Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 10 March 2011 at 10.00 am
County Hall

Membership

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

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

Notes:

Date of next meeting: *19 May 2011*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

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

Committee Officer - *Roger Edwards, Tel: (01865) 810824*
roger.edwards@oxfordshire.gov.uk

Peter G. Clark

Peter G. Clark
County Solicitor

March 2011

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 10)

To approve the minutes of the meeting held on 20 January 2011 and to note for information any matters arising from them **(JHO3).**

4. Speaking to or Petitioning the Committee

5. Public Health
10.10

The regular report from the Director of Public Health on matters of relevance and interest.

6. Chipping Norton Hospital - Staff employment conditions (Pages 11 - 14)
10.30

The new Chipping Norton Hospital is due to open later this year. It will be run on behalf of the NHS by the Orders of St John Care Trust. In 2005 and again in 2007 the PCT stated the following with regard to the employment of nursing staff at the hospital:

i. *To enable staff at the Hospital to decide which choice was better for them as individuals, they would be given the option of whether to remain as NHS employees and be seconded to the Orders of St John (OSJ) for a period of three years or to transfer under TUPE to the OSJ*
ii. *The PCT would not indicate a preference with regard to the above options*
iii. *In the event that an NHS employed staff member was to leave during the three year period, their replacement would be placed on NHS terms and conditions for the remainder of the three years.*

At the end of the three years a review would take place.

The transfer of existing staff is being undertaken in accordance with the first two statements above. However the PCT has now decided that new staff employed during the three year period would be employed by the OSJ.

The purpose of this item is to help members understand why the PCT view on employment has changed and for the HOSC to consider whether any further action is required. A representative of the PCT will attend the meeting.

Copies of two letters are attached for information:

1. From the Acting Chairman of the HOSC to the PCT (**JHO6a**)
2. The reply from the Chief Executive of the PCT (**JHO6b**)

7. Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust)

11.00

As part of a series of items of business aimed at bringing members of the Committee up to date on the position of local NHS Trusts, John Morgan, Chief Executive of the Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust), will give an update on the current situation and how he sees the future for the Trust.

8. Health Trainers - Proposal by NHS Oxfordshire (the PCT) to cease the service (Pages 15 - 48)

11.30

The Health Trainer initiative was set up by the PCT in July 2006 as an experimental approach to try to improve the health of hard-to-reach individuals. Recently the PCT undertook an evaluation of the service and decided that it could not be shown to be providing good value for money. The PCT is therefore proposing to close the service.

The staff involved believe that changes could be made that would improve the outreach service and that, before the service is closed, there should be full public consultation.

Members should consider the evidence to be provided and decide whether they believe that this a substantial service change that would require full public consultation.

Speakers will include the Director of Public Health, the Convenor for the Oxfordshire PCT Unison Branch and a LINk representative. The following papers are attached:

1 Equality Impact Assessment (HIA) (**JHO8a**)
2 Consultation paper from the PCT (**JHO8b**)
3 Paper, “In Defence of Public Health” from Unison (**JHO8c**)
4 Oxfordshire LINk briefing (**JHO8d**)

9. Developing the new Oxfordshire Health and Wellbeing Board

12.15

The Health and Social Care Bill that is going through Parliament now is intended to give effect to the reforms requiring primary legislation that were proposed in the NHS White Paper *Equity and Excellence: Liberating the NHS*. The Bill introduces a statutory duty for all upper-tier local authorities to create a Health and Wellbeing Board and develop a new joint health and wellbeing strategy.

The Director of Adult Social Care and the Director of Public Health will explain to members what the latest position is in planning and developing the new Board. Members will be able to follow up on their comments at the last meeting that the Board should be subject to the scrutiny of the HOSC.

10. Oxfordshire LINk Group – Information Share (Pages 49 - 52)
12.45

The regular LINk briefing paper is attached (**JHO10**). LINk representatives will be available at the meeting to answer members' questions if required.

11. Chairman's Report
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, ie where the matter affects (either positively or negatively):

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

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

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

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

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

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

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

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

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

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

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

Present:

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

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

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

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

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

There were no declarations of interest

3/11 MINUTES
(Agenda No. 3)

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

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

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

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

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

5/11 PUBLIC HEALTH
(Agenda No. 5)

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

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

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

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

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

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

The Chief Executive expanded on these comments as follows:

GP Consortium

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

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

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

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

PCT Consortium Transfer of Responsibilities

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

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

PCT Clustering Arrangements

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

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

Provider Organisations

a NOC/ORH Merger

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

b CHO/OBMHFT

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

c Foundation Trust Pipeline

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

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

d Ridgeway Partnership

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

PCT Restructuring

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

County Council Perspective

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

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

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

Public Health

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

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

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

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

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

Further information following member questions

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

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

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

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

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

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

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

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

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

(Agenda No. 7)

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

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

Jeremy Glyde – NHS Specialised Services Programme Director

Simon Jupp – South Central Specialised Services Director

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

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

Caroline Langridge }

Kim Holmwood } Young Hearts

Jude Kelly }

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

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

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

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

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

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

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

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

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

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

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

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

(Agenda No. 8)

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

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

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

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

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

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

9/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE
(Agenda No. 9)

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

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

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

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

10/11 CHAIRMAN'S REPORT
(Agenda No. 10)

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

..... in the Chair

Date of signing .....

INVESTOR IN PEOPLE

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My ref: Your ref: Date: 26 January 2011

This matter is being dealt with by Roger Edwards	Direct line 01865 810824
	Email: roger.edwards@oxfordshire.gov.uk

Dear Sonia

Chipping Norton Community Hospital

The following relates to concerns expressed by the Chipping Norton & District Hospital Action Group, by West Oxfordshire District Council and by other people in the Chipping Norton area relating to the staff terms and conditions of employment at Chipping Norton Hospital.

As you will know, the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) was given undertakings in both 2005 and 2007 with regard to the employment of nursing staff at Chipping Norton Community Hospital. Namely that:

1. To enable staff at the Hospital to decide which choice was better for them as individuals, they would be given the option of whether to remain as NHS employees and be seconded to the Orders of St John (OSJ) for a period of 3 years, or alternatively to transfer under TUPE to the OSJ
2. The PCT would not indicate a preference with regard to the above options
3. In the event that an NHS employed staff member was to leave during the 3 year period, then their replacement would be placed on NHS terms and conditions for the remainder of the 3 years
4. At the end of the 3 year period, members of staff who had chosen secondment would be given the option of transferring to the OSJ or continuing to work for the NHS at a different site. No member of staff would be forced to transfer to the OSJ at any time
5. At the close of the 3 year period a full and open review would take place with:
    a. all evidence being made public
    b. all interested parties being given the opportunity to put forward their views
    c. cognisance being taken of those views

6. There was an expectation that there would be continuing Section 242 (formerly section 11) consultation throughout the 3 year period

The HOSC was disappointed to hear that the PCT is considering not implementing the agreement in relation to item 3 above and has stated that any new appointments during the three year period would be automatically to OSJ. If that were to happen it would plainly be against both the spirit and the letter of the previous agreements.

This matter was raised by us when Peter Skolar and I met you in December. At that time you said that you would be seeking advice from the Treasury. I would be grateful if you would let me know what advice you have received and whether it has influenced the decision on staff appointments. Our understanding is that both the Treasury and the Department of Health have said that there is no legal imperative for new staff to be appointed to the OSJ. It would also be helpful to know what other criteria have been used in deciding on this course of action.

The HOSC expects that the PCT would abide by the agreements made previously. Consideration would have to be given to referring the matter to the Secretary of State if the agreement was to be set aside unilaterally.

I look forward to your reply.

Yours sincerely

Councillor Susanna Pressel
Acting Chair of the Oxfordshire Joint Health Overview and Scrutiny Committee

The Oxfordshire Joint Health OSC comprises councillors from Oxfordshire's County, District and City Councils as well as co-opted members of the public

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Susanna Pressel
Acting Chair
Joint Health Overview & Scrutiny Committee
Oxfordshire County Council
County Hall
New Road
Oxford
OX1 1ND

21 February 2011

Dear Councillor Pressel

Chipping Norton Community Hospital

I write in response to your letter dated 26 January 2011.

