to provide the transport services but charge these providers for this service. The providers in turn would be expected to pass on this charge to users This will be at similar levels as that charged for Tier 3 transport.

Tier 3 – Health and Wellbeing Resource Centres

18. An innovative Tier 3 strategy had been developed that would provide day opportunities to older people. This was structured around a small core funding guarantee from the Council with the majority of income needing to be generated by the provider through service user attendance.

19. The success of the Tier 3 strategy therefore relied on the provider attracting service users. However it has become evident during the course of the process that external bidders were reluctant to enter into the current grant award exercise due to uncertainty over the number of service users and the financial risk this poses. The service and business proposition put to the supplier market has not proved attractive with the result that only the Internal Service submitted a completed application. Throughout this exercise the project explored and challenged the various business and financial scenarios that have been presented to learn more about what might be possible. However the project does retain concerns over the sustainability of the model so is looking to explore alternative options

20. There is still a desire to continue to deliver innovative day care for people with the highest level of need; therefore for the immediate future the current funding arrangements for day services will continue. However through this process it has become evident that the service can be modernised, delivered more efficiently and innovatively. In line with other services there is a need a need to look at efficiencies and innovation within day services, including extended opening, new activity programmes and charging and/or reducing level of funding. For the period up to March 2014 services will remain with the existing providers.

21. Virtually all the Transport to the well being centres is provided by Fleet Transport and this is set to continue. Service users who are not eligible for care services under FACS will be charged a reasonable rate for this, which will be tested through detailed consultation.

Changes proposed

22. In line with the principles laid out above the following changes are proposed:

Revised Transport Charges

The following outline the proposed transport charging model:

- Transport will be provided or funded (through the RAS) to and from day services for people who have been assessed as FACS eligible.
- Once a person has been deemed FACS eligible, the Care Manager will assess the transport options available to access the required services.
- The Council will only provide or fund transport when it cannot be arranged or purchased by the individual.

Proposed Transport Charging for Non-FACS Eligible Clients Attending Tier 2 Centres

23. It is proposed that the current practice is continued, with greater visibility and clarity to Commissioning of the transport arrangements by providers.

24. Providers may, if they wish, use ITU – however, this will be under a separate agreement between ITU and the provider. The cost of providing the service will be an agreement between the provider and ITU; and the charge to the service user will be decided by the provider. The Council has no control over the charge to the service users. However, we believe that the charge should not exceed the £5 which will apply for transport to Tier 3 services.

Proposed Transport Charging for Non-FACS Eligible Clients Attending Tier 3 Centres

25. Non-FACS clients attending Tier 3 centres will be charged £5 per return trip (subject to consultation), with potential increases in the future. This does not cover the total cost of providing the service, but rather seeks to minimise the deterrent effects of charging on clients' willingness or ability to pay. A flat rate charge is proposed, regardless of distance travelled.

26. This should generate income of £0.2m in YR 1.

Revised Attendance Charges

Proposed Attendance Charge for Tier 2 Centres

As part of their business cases provided to Commissioning through the recent procurement process and reviewed in terms of value for money.

Proposed Attendance Charge for Tier 3 Centres

27. For Tier 3 Health & Wellbeing Resource Centres, ITU will continue to be paid to transport all clients to these centres.

28. The proposed charge to attend a day centre for a full day is £25 (subject to consultation). This will be made up from £15 for the attendance; £5 for lunch; and £5 for transport. This represents a £15 per day increase in attending. If people do not require transport they will be charged £20 for lunch and attendance.

Potential Impact of the Changes

29. The impact of introducing the new charges will include:

a. Future Service users
It is recognised that there may be an impact on future day centre attendees (both Tier 2 and Tier 3), if the ITU Fleet is not be available or other suitable alternatives are not available. The impact could be a reduction in the number of people electing to attend day centres because of the change in their transport arrangements

b. Funding for Internal Day Centres
The future viability of the day centres will be predicated on the generation of income from service users who are self-funders. If people do not have access to the centres, or are unable to pay for transport, then there is likely to be an impact on the revenue received by the centres.

c. Impact on Family, Friends and Carers
It should be recognised that the impact of this policy will be broader than just on service users themselves. There may also be an impact on family, friends and carers, who may now need to assist service users in finding

other modes of transport. But they still have the choice to pay for it from ITU.

d. ITU Fleet

The ITU Fleet currently consists of approximately 75 employees and 65 vehicles providing transport for social care clients; daily school journeys for Special Education Needs pupils; non-emergency patient transport for the NHS as well as an expanding number of public bus services.