I can confirm that Staff based at Chipping Norton Community Hospital have been given the option of TUPE Transferring to the Order or St John or remaining an NHS employee using the Retention of Employment (ROE) Model of Secondment. As you may know this model ceased to be available in 2009, but has been agreed on an exception basis by the Secretary of State for Health. I can confirm that the PCT has not indicated a preference with regard to the above options and all 33 Staff have now chosen to be seconded using the ROE Model, rather than transferring across using TUPE.

You are right to point out that a previous commitment was made in 2007 to HOSC that if any staff left during the secondment that they would be replaced by the PCT for the remainder of the secondment.

However, as we have been working through the practical details of this project, including the finances, it has become necessary to revisit this commitment. I believe that this is the right thing to do for two very good reasons:

1. The efficiencies envisaged within the original business case for this project, assumed freedom for employing staff. This would include OSJ having the ability to share staff across the whole facility, developing rotas and working patterns that maximised the flexibilities of a larger site with both social care and NHS care combined. For example, staff seconded under ROE can only work on NHS care and not work in other parts of the facility. The original business case assumed a level of staff turnover which would have allowed new staff to be employed on OSJ terms and conditions that were then reflected in the financial modelling. We are currently working hard to identify how the cost pressure presented to the PCT as a result of the secondment period can now be met and allowing OSJ to recruit to any vacancies has the potential to reduce this cost pressure.

2. The organisational changes for the local NHS over the next three years are significant. Staff at Chipping Norton Hospital are currently employed by the PCT and will be transferring under TUPE to be employed by Oxford Health NHS

Foundation Trust (previously OBMH) on 1 April this year at which time they will already be on secondment to OSJ. Merging Community Health Oxfordshire with the Foundation Trust is a complex piece of work with detailed negotiations needed about a wide range of issues. The agreements made for the current Chipping Norton staff. Are included within this. We are talking about not more than 11 nurses.

As a result we have now agreed with OSJ that they will be responsible for recruiting to any vacancies that may arise once the service transfers at the end of this month.

I appreciate that this represents a change to the previous commitment, however, given the context and financial environment we are working within, I feel it is important to prioritise our commitment to current staff.

I would like to stress that this will not affect patient care. In fact, we have been very clear that the service specification reflects the current service at Chipping Norton and so patients should experience no change to the service other than a vastly improved environment including single en-suite rooms.

I am very aware that there remain some concerns about how the new service will operate and whether there will be an impact on patients. We have built into the service specification an agreement to review the service at the end of the first year, particularly looking at the following areas:

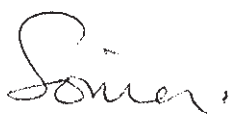
- Medical cover and medicines management
- Patient average length of stay and acuity of patients
- Key performance indicators (including quality and governance)
- Systems and integration
- Staffing model

The situation relating to the First Aid Unit has also moved on. The PCT have agreed to provide support to the Ambulance Trust to develop a different model of urgent care service to be based at the new hospital which could provide a template for other similar communities. During weekday evenings, all day on bank holidays and weekends an Emergency Care Practitioner (ECP) will be based at the hospital and will treat patients who walk in. In addition, an ambulance, based at the hospital will be available for attending emergency calls that will then improve the response times in this area.

This will be a pilot and would seek to increase activity by diverting people from using other urgent care services. We have listened to the concerns of Councillor Biles and others in the community and there is a clear perception that there is greater local need than is being demonstrated through the current activity levels. During the period of the pilot we will monitor usage of the unit and feed this into the evaluation.

I hope this has helped to clarify the position. If you require I would welcome the opportunity to discuss this with you and your colleagues further.

Yours sincerely



Sonia Mills
Chief Executive

Oxfordshire NHS
Primary Care Trust

Equality Impact Assessment (EIA) - Evidence Form

The PCT strives to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of your policy, protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and PCT's Equality and Diversity Steering Group.

Policy/Proposal/Service Title	**PROPOSAL FOR HEALTH TRAINER INITIATIVE**
Name of EIA Lead	Val Messenger, Deputy Director of Public Health
Others involved in assessment	Jackie Wilderspin, Assistant Director of Public Health
Date EIA commenced	19 January 2011

EIA Completed and Approved

Signature (Lead Director): _____

Name (print) ___Jonathan McWilliam_____

Job Title: ____Director of Public Health_____

Date: _____

ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LEAD FOR EVIDENCE AND PUBLICATION.

STAGE 1: Standard Screening

EIA questions	EIA Narrative	Sources of Evidence
1. What is purpose and objectives of the policy, proposal or service?	The proposal to cease the health trainer initiative has the following purposes 1. To ensure that only effective services are provided by Oxfordshire PCT 2. To ensure that only efficient services are provided by Oxfordshire PCT and that we can demonstrate good value for taxpayers money	In the development of the proposal evidence was sought from: • EIAs for implementing the initiative (see section 3 below) • Health Trainer Data 01.04.2008 – 03.09.2010 • A review of the effectiveness, efficiency and evidence base for all Public health Functions in 2010 • Data on Heath Trainer City clients 01/04/09 – 15/11/10
2. Who is the policy, proposal or service aimed at?	The proposal is aimed at Oxfordshire residents who currently use or may have expected to access health trainers	n/a
3. Does it affect one group less or more favourably than another (see groups below)?	**There is some evidence that the initiative is accessed more by some of the groups considered, however despite sterling and determined efforts by health trainers the initiative has not been able to demonstrate clinical effectiveness or good return on investment, people accessing health trainers may be better served by investment in other initiatives.** • The initiative currently contacts approximately 250 clients per year. Around 150 agree health plans mostly for weight loss and exercise whilst the remainder are advised how to access services direct. Success rates on completion of health plans were generally low with around 1 in 4 meeting agreed plans for diet and exercise and less than 1 in 5 for quitting smoking. • This makes the cost per contact £1,400 per patient and the cost per health plan produced £2,300 per individual. Achieving targets in health plan cost £10,250 per person. • The services to which people are signposted e.g. for	EIAs for : • Health Trainer Service- Black and Minority Ethnic Communities in Oxford City • Health Trainer Service- Banbury • Expansion of the HEALTH TRAINER SERVICE- OXFORD • NHS Oxfordshire Consultation document on proposed new organisation structure for the commissioner 19.1.11

EIA questions	EIA Narrative	Sources of Evidence
	smoking cessation, exercise on referral and slimming on referral still exist so support is still available and can be accessed via GPs or health advocates, etc.. • Interpretation services and health advocates are available to facilitate access to services • Interpretation Services mean that all primary care services in Oxfordshire can access both face to face and telephony interpreting services to facilitate their work with people for whom English is not their first language. In 2009-2010 this was accessed in 47 different languages. • NHS Oxfordshire's Health Advocacy Service promotes appropriate access to primary care services and preventive health initiatives to Black and Minority Ethnic (BME) communities throughout Oxfordshire. Providing help with prevention and health promotion work (e.g. by encouraging women to come for screening or supporting diabetes treatment compliance); supporting patients to access appropriate services; and providing formal or informal cultural advice to health professionals • The introduction of the national NHS health Checks and family intervention Project will introduce new mainstream services which will facilitate access to support for health behaviour advice.	
Male or Females	**No** – Of the 433 clients signposted by the Oxford city health trainers 215 were female (50%). In addition the EIAs for introduction of the initiative felt that neither gender would be affected negatively or positively.	Data on Heath Trainer City clients 01/04/09 – 15/11/10 EIAs listed in 3 above
People of different ages	**The initiative is only available for adults** • The initiative has not been able to demonstrate clinical effectiveness or good return on investment, so any impact is estimated as minor. • The services to which people are signposted e.g. for smoking cessation, exercise on referral and slimming	EIAs listed in 3 above

EIA questions	EIA Narrative	Sources of Evidence
	on referral still exist • People accessing health trainers may be better served by investment in other initiatives e.g. NHS health checks which will offer people aged 40-74 comprehensive health checks followed by signposting or treatment dependent on health risk identified.	
People from different ethnic groups	**Of the people making use of this initiative 27% who gave their ethnic group were not White-British. The Oxfordshire Data Observatory briefing on Ethnicity (June 2010) Says that, in 2007, 28% of Oxford City Residents classed themselves as either Black Asian or other minority ethnic group (BAME) or White Other. The figure for Cherwell was 11%. From this data use of health trainers by people from different ethnic groups does not appear disproportionate.** • The initiative has not been able to demonstrate that it is effective or efficient and so the actual impact is estimated as minor. • The initiative currently contacts approximately 250 clients per year. Around 150 agree health plans mostly for weight loss and exercise whilst the remainder are advised how to access services direct. Success rates on completion of health plans were generally low with around 1 in 4 meeting agreed plans for diet and exercise and less than 1 in 5 for quitting smoking. • This makes the cost per contact £1,400 per patient and the cost per health plan produced £2,300 per individual. Achieving targets in health plan cost £10,250 per person. • The services to which people are signposted e.g. for smoking cessation, exercise on referral and slimming on referral still exist so support is still available and can be accessed via GPs or health advocates, etc..	Health Trainer Data 01.04.2008 – 03.09.2010

EIA questions	EIA Narrative	Sources of Evidence
	• Interpretation services and health advocates are available for this population group • Interpretation Services mean that all primary care services in Oxfordshire can access both face to face and telephony interpreting services to facilitate their work with people for whom English is not their first language. In 2009-2010 this was accessed in 47 different languages. • NHS Oxfordshire's Health Advocacy Service promotes appropriate access to primary care services and preventive health initiatives to Black and Minority Ethnic (BME) communities throughout Oxfordshire. Providing help with prevention and health promotion work (e.g. by encouraging women to come for screening or supporting diabetes treatment compliance); supporting patients to access appropriate services; and providing formal or informal cultural advice to health professionals • The action plan which will mitigate further against any effect includes raising awareness of the health advocacy service, handing over of clients requiring ongoing care to the health advocacy service and ensuring awareness of interpreting services. • The introduction of the national NHS health Checks and family intervention Project will introduce new mainstream services which will facilitate access to support for health behaviour advice. **SEE ACTION PLAN** **For the reasons given above we believe that the proposal should not have a disproportionate effect on people from different ethnic groups**	
People of different religious beliefs	**No** – data on religious beliefs was not routinely collected as the initiative was not targeted at people with specific beliefs. The EIAs for introduction of the initiative felt that people with particular religious beliefs should not be	EIAs listed in 3 above

EIA questions	EIA Narrative	Sources of Evidence
	affected either negatively or positively.	
People who do not speak English as a first language	**Data is not routinely available on the language spoken by people making use of this initiative** In general clients not speaking English would be supported using the interpretation service or health advocates as the initiative doesn't support most language groups; however one health trainer is bi-lingual and specifically interacts with south Asian communities that do not speak English. Data is not available on those who do not speak English, but South Asians (including British south Asians) made up 17% of contacts. • The initiative has not been able to demonstrate that it is effective or efficient and so the actual impact is estimated as minor. • The services to which people are signposted e.g. for smoking cessation, exercise on referral and slimming on referral still exist. • Interpretation services and health advocates are available for this population group • Interpretation Services mean that all primary care services in Oxfordshire can access both face to face and telephony interpreting services to facilitate their work with people for whom English is not their first language. In 2009-2010 this was accessed in 47 different languages. • NHS Oxfordshire's Health Advocacy Service promotes appropriate access to primary care services and preventive health initiatives to Black and Minority Ethnic (BME) communities throughout Oxfordshire. Providing help with prevention and health promotion work (e.g. by encouraging women to come for screening or supporting diabetes treatment compliance); supporting patients to access appropriate services; and providing formal or informal	EIAs listed in 3 above Health Trainer Data 01.04.2008 – 03.09.2010

EIA questions	EIA Narrative	Sources of Evidence
	cultural advice to health professionals • The action plan which will mitigate further against any effect includes raising awareness of the health advocacy service, handing over of clients requiring ongoing care to the health advocacy service and ensuring awareness of interpreting services. **SEE ACTION PLAN**	
People who have a physical disability	**No -** data on physical disability was not routinely collected as the initiative was not targeted at people with physical disabilities. The EIAs for introduction of the initiative felt that people with physical disabilities should not be affected either negatively or positively.	EIAs listed in 3 above
People who have a mental disability	**No -** data on mental disability was not routinely collected as the initiative was not targeted at people with mental disabilities. The EIAs for introduction of the initiative felt that people with mental disabilities should not be affected either negatively or positively. There is some data on emotional well-being which showed only 1% of clients setting personal health plans identified this as their primary issue.	EIAs listed in 3 above Health Trainer Data 01.04.2008 – 03.09.2010
People with learning disabilities	**No -** data on people with learning disabilities was not routinely collected as the initiative was not targeted at this group. The EIAs for introduction of the initiative felt that people with learning disabilities should not be affected either negatively or positively. A Direct Enhanced Service is available for GPs to offer annual health checks to people with learning disabilities	EIAs listed in 3 above
Women who are pregnant or on maternity absence	**No** – data on pregnancy and maternity was not routinely collected as the initiative was not targeted at people who are pregnant or on maternity absence. The EIAs for introduction of the initiative felt that women who are pregnant or on maternity absence should not be affected either negatively or positively.	EIAs listed in 3 above

EIA questions	EIA Narrative	Sources of Evidence
Single parent families	**No -** data on single parent families was not routinely collected as the initiative was not targeted at this group. The EIAs for introduction of the initiative felt that single parent families should not be affected either negatively or positively.	EIAs listed in 3 above
People with different sexual orientations	**No -** data on sexual orientation was not routinely collected as the initiative was not targeted people with different sexual orientations. The EIAs for introduction of the initiative felt that people with different sexual orientations should not be affected either negatively or positively.	EIAs listed in 3 above
People with different work patterns (part-time, full-time, job-share, short-term contractors, employed, unemployed)	**No -** data on work patterns was not routinely collected as the initiative was not targeted people with different work patterns. The EIAs for introduction of the initiative felt that people with different work patterns should not be affected either negatively or positively.	EIAs listed in 3 above

People in deprived areas and people from different socio/economic groups	**The initiative is targeted at the adult population (aged 18+) in specific wards in Oxford City and Banbury (Blackbird Leys, Rose Hill, Wood Farm, Barton, Ruscote, Neithrop, Grimsbury and Castle & Hardwick)**. • The initiative has not been able to demonstrate that it is effective or efficient and so the actual impact is estimated as minor. • The initiative currently contacts approximately 250 clients per year. Around 150 agree health plans mostly for weight loss and exercise whilst the remainder are advised how to access services direct. Success rates on completion of health plans were generally low with around 1 in 4 meeting agreed plans for diet and exercise and less than 1 in 5 for quitting smoking. • This makes the cost per contact £1,400 per patient and the cost per health plan produced £2,300 per individual. Achieving targets in health plan cost £10,250 per person. • The services to which people are signposted e.g. for smoking cessation, exercise on referral and slimming on referral still exist. • Interpretation services and health advocates are available where required • The introduction of the national NHS health Checks and family intervention Project will facilitate access to support for health behaviour advice. • The action plan which will mitigate further against any effect includes safe handover of clients requiring ongoing care and introduction of the NHS health checks and Family Intervention Project. **SEE ACTION PLAN**	EIAs listed in 3 above NHS Oxfordshire Consultation document on proposed new organisation structure for the commissioner 19.1.11
Asylum seekers and refugees	**No -** data on asylum seekers and refugees was not routinely collected as the initiative was not targeted at this group. The EIAs for introduction of the initiative felt that	EIAs listed in 3 above

	asylum seekers and refugees should not be affected either negatively or positively	
Prisoners and people confined to closed institutions, community offenders	**No** - Health trainers in Prisons and the probation service are currently unaffected by this proposal	EIAs listed in 3 above NHS Oxfordshire Consultation document on proposed new organisation structure for the commissioner 19.1.11
Carers	**No -** data on carers was not routinely collected as the initiative was not targeted at this group. The EIAs for introduction of the initiative felt that carers should not be affected either negatively or positively. There are other services which are targeted at carers	EIAs listed in 3 above
Rural and/or isolated communities	**No** – The initiative does not serve these communities	EIAs listed in 3 above
4. Have you identified any potential discrimination or adverse impact that cannot be legally justified? If unsure, consult with the PCT Equality and Diversity Lead.	**No.** • Any minor adverse impact can be justified due to the imperative to ensure that taxpayers money is spent on cost effective interventions. The initiative has not been able to demonstrate that it is effective or efficient and so the actual impact is estimated as minor. • The initiative currently contacts approximately 250 clients per year at a cost of £369K. Around 150 agree health plans mostly for weight loss and exercise whilst the remainder are advised how to access services direct. Making the cost per contact £1,400 per patient and the cost per health plan produced £2,300 per individual. Achieving targets in health plan cost £10,250 per person. We will mitigate any adverse impact by implementing the actions outlined in the attached action plan.	