As social care clients are by far the largest group transported by the ITU Fleet, a reduction in their number may affect the overall size of the Fleet and could affect its future financial viability as currently structured, and therefore its ability to serve other customers.

30 **Financial impact**

Day Services

The above proposals means that there are potential savings of in the longer term in the Medium Term Financial and that Day Services in both tiers need to build sustainable business plans for the longer term. Increasing the charges as laid out above would generate approximately £500k of income based on current service user numbers.

Transport

The current Medium Term Financial Plan 2011/12 to 2014/15 originally included a saving in 2012/13 of £1.3m by reducing the funding in-house ITU to and from day centres. The saving has now been reduced to a more realistic figure of £0.6m, transitioned over the 3 years following implementation (Yr1 2012/13 £0.2m, Yr2 2013/14 £0.5m Yr3 2014/15 £0.6m)

31 **Advantages and Disadvantages of this approach**

Increasing the Charges for Day Centre Attendance

Advantages

- The charges more properly reflect the cost of providing the services to those who are not entitled to social care support
- Enables efficiency savings to be made which can re reinvested into providing quality and varied services
- It benchmarks well with other authorities who charge for day services and is still cheap for similar services in Oxfordshire
- There is greater equality between FACs eligible and Non-FACs eligible clients
- Services will develop a more attractive offer for both FACS eligible and non-FACS eligible clients

Disadvantages

- Some clients will not have the money to attend as they currently do

- Having the availability of resources may dictate access to services

Increasing the Charges for Transport

Advantages

- The charges more properly reflect the cost of providing the services
- Enables the proposed small efficiency savings to be delivered
- It recognizes that the contribution from Transport is more than just driving and providing the vehicle, it is the whole care and support package that goes with this
- This would seem to be in keeping with those who may not be FACs eligible but who are on mobility allowance
- This is potentially in more in line with prices being charged by Community Transport schemes

Disadvantages

- Some clients will not have the money to attend as they currently do and will have to make other choices such as friends, relatives and accessing community transport where possible – these might not always be either available or affordable

In General

The advantages and disadvantages are very similar for raising the charges for both services. Many of the disadvantages would be addressed by some kind of means testing but this will come with its own disadvantage of administration costs.

It is expected that consultation on these price increases will provide more feedback on this and may raise other issues in itself.

Next Steps

32. It is the intention to undertake a public consultation on the following:
- The new Tier 3 Service
- Tier 3 charges (including transport)

33. It is expected that the consultation will be completed by late summer 2012.

34. Scrutiny Committee is asked to:

i) Agree the principles
ii) Discuss the advantages and disadvantages of this approach and provide guidance as to the proposal being consulted on
iii) Once consultation has been completed review the results and any changes to those proposals and comment on the possible ways forward.

Simon Kearey /Sara Livadeas Date: 27 February 2012

Appendix I (Demographics of Day Centre and Transport Usage)

Day Centre Usage

Current usage of Day Centres for Older people (attendees)

	Tier 3	Tier 2	Total
No. of people attending a day centre in Oxfordshire	1687	1069	2756
No. of these who are Fair Access to Care (FACs) eligible*	1171	65	1236
Percentage who are FACs eligible	69%	6%	45%

Transport Provision

No. of people receiving transport provided by the County Council	1386
Including people receiving ITU transport *Including people receiving taxis organised by ITU*	*1225* *161*

Mobility of ITU passengers (excludes taxi passengers):

Able bodied	Requires assistance with walking	Uses walking frame	Wheelchair user	Other disabilities
14%	53%	17%	14%	3%

Oxfordshire Travel Advice and Information Line new referrals to County Council day centres (January – March 2011).

Family/ friends/ carers	Taxi	ITU	Community transport	Travel independently	Did not attend
26%	10%	25%	7%	6%	24%

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Assuring Quality in Externally Provided Social Care

Adult Social Care Scrutiny Committee – 6th March 2012

1. Introduction

This paper sets out the challenge facing Oxfordshire County Council in promoting and securing good quality care from external service providers. It represents the first stage in the creation of a plan to improve the quality of provision. A significant amount of activity is currently being carried out on a day to day basis by our contracting teams to monitor and promote quality however, the current reorganisation of the Joint Commissioning Service presents an opportunity for the Council to review and improve the approach.