Appendix 3

EIA Action Plan Follow-up

(for EIA of existing services, policies or projects)

EIA Recommendations	Key actions required	Officer Responsible	Progress Made
People from different Ethnic Groups: Need to mitigate any impact as much as reasonably possible	1. Ensure awareness of health advocacy service 2. Handover clients to health advocates where appropriate 3. Ensure awareness of interpreting services	1. C.Newall 2. M. Dent 3. M. Hardwick	1. Part of existing service requirements 2. Clients requiring on going care to be identified to M.Dent as part of handover arrangements 3. Will be built into re-procurement of the service for June 11.
People who do not speak English as a first language: Need to mitigate any impact as much as reasonably possible	1. Ensure awareness of health advocacy service 2. Handover clients to health advocates where appropriate 3. Ensure awareness of interpreting services	1. C.Newall 2. M.Dent 3. M.Hardwick	1. Part of existing service requirements 2. Clients requiring on going care to be identified to M.Dent as part of handover arrangements 3. Will be built into re-procurement of the service for June 11.
People in deprived areas and people from different socio/economic groups: Need to mitigate any impact as much as reasonably possible	1. Safe handover of clients 2. Ensure that implementation of new services (e.g. NHS health checks and the new Family Intervention Project) take into account local inequalities, such as deprivation	1. JW/MD 2. T.Porter	1. Plan for client handover developed and shared with health trainers 25/1/11 2. Plan to introduce interim NHS health checks LES to commence April 2011 and to go out to formal tender for full service to commence around April 2012.

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PROPOSAL TO CEASE OXFORDSHIRE'S HEALTH TRAINER INITIATIVE: CONSULTATION PAPER FOR OXFORDSHIRE'S JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY 10 MARCH 2011

1. Summary

One of the major roles of the Director of Public Health is to provide the people of Oxfordshire with a range of services that will improve health and give excellent value for every penny of taxpayers' money. This includes setting up new services, reviewing existing services and ceasing services that do not give good value for money. As a custodian of the public purse the Director of Public Heath has to ensure that each penny spent gives the best return in terms of health outcomes. This means that, as for other public bodies, difficult decisions have to be made: when value for money is poor and improvements cannot realistically be made, some programmes must inevitably cease.

As part of a much wider review, the Health Trainer Initiative (which was set up by the Public Health team in 2006) has been shown to give a poor return on investment. The initiative does not reach sufficient numbers of people, is extremely expensive and the service model cannot realistically be improved. In the meantime, more promising alternatives have come forward. It is therefore proposed to cease this initiative as soon as possible. The Health Overview and Scrutiny Committee are asked to scrutinise this proposal. This is particularly important because the service was originally set up to reduce health inequalities.

It is emphasised at the outset that the motivation for ceasing this service is its lack of effectiveness and poor value for money demonstrated as part of a review begun in 2009. The motivation is not cost reduction.

2. Context within which these changes are proposed

Along with all public sector bodies, the Public Health function is going through a period of unprecedented change. This section outlines the reasons for change relevant to this service. Throughout this period, we are committed to keeping a strong public health function in Oxfordshire and to transfer it successfully to Local Authorities in 2013.
To prepare for this, since November 2009, the public health team have been reviewing all work programmes in detail to ensure that they meet the needs of the future. A number of these changes are directly relevant to the proposals for the Health trainer initiative. These are:

- Transferring services currently provided in-house by the public health team into NHS provider Trusts. The smoking cessation advice service and TB community nurse service are examples. They are planned to transfer to the Mental Health Trust shortly, along with other Community Health Oxfordshire services. This is not a straightforward process. NHS provider trusts go through a process of *due diligence* to ensure that the services they accept are financially viable; that they can deliver the outcomes required; and that

they are guaranteed to have the support of commissioners for the medium term.

- Preparing to transit the Public Health function to Local Authorities under a nationally set capitation budget. Benchmarking shows that the Oxfordshire public health team is considerably larger than teams in neighbouring counties (up to four times bigger) and any national budget is highly unlikely to cover current costs - this would put local Authorities in the invidious position of inheriting a service that could not be afforded. National 'shadow' budgets for public health will be produced from April 2012. It is important therefore that all services are reviewed and that we can justify every penny spent.

The public health team are also required to accommodate other changes which include:

- The need to divide all services currently managed within the directorate into those destined for transit to local authorities in 2013 and those destined to remain in the NHS. (Examples are managing prescribing in the county and priority setting for expensive cancer drugs).

- Preparing to provide improved support to GP commissioning consortium and NHS 'Clusters' as they form.

- Dividing services carefully into those which will remain local (including health improvement and fighting health inequalities) and those which will move to regional or national levels in due course (including some screening and immunization services)

To help make decisions about these changes it was necessary to undertake an extremely thorough evidence-based, value for money review of all public health services. Over one hundred services and initiatives have been considered in detail and we now have a very good understanding of what 'works' and what does not for each of these services, and we also know which services give a good return on public money.

To support the public health team in this work and ensure good governance, a Public Health Transition Group was set up which includes the Chair of Oxfordshire's Joint Health Overview and Scrutiny Committee and a PCT non-executive director. This was reported at the last Health Overview and Scrutiny Committee meeting.

The Health Trainer Initiative is therefore just one of many services that have been reviewed. It is proposed to cease the service because, unfortunately, it shows particularly poor performance and poor value for money which cannot be practically ameliorated. The main 'driver' for this proposal is the drive to give good value for money. This proposal is not motivated by the need to make 'cuts' to budgets.

3. What is the Health Trainer Initiative?

3.1 Description and History of the Health Trainer Initiative

The purpose of the service is to **prevent premature death in adults** in areas where there is a **wide gap between death rates** between the best off and the worst off, by **working with individuals** to set health goals and to meet those goals.

The concept behind health trainer initiative was first described in the Choosing Health White Paper in 2004. In Oxfordshire, a pilot Health Trainer initiative was set up in July 2006 as an experimental approach to try to improve the health of hard-to-reach individuals in deprived parts of Oxford City and Banbury. The public health team supported this initiative because we believed it might prove to be the key to reaching out to 'hard to reach' communities. As a team it is our intention to seek out the best ways of reducing inequalities within this county. We invested more in this service then elsewhere in the South Central Region because we wanted to give it the best chance of succeeding. The public health team have invested considerable time, effort and belief in trying to make this initiative work.

The idea behind the service is a good one, it is to employ residents from local communities to contact 'hard to reach' individuals to either 'signpost' them to other services and if possible, to work with them to set a personal plan for health improvement (usually around weight loss, exercising or smoking) and support them as they put the plan into action.

The service was set up to focus on specific deprived wards within Oxford City and Banbury these are Blackbird Leys, Rose Hill & Littlemore and Barton in Oxford City, Neithrop, Grimsbury and Ruscote in Banbury. Around 15 staff have been employed at any one time, mostly part time. Currently there are 11 Health Trainers directly employed by the PCT, making up 6 full time equivalent posts.

Health Trainers are non-clinical staff, therefore cannot give medical advice. They cannot see clients with long term medical conditions or conditions which Health Trainer input may have an adverse impact on, *without gaining consent and specific advice from the client's GP.*

3.2 Service activity

The in-depth review described above included an analysis of the number of clients seen from April 2008 – September 2010 and calculated the costs incurred for the outcomes gained.

A summary of the data collected by the Health Trainers from April 2008 to September 2010 shows that:

- 260 new clients were seen by the service on average in a year. This is a low figure, representing only one new client seen per working day by the combined efforts of all health trainers.
- 150 clients agreed to a targeted health plan on average in the year, most of whom concentrated on losing weight or increasing their physical activity levels. Clients set their own targets for weight loss, with advice from the health trainer. Again, this figure is very low representing 3 health plans agreed by the combined efforts of all health trainers per working week.

- Only one in four clients achieved their health objective. This means that in total only 36 clients on average fully achieved their health objective each year.
- In terms of numbers of individuals achieving their health objectives each year, the data shows that in each year, approximately:

    - only 1 client per year met their 'emotional wellbeing' target
    - only 2 clients per year met their quit-smoking targets
    - only 14 people per year met their exercise targets
    - only 18 individuals per year met their diet/nutrition targets.

Full-service activity data is included in Annex one.

3.3 Service costs

Over one million pounds has been allocated to this initiative over the last 3 years. The budget for the service has been increased year on year as follows:

Financial Year	Budget
2008/09	£307k
2009/10	£341k
2010/11	£369k

These figures exclude any additional costs of managing the service within the central public health team.

The total budget allocated to this service for the period of data collection mentioned above (April 2008 to September 2010 was therefore 832K, excluding any additional costs within the central public health team (307k + £341K + half of £396K).

Over £1,000 of tax-payer's money is budgeted to maintain this service every single day.

3.4 People employed, staff turnover and sickness absence

The total number of staff employed by the Health Trainer initiative since July 2006 is 29. Each member of staff is given basic training for up to 2 months before beginning client work and ongoing training throughout their employment. Fifteen members of staff have left their posts with an average of 17 months service (range 6-27 months). The average length of employment for all members of staff, including those currently in post, is 23 months.
Staff turnover for this staff group has been high compared with elsewhere in the PCT.

Sickness absence rates in this staff group have also been very high. The PCT average for sickness absence is 2.6% and the standard aimed for is 3% or less.
Health trainer sickness absence in 2009/10 was 16%, i.e. 6 times higher than the PCT average, and sickness absence in the current financial year to date is 14%, i.e. 5 times higher than the PCT average. Coupled with turnover and the need for thorough training of new staff, this means that the management input required by this staff group is intensive.

4. Why is it proposed to cease this service? The five reasons are as follows:

4.1 Lack of impact on population health because of the low number of new clients seen
4.2 Poor value for money and return on investment
4.3 High cost and low impact of the service when benchmarked against other services
4.4 Inability to transfer this work to an NHS provider trust as a commissionable service
4.5 The opportunity cost - while the initiative remains, more promising alternatives cannot be fully pursued.

Theses five reasons are explored in detail below

4.1 Lack of Impact on Population Health in Deprived Parts of Oxford City and Banbury -Low Number of new clients seen

The main points are:

Only 250 new clients per year were reached by this service on average.
This is a very small number by any standards.
This equates to only one new service contact generated by around 11 health trainers every working day.

Of these an even smaller number agreed a health plan (150 per year on average), and of these only tiny numbers of people achieved their own personal targets per year (2 smoking quitters, 14 meeting exercise targets and 18 achieving weight loss targets on average per year).

The inescapable conclusion is that the impact of this initiative on the health of the population has been very slight indeed, particularly when it is recalled that the point of the service is to prevent premature death in adults.

4.2 Poor value for money and return on investment

An analysis of the cost effectiveness of this initiative shows that the cost to the taxpayer from April 2008 to September 2010 was on average:

- **£1,300 per new client contacted**, whether or not a favourable result was achieved. (£832k / 640 clients)
- **£2,200 per individual health plan produced**, whether or not the targets in the plan were met.(£832k / 372 health plans)
- **£9,300 per individual for successfully giving up smoking** for 4 weeks (£832k / 89 total successful health plans delivered)
- **£9,300 per individual for meeting any agreed exercise target**
- **£9,300 per individual for successfully meeting any agreed dietary or weight loss target**
- It is not known whether or not these benefits were maintained.

These figures can only be described as extraordinarily expensive and demonstrate exceptionally poor value for money.

4.3 High Cost and Low Impact of Service Shown by Benchmarking and Comparative Data

Although it is difficult to find exact comparisons, but looking at the costs of other types of health service contacts from a range of sources gives stark results:

- £27 per standard GP consultation.
- £11 per adult health check carried out by outreach nurses in an Oxfordshire pilot project
- Health and Social Care advisor employed by the local authority £31 per hour, which might be the time spent with one client.
- For £228 a child can receive the full childhood vaccination regime
- For £741 an elderly person can receive cataract surgery.

Perhaps the best comparison is with the public health team's own Oxfordshire Stop-Smoking service which helps people stop smoking for **£145 per smoking quitter, and achieves 3,300 smoking quitters per year.** (ie reaching around 13 times more people than the health trainer initiative). This service is also specifically targeted at hard-to-reach groups. **This service is a staggering 64 times more cost-effective that the health trainer initiative.** (£145 per quitter compared with £9,300)

4.4 Inability to Be Able to Transfer This Service to a Provider Trust

As mentioned above, services directly provided by the Public Health team are currently being transferred to provider trusts. Services can only be accepted by provider trusts where due diligence checks show the service is viable and specified outcomes can delivered. In addition, the PCT as commissioner has to state its willingness to continue to commission these services for a number of years to provide stability.
With regard to the Health Trainer Service, effectiveness and good value for money cannot be demonstrated, and thus it would be impossible for the PCT to guarantee future commissioning of this service.
This is a further indication that **the service is not viable within the current operating principles of the NHS - it is simply not commissionable in its present form, nor can realistic changes be envisaged that would make it commissionable in the future.**

4.5 The opportunity cost - while this initiative remains, more promising alternatives cannot be fully pursued.

Section 8 sets out the other initiatives which have either begun or are proposed to substitute or replace this initiative. These cannot be pursued fully while this initiative remains.

5. Are Similar Steps Being Taken Elsewhere?

The Health Trainer Service in Milton Keynes has recently been decommissioned by the PCT. This was contracted out to a provider organisation and the contract has not been re-tendered.

6. What is the Likely Impact of ceasing this service on the population and how can the impact be mitigated?

The coverage of the health trainer initiative (which sees on average 250 new clients per year and agrees only 150 health plans) is very small indeed compared with the total adult population of the target population. This means that the impact on any section of the population is very small. When it is also taken into account that only around 36 clients per year meet their agreed targets, the impact of the service falls from being very small to being extremely small.

An Equality Impact Assessment has shown that the impact on individual vulnerable groups of ceasing this service, including ethnic minority groups, will be slight because of:

- the small number of new clients contacted and the even smaller number of those successfully meeting their own targets
- poor evidence of cost-effectiveness among those who were contacted
- other services (existing and new) which will mitigate any potential impact (described below).

7. What is the Likely Impact of ceasing this service on staff and how can the impact be mitigated?

The formal proposal to cease this service was set out as part of a wider PCT Staff Consultation document issued on January 19th 2011. No action was taken apart from to consult with staff and inform affected staff groups that they were 'affected by change' - a technical Human Resources term meaning that proposals are under discussion which may affect individual posts.

Staff-side unions were engaged in this consultation through the usual formal and informal channels. It is anticipated that union representatives will brief the Health Overview and Scrutiny Committee on their specific concerns. The consultation document was launched at a staff meeting, and following this, within the Public Health Directorate, meetings with all staff groups affected by change were held on 20 and 21 January, including Health Trainers. This was followed up by detailed meetings with all individuals involved to ensure understanding of how they may be affected by change, options for national and local redundancy schemes, offers of suitable alternative employment and redeployment support plus their option to respond to the consultation.