2. Background

The quality of care delivered to people in Oxfordshire is critically important to their wellbeing. Members, Officers and the wider public all have an interest in ensuring that people receive the very best service for a given level of funding.

Over 15,000 adults in Oxfordshire receive care and support services that are funded by the Council in some way. In addition, there are several thousand people who fund their own care independently, and are not known to the Council. Services are provided by over 300 internal and external suppliers, using a wide variety of contracts which range from a few hundred pounds to over £20m per annum. The Council also has an interest in emerging unregistered services such as Personal Assistants which are not directly contracted, but where individual citizens are vulnerable to exploitation.

Most care and support services are 'registered' by the Care Quality Commission (CQC), which has the primary duty to monitor and maintain quality standards against nationally set minimum standards. However, the CQC has been drastically cut back in recent years, and there is an increasing expectation that the Local Authority will become more involved in issues of quality, even if there is no statutory basis for intervention. Some key services are not 'registered' (e.g. Day Support, Lunch Clubs, Advice and Information, Personal Assistants), and anyone using such services does not have even the minimum protection offered by CQC. There have been a number of recent local and national cases where care standards have fallen below an acceptable minimum in both domiciliary care services and in residential/ nursing care.

Within the Council current monitoring arrangements vary according to service area and client group. Some people have relatively close monitoring of their support arrangements, while others are only monitored occasionally. Our aim should be to build on good practice which exists, and build in consistent management arrangements to ensure that quality monitoring is maintained equitably across the sector as far as possible.

The Director of Social & Community Services is fully committed to improving care standards across the sector, within available resources. Any programme of quality assurance has to be affordable and realistic.

3. **Main Risk Areas**

There are three areas of known risk where the Council should consider to what extent it should improve the monitoring and management of service quality in the short term:

Unapproved Personal Assistants (PAs)
There are around 300 unapproved PAs operating under the Direct Payments system. These staff have been directly employed by Service Users, and there is little direct monitoring of standards, apart from infrequent routine operational reviews. A further 100 PAs operate under the 'Support with Confidence' approval scheme, and are more closely checked by OCC.

Low Cost and Inexperienced Domiciliary Care Providers
Following a tendering exercise, 49 Domiciliary Care suppliers were given new spot contracts in July 2011. This process was designed firstly to reduce the price and bring it closer to national norms for domiciliary care; and secondly to release the Council from block contract commitments. A number of the suppliers were new to Oxfordshire and require close monitoring and support to enable them to deliver services at the appropriate quality.

Variability of residential care provision
As noted above there has been reduced monitoring by CQC, who in any case only uphold minimum standards. Within Oxfordshire older people paid for by the Council are in the main very frail and often suffer from dementia – so they are less able to voice concerns. Approximately 60% of older people in care homes pay for themselves so are not monitored by the Council at all. We continue to support a significant number of learning disabled people in (spot) placements out of county and can provide only very light touch monitoring of these placements (at best an annual review of their care). At the moment the majority of placements in care homes both in and out of county are spot placements so they are not routinely monitored by the contracts team – they are individually reviewed by our operational teams.

4. **Future Approach to Quality Assurance**

The responsibility for commissioning and maintaining good quality services rests with the Joint Commissioning Team. The Deputy Director for Joint Commissioning will oversee the production and implementation of a plan for improvement of Quality Assurance, which has been discussed with the Scrutiny Working Group (see Appendix 1). Broadly speaking it is proposed that our approach to raising and maintaining quality falls in to two main areas:

- Community leadership, and
- Improved monitoring arrangements.

5. **Community leadership**

1. Setting Standards

Service Providers have the primary responsibility for delivering good quality care. The Council has a key role as an influencer and community leader as well as a commissioner of care. We will work in partnership with service providers and other stakeholders to create an agreed set of standards by type of service. We will develop the existing arrangements for bringing Providers together (the Provider Forums) and support them to maintain and improve quality. We anticipate the involvement of service users and other stakeholders in this process.

2. Enhancing the Role of Members

A number of Members have expressed interest in taking an active role in quality assurance and some have existing relationships with service providers (acting as Trustees and so on). This could include developing a relationship with key care facilities in their local area, and working in partnership with Officers to improve standards. Perhaps members could 'adopt a care home' for a year? What do we have to learn from the Council's Corporate Parent role where members take an active role in visiting Children's Homes? The creation of a 'Care Home of the Year' Award has been mooted.