During this staff consultation, it became clear that it would be beneficial to seek the opinion of the Health Overview and Scrutiny Committee (HOSC) on this issue, and so the PCT requested HOSC to scrutinise the issue and give their opinion and advice as soon as practicable.

It was proposed to staff-side representatives that the Health Trainer initiative should be formally taken out of the PCT staff consultation at this point so as to allow unfettered debate at HOSC. This was agreed to, and so the present position is that the Health Trainer initiative is suspended from the PCT consultation pending the discussion with HOSC.

Depending on the opinion and advice of HOSC, the next steps will be negotiated in the usual way through the PCT's Staff Partnership Forum. Whatever the outcome, the PCT will safeguard the legal rights of its staff.

At no time have any Health Trainers been formally put 'at risk' of redundancy, although if the service were to cease, it would clearly be disingenuous to guarantee that they would not be affected as individuals.

Whatever the outcome, the staff employed as Health Trainers have all received extensive training including qualification at level 3 City and Guilds as part of their training. Their range of competences and experience gained is applicable to a range of roles.

8. What Services are Proposed to Substitute for or Replace this Initiative?

Examples of existing; new and potential services (with approximate investment) that will be in place to minimise the very small impact of this proposal are set out below:

Services Recently put in place

- The Family Intervention Project which teams up the staff of Children and Young Peoples' Services with Community Nurses and the Criminal Justice System to target our most needy families. This initiative is showing very good return on investment in Oxford with savings of £59K on average for the 28 families engaged so far. The idea is to be of benefit to adults as well as children. We are seeking to invest further in this service.

Existing services which support lifestyle change

- Oxfordshire Smoking Advice Service and other stop smoking services £525Kpa
- Slimming on referral service for Primary Care £85Kpa
- Exercise on Referral (PCT contribution) £10Kpa

Existing services targeted at vulnerable groups

- Interpretation Services £125Kpa
- Health Advocacy Service which aims specifically to improve access to NHS services for a range of Black and Minority Ethnic communities in areas of social deprivation £160Kpa
- We have also recently managed to maintain the 'Benefits in Practice' (BIP) scheme in deprived areas despite funding cuts from other agencies - this scheme places Citizens Advice Bureau benefits advisors in General Practice to help the worst-off access the benefits to which they are entitled. Cost to the PCT of maintaining BIP in the city is £20K pa

New Services:

- Benefits in practice (Banbury) as part of the Public Health review we reallocated investments on Benefits in practice and will be setting up a service in Banbury 13.5Kpa

- The new NHS Health Checks programme which aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. NHS Health Checks will start being offered in Oxfordshire in 2011/12 with full roll-out planned for 2012/13. The estimated cost of providing this service is £225K per year, based on information on costs we have gathered from pilots.

Potential New services

- The Department of Health are expected to produce documents on the future direction for Obesity and physical activity together with more guidance on the Public Health Responsibility Deal in Spring 2011. These documents together with information on local needs will steer our commissioning plans for the future.

Whatever the outcome, these investments signal the need for a change of tack reflecting our learning from the Health Trainer initiative. In future we would propose to commission services from existing or new service providers rather than provide services in-house ourselves.

Our overall aim will be to shift the large blocks of money spent on generic services in our county each year so that they better meet the needs of deprived communities whether urban or rural. The public sector spends over £2billion on services in Oxfordshire each year. We believe that by specifying contracts more tightly around health improvement and health inequalities, we can influence this spending to achieve a greater benefit to the population. In this way we believe we can influence the spending many millions of pounds of public money rather using our current management effort on running small services ourselves which may not give good value.

This work will be overseen by the Public Health Transition Group mentioned above and we welcome and invite full HOSC participation in this work.

9. What Consultation Has Taken Place and Why has Formal Public Consultation Not Taken Place?

The following groups have been consulted or will have been consulted by the time of the HOSC meeting:

- The Public Health Transition Group
- The PCT Executive and Board
- The PCT's staff partnership forum
- The health trainers, collectively and individually
- Individual County and District Councillors in the areas where the initiative is targeted and elsewhere
- The LINk Steering Group on the 2nd of March 2011
- The Joint Health Overview and Scrutiny Committee on the 10th of March 2011.

At the HOSC meeting, we would wish to reach a view of how best to apply the paragraph below to this proposal:

"Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s)".

Looking at the data, our own view is that this proposal does not constitute a substantial variation in service provision because:

- The numbers of people affected are by the initiative in total are very small indeed with annual average figures of 36 successful plans achieved out of a total around 150 plans and 260 new contacts.

- The initiative is not effective - it simply does not make a discernible impact on mortality in socially deprived communities

- The initiative is very far from being cost effective: our conclusion is that taxpayer's money is not well invested here. Alternative approaches show greater potential for success.

- The Equality Impact Assessment for this proposal does not point to a specific community group to be consulted with. The conclusion is that ceasing the service would not have a differential impact on any particular group of people, including black and ethnic minority communities.

Our conclusion therefore is that, on balance, the public interest would be best served by ceasing this service on the basis of the information in front of us and to use the experience gained to develop alternatives which are more likely to be effective. We do not believe that wider consultation would be helpful in this case. We ask for the opinion and advice of the Health Overview and Scrutiny Committee on this matter.

10. What Next Steps are Proposed and What Is the Joint Health Overview and Scrutiny Committee Requested To Do?

In the light of this information, as Director of Public Health, I am compelled to conclude that the only logical step is to propose ceasing the Health Trainer initiative. This is a difficult proposal to make as my team and I have initiated, developed and championed this initiative over a number of years. Nonetheless, the facts will not be denied, we must provide the public with the very best services they deserve and I conclude that this service cannot realistically be changed or modified to be cost effective. The main reasons are summarised again here:

- **Lack of Impact on Population Health: we will not reduce inequalities in mortality through this initiative**
- **Low Numbers of new patients seen, low numbers of health plans produced and poor effectiveness of those plans** (36 successful plans on average per year)
- **Very poor value for money and return on investment** (£9,300 per successful plan)

- **High cost and low impact of the service when benchmarked against other services** (£9,300 per successful plan compared with £145 per quitter from the Oxfordshire Stop Smoking Service)
- **Inability to transfer this work to an NHS provider trust as a commissionable service**
- **The opportunity cost - while the initiative remains, more promising alternatives cannot be fully pursued.**

The Health Overview and Scrutiny Committee are there therefore respectfully asked to:

- **Debate this issue and give a general opinion and advice based on the content of this paper and other presentations received at HOSC**

- **Support the conclusion that the best way forward is to cease this initiative and to pursue alternative service models as the way forward.**

Jonathan McWilliam - Director of Public Health for Oxfordshire
Jackie Wilderspin - Assistant Director of Public Health
Shakiba Habibula - Deputy Director of Public Health
Val Messenger - Deputy Director of Public Health

February 2011

Supplementary Information: Frequently Asked Questions

1. Is this change prompted by the need to cut NHS budgets?
No. This change is prompted by a comprehensive analysis of the effectiveness and value for money in Public Health services. Although it is consulted upon within a PCT document which does seek savings, this proposal is not motivated by a need to make financial savings.

2. Was the data collected fairly given factors in 2010 such as the swine flu pandemic?
The data was averaged over the period April 2008 to September 2010. This sort of fluctuation in activity would not affect the conclusions in this paper.

3. Why weren't the health trainer team allowed to work with under 18 year olds?
The aim of the service is to reduce the gap in life expectancy, therefore the target population is those at risk of premature death. This means targeting clients aged 40-60 with risky lifestyles and behaviours. Spending time with under 18s would have reduced cost effectiveness even further.

4. Why weren't health trainers allowed to do group work?
The health trainers do carry out some group work but the main aim was to use the initiative as a way of recruiting individual clients who are hard to reach. From the outset the aim has been to help individuals to change behaviour and reduce risk of premature death. Group work alone will not deliver this.

Much of the client work shows that people have complex issues. Group work may only give general information and the aim of the service is to give specific and appropriate support to individuals.

5. You weren't measuring the right things in your review. You have ignored the qualitative aspects, quality of life, confidence and self esteem issues and feedback that clients have given.

The cost effectiveness calculation has to be based on measureable outcomes such as significant weight loss (e.g. 5% of body weight), smoking cessation or self reporting of meeting a specific goal. Additional factors based on subjective assessments e.g. self confidence may or may not improve, and they are of value to clients, but they will not reduce premature death and that is the point of the service.

Individual clients will of course report good successes from the service, but we need to measure the impact of the service as a whole if we are to improve the population's health.

6. Aren't we missing some other important outcomes such as work on mental wellbeing?

In two and a half years only 6 people were seen by the service with improving mental wellbeing as their primary goal, I.e. around 2-3 people per year. Of these 6, only 2 achieved their goals i.e. less than one person per year. There may well have been other benefits to mental health and self-esteem, through contact with this service and these are welcomed, but these were not the primary point of this initiative.

7. Why can't you just reduce the size of the service rather than ceasing it completely?

Why didn't you engage the team and ask for their ideas in making improvements?

The real problem lies in the basic design of the service. We judge that whether this initiative were larger or smaller it would not produce effective results nor could it give a good return on investment. We conclude that this service model will not reduce premature death whatever its detailed size or shape. This issue isn't about making adjustments to a service that almost works, the facts show that the service is very far from working.

A very rough estimate may help to illustrate the point here: to become viable and commissionable, the service would probably have to achieve successful outcomes for its clients at a cost of around, say, £300 per successful plan delivered. On present performance this would require an increase of 30 fold in recruitment of new clients per health trainer which is clearly unachievable for this service model.

8. Were staff not told there was a problem?

All team members knew the importance of demonstrating the effectiveness of the service through regular data collection. Each month staff had to send monthly reports about clients and outcomes. They were not given individual targets but were aware that the number of clients mattered.

Individual staff have received regular one to one reviews of performance.

The results of the review of services undertaken in the Public Health department were fed back to staff. As pointed out above, we believe that the solution cannot

lie in making adjustments to the service model, the problem lies within the service model itself.

9. Isn't there national concern to protect Public Health posts at present?
Ministers are concerned that very specialist public health skills are not lost before Public Health England is formed. This applies only to those who have completed specialist training at consultant level. It does not apply at all to middle managers or health trainers. Health Trainers do not have the specialist public health skills that ministers have voiced concern about losing.

Annex 1

Health Trainer Activity Data from 01.04.2008 to 03.09.2010

Gender	Count
Male	234
Female	413
Total	647

Ethnicity	Count
A: White - British	430
B: White - Irish	7
C: Other White Background	11
D: Mixed - White and Black Caribbean	6
E: Mixed - White and Black African	3
G: Mixed - Any Other Mixed Background	5
H: Asian or Asian British - Indian	36
I: Asian or Asian British - Pakistani	74
J: Asian or Asian British - Bangladeshi	4
K: Any Other Asian Background	3
L: Black or Black British - Caribbean	12
M: Black or Black British - African	10
O: Chinese	1
P: Any Other Ethnic Group	3
Z: Not Stated	42
	647

Comment: the table above shows that the ethnic minority groups contacted reflect the composition of the populations targeted by the health trainer service.

Heath Trainers Clients Progress against PHP											
	CVD	General Practice	Health Promotion Event	Health Visitor	Other	Pharmacy (non CVD)	Phone	Poster/Card	Referred from HT champion	Self	Total
Not required	46	2	163	1	4	0	3	0	1	55	275
Not recorded	0	3	3	1	9	0	0	5	0	1	22
ACHIEVED	3	13	21	1	10	2	3	3	1	33	90
NOT ACHIEVED	3	10	20	1	10	5	2	12	1	41	105
PART ACHIEVED	6	13	42	2	8	5	5	4	0	61	146
Total	58	41	249	6	41	12	13	24	3	191	638

HT Clients Progress against PHP											
	CVD	General Practice	Health Promotion Event	Health Visitor	Other	Pharmacy (non CVD)	Phone	Poster/Card	Referred from HT champion	Self	Total
Eligible did not want to proceed			1		1					1	3
Proceed to PHP	12	39	86	5	42	12	11	24	2	139	**372**
Eligible service mot wanted					1						1
Info Only	44	1	158	1			2			43	**249**
Not Eligible			1								1
Recommended to Primary Care										6	6
Referred to accredited			2								2

Health Trainer											
Signpost Only	2	1	1							1	5
Total	58	41	249	6	44	12	13	24	2	190	**639**

Comment: The above table shows that of the 639 clients seen over 29 months, 249 received information only (signposting), and 372 went on to make personal health plans (PHPs).
Approximate annual averages for these figures are 260 new clients seen and 150 health plans made.

HT Clients Progress against Primary Issue												
	Alcohol		Diet		Emotional Wellbeing		Exercise		Smoking		Total	
	Client	%	Client	%	Client	%	Client	%	Client	%	Client	%
Not Required	-	-	-	-	-	-	-	-	-	-		
Not recorded	-	-	18	10%	-	-	3	2%	1	4%	22	
ACHIEVED	**4**	**57%**	**45**	**25%**	**2**	**33%**	**34**	**23%**	**4**	**17%**	**89**	
NOT ACHIEVED	1	14%	59	32.5%	-	-	33	23%	11	46%	104	
PART ACHIEVED	2	29%	59	32.5%	4	66%	75	52%	8	33%	148	
TOTAL	**7**	**100%**	**181**	**100%**	**6**	**100%**	**145**	**100%**	**24**	**100%**	**363**	

Comment: The table above gives the hard outcome data for the health trainer initiative.
Over 29 months, 363 people made health plans, of whom 89 achieved their primary goal (a success rate of about 1 in 4).
The bottom row shows that the majority of plans were about diet and exercise, with far smaller numbers focussing on alcohol, emotional wellbeing and smoking.
The central row in bold labelled 'achieved' is telling - this shows the numbers of actual individuals who met their targets over the 29 months ie 4 people for alcohol, 45 for diet and so on.
This gives annual success figures for individuals as follows:

- **Alcohol: between 1 and 2 people were successful per year (4 divided by 29 months x 12)**
- **Diet: between 18 and 19 people were successful per year**
- **Emotional Wellbeing: about one person per year was successful.**
- **Exercise: about 14 people per year were successful**
- **Smoking: between 1 and 2 people per year were successful.**

	Diet & Exercise	
	Client	%
Not Required	21	6%
Not recorded	-	-
ACHIEVED	79	24%
NOT ACHIEVED	92	28%
PART ACHIEVED	134	42%
TOTAL	326	100%

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An injury to one is an injury to all
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In defence of Public Health.

This short paper looks at the maintenance of the Public Health Trainer Service in the context of the health needs of the local population. It addresses the proposals in an internal ***NHS Oxfordshire*** (PCT) consultation document ***"Proposed new organisation structure for the commissioning arm of NHS Oxfordshire"*.** This paper, issued to staff on 19th January 2011 includes public health cuts and proposes a rapid move to dismiss all staff involved in the Healthy Living Partnership, Health Trainer service. Community Development Workers would be cut from three to one. NHS Oxfordshire (Oxfordshire PCT) originally consulted with local stakeholders, communities, and the public in the process of setting up these services. NHS Oxfordshire now wishes to withdraw these services without public consultation or properly considering the direct, indirect, and disproportionate negative impacts that the potential loss of these services might have on certain 'protected groups' and vulnerable, disadvantaged communities currently bearing the brunt of adverse health inequalities.

Premature death.

Oxfordshire is an area of huge health inequalities. A headline indicator is that men in the most disadvantaged areas of Oxfordshire are likely to die 7 years before those in the most affluent areas. For women the figure is almost 6 years. Improving this appalling statistic was one of the principle motivators for setting up the health trainer service. The Director of Public Health and his team are to be congratulated on a number of useful public health initiatives to rectify this situation – in fact even the alarming figures above already show a significant improvement over recent years.