3. Leadership Programme

OCC has a key role in encouraging strong leadership across the Provider market. It is proposed that OCC should commission and fund a training programme for local leaders and senior managers in the sector. This is similar to an emerging development plan in CEF where a leadership programme for Head Teachers is being considered. This builds upon a recent Geriatric Society Paper "Quest for Quality" describes the variable and often poor quality of support offered by the NHS to the estimated 400,000 people in Care homes. It highlights 'the need to build joint professional leadership from the health, social and care home sectors, statutory regulators and patient advocacy groups to find the solutions that none of these can achieve alone'. GPs have an important role to play here.

6. Monitoring

4. Tendering and Proactive Monitoring

Delivery of good quality care starts with selecting the right suppliers and working closely with the appropriate number of contractors in each sector of the market. The current tendering and contract arrangements will be reviewed to ensure that only the best suppliers are delivering care for OCC (within the available funding –consideration is given to quality and cost currently), and that the right balance of spot and block contracts is achieved. Monitoring arrangements will be enhanced, including unannounced visits where appropriate. Feedback mechanisms from operational staff will be improved so

that any comments or concerns from service users are communicated directly to contract monitoring staff for action. Key contracts should be monitored via a visit at least once a year, with action plans put in place to improve services, and these plans should be monitored monthly. More work is required to determine the frequency of monitoring depending on the size and complexity of the contracted service.

5. Helping people raise concerns

Formal and proactive monitoring arrangements are an essential tool for assuring quality, but are only part of the solution. Council staff cannot cover all Providers all the time. We need to encourage 'the community' to take an active role in making services safer, by acting as the 'eyes and ears' of the Council and reporting any concerns about the delivery of care. Current ideas for this area include promoting Relatives Groups in care homes, use of active Trustee, circles of friends, and increased use of LiNK and Healthwatch. There is already a group of volunteers working with the contracts unit to visit and seek views from service users, and this function will be enhanced.

In addition to routine monitoring visits and reviews, individual service users can be assisted to raise concerns, through a well advertised phone number and exploration of new technology such as Skype and internet groups for the increasing number of people who have access to these methods of communication. This will increase their sense of connectedness and safety.

6. Organisational Restructuring

The restructure of the Commissioning and Contracting teams in adults and children is now underway. This includes arrangements for procurement. One of the elements of the new structure will be a new Tier 3 post of 'Quality, Procurements and Contracts Manager' to ensure a consistent and tightly managed approach to quality assurance across over 300 contracts valued at over £180m per annum. Currently the management of contracts in CEF is under consideration. The number of contracts is significantly higher if individual placements are included.

7. Recommendations

1. Create and implement a plan to maintain and improve the quality of externally purchased services.

2. Develop a risk based approach to contract monitoring.

3. Develop a system for incorporating informal feedback – including from service users, carers, staff, whistle blowers, Members, GPs, Health watch.

4. Prioritise establishing Relatives Associations for Care Homes.

Contact Officers

Sara Livadeas - Deputy Director - Joint Commissioning

Martin Bradshaw – Strategic Programmes – Joint Commissioning

27th February 2012

Appendix 1

Questions considered by the Scrutiny Working Group:

1. In an era of reduced staffing budgets, personalisation and individual choice, is it possible for the Council to assure quality across every service user and every Provider in all circumstances?

2. What are the areas of most concern/risk? Are we seeking consistency of approach or should there be a risk based approach to monitoring?

3. Should we be concerned about quality in services where OCC is not purchasing any care?

4. What do we do about unapproved PAs? Do PAs introduce more risk in to the system? Or less as the client is choosing who to let in to their home?

5. How can service users be involved in setting standards?

6. How can members be more involved in raising standards?

7. What is the role of GPs; Health watch; relatives; staff?

8. How do we help people to raise concerns? Can the role of Relatives Groups be formalised/ encouraged?

9. Should we reduce the number of contractors significantly and work more closely with a small group to improve quality? Back to blocks? Who looks after the spots?

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Oxfordshire Local Involvement Network
Update for Adult Services Scrutiny Committee
meeting 6th March 2012

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

LINk Core Group

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

Ongoing projects and engagement:

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

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

Self Directed Support (Personal Budgets)

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

'Enter and View' visits to Care Homes

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

Update from other projects:

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

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

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

The resulting report will be shared locally and nationally.

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

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