Challenging the cuts rationale

The rationale behind the rapid closure of these services appears to be that they have run their course or have been tested and found to be ineffective – the latter claim being particularly true of the Health Trainer service. There are concerns that these claims are a smokescreen for an attempt to transfer the cost of the financial crisis to a section of the population least able to absorb significant service cuts.

Contesting NHS Oxfordshire's claims of inefficiency in the health trainer service.
Typical NHS provider services invest around 75% of their income on wages for frontline staff. This service, however, allocates about 33% of its income on frontline staff wages. ie £135k out of £400k. Frontline staff struggle to show they are 'value for money' because of the exceptionally high structural costs of the service. This configuration inflates costs per patient contact by 600%.
Our view is that this is a problem which can be fixed without ending the provision and urge that the service, like the Smoking Cessation Service, is transferred to the Community Health Oxfordshire side of the PCT en route to Oxford Health Foundation Trust.
Cost figures also assume the service is fully staffed. This is not the case. Each year PCT

does NOT in fact spend the claimed £400k on the service. There is a significant underspend because of vacancies. At the time of writing this report UNISON is working with management to try to quantify this. Again this significantly skews the calculations of the costs of the service. The significance of this is that the closure of the service and sacking of the frontline staff will NOT make the forecast savings for the PCT.

An ineffective service?
Health Trainers challenge the way the data was collected, what was measured and the lack of feedback in any audit cycle. A process of discussion between the management and workforce would allow solutions to alleged ineffectiveness to have been explored. One health trainer commented that supporting people in areas of low wages with multiple re-enforcing problems is not going to lead to a series of quick wins. The example the trainer gave was of a client with debt problems losing her home, losing self confidence and failing to follow the agreed exercise programme. Did this intervention 'fail' or should we note the initial progress and aim to resume the work once the immediate crisis had been resolved? This is also partly an issue of measuring behaviour change and appreciating that over a period small quantitive changes will lead to qualitative change. Health Trainers have also been of the view that supporting clients on a one-to-one basis over a period up to 3 months is inevitably expensive. They have long been pushing for increased involvement in group sessions and engaging with teenagers as well as adults and have spoken of the value of being located in health centres.

Experience of others
The South Central Strategic Health Authority continues to promote the health trainer service across our region even offering grants to assist PCTs in running this service. UNISON has urged NHS Oxfordshire to apply for support. We note too that West Berkshire PCT is maintaining its health trainer service for the people of Reading.

Key points

The Health Trainers, themselves drawn from target communities, have been trained in the principles of public health and modifying health related behaviours with clients. They are an absolutely invaluable front line resource intimately connecting Public Health officials with key communities they must serve.

UNISON's view is that simply shutting down a service as a response to a poor evaluation results is not responsible. The problem of deprivation remains – it needs to be fixed. We call for a period of public consultation about this service with a view to strengthening it and making it as efficient and effective as possible.

We urge the Joint Health Scrutiny Committee to press that *at the minimum* a full public consultation takes place regarding the future of the Health Trainer service.

We urge that the PCT (NHS Oxfordshire) is required to publish a detailed impact assessment of their plans to cut their staffing by over 30% this year and that this assessment is presented for public consultation and debate.

Oxfordshire LINk briefing: the proposed PCT reconfiguration.

Oxfordshire LINk has a duty to ensure the voices of hard to reach and minority groups are heard.

Financial situation: The PCT has 4.4m savings to make over the next three years. They are on track with their proposed 2.2m saving for this year and to maintaining a financial buffer in excess of £700,000. The PCT is not looking to save money by freezing incremental salary rises in October this year as advised by NHS Employers; freezing incremental rises this year for those staff on salaries in excess of band 7 level (circa over £40,000) would provide further savings. Monies received from various financial partners of the Oxfordshire Healthy Living Partnership (OHLP) will be probably be lost if the service closes due to loss of the Public Health coordinator posts proposed in the reconfiguration document (Please see the attached separate detailed report on OHLP and Health Trainers for further information).

Proposed reconfiguration: There are several key frontline public health posts that target our known areas of deprivation which the PCT are seeking to remove to further save monies; these posts comprise Health Trainers and their coordinators. Service improvement suggestions that would probably lead to improved effectiveness and efficiency that were put forward by the Health Trainers were not implemented e.g. more group work. GP consultations do not allow time for in-depth, tailored behavior change advice and support. Many GPs refer to Health Trainers for this very reason, often sending their most intransigent patients. Health Trainers offer a broad service, allowing time for clients to review their health and lifestyle, and identify and prioritise the changes they need to make. The Health Trainers are recruited from the areas and target population they serve. Removing these 'key for equality of access' frontline public health posts does not save money in the long run and appears to go directly against the current guidance issued by the Chief Executive of NHS England, this is also attached and the Public Health guidance is covered on page 8 of the letter.

Strategy: The strategic direction of the proposed reconfiguration in regard to the frontline public health posts does not match that of Oxfordshire Social and Community Services in that it is not preventative.

Equality Impact Assessment (EIA):

The Health Trainers specific EIA that was carried out holds no data on BME clients, reporting this is because they were not specifically targeted. The Health Trainer service, set up in 2006 specifically targeted hard to reach groups and our BME citizens fall within the definition of 'hard to reach' which also includes prisoners and other groups. This and other similar inaccuracies within the EIA are of grave concern. Some of the changes proposed in the EIA are welcome but

certainly not as an alternative to the Health Trainer service and the likely knock on effects of closure of the OHLP (see pages 4 and 5 of the attached report under the headline ‘Completion of Chances for Change Projects’), rather as an improvement for issues of equality of access.

Oxfordshire Local Involvement Network
Update for Oxfordshire Joint Health
Overview & Scrutiny Committee meeting 10th March 2011

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards during the first quarter of this year.

Ongoing projects and engagement:
Self Directed Support (Personal Budgets)
The first phase of LINk research into the experience and perceptions of clients of traditional social care services and Self Directed Support was carried out in June 2010 and reported in September 2010. The next phase of research which is planned to involve re-interviewing the clients who were part of the 2010 survey, plus an additional 30 clients, so that the 2011 research sample includes a minimum total of 50 respondents. As this project will include a significantly larger sample than the 2010 work it is proposed that a mix of face-to-face meetings, group discussions and telephone interviews are carried out:

- Half of the sample are planned to be interviewed in a home visit by a trained healthcare professional. This approach worked well in the 2010 project and means that the interviewer can personalise the discussion and focus on issues of particular concern to the respondent.
- At least 10 people from ethnic minority groups will be included in this 2011 phase of the research. Only 1 person (out of 20) in the 2010 sample was non-white British. It is envisaged that participants will be reached through existing ethnic minority support networks/groups in Oxfordshire and with the help of appropriate public sector professionals.
- The remainder of the sample will be interviewed by phone - primarily to keep costs down.

As in 2010, and where appropriate, the views of the client will be supplemented by (or provided by) a proxy such as a carer, family member or caring professional.

N.B. The viability of carrying out the full research proposal will rely on sufficient LINk funding being available for all work projects during 2011-12. It is likely on present information that only a part of this can be funded to continue in the next financial year.

'Health' Hearsay in partnership with the Nuffield Orthopaedic Centre
Following a similar model to Social Care 'Hearsay', this event, to gain patient and carer views about NOC Outpatient services, took place on 29th November 2010. The purpose was to find out what patients most wanted to see changed and to invite suggestions about how to implement improvements. LINk has received a commitment from NOC Directors and staff that they would respond and devise an action plan (where feasible) to take forward those recommendations. The 'Making Change' report has now been completed with 5 key priorities covering 'before, during and after the appointment', which patients and carers wished to see changes made, have been explained in detail in the report. The NOC have committed to providing a first update on progress in May 2011. The full report can be obtained from the LINk office or http://www.makesachange.org.uk/cms/site/news/oxfordshire/health-hearsay-feedback.aspx

Second 'Social Care' Hearsay event – 11th March 2011
As members will be aware, this event is for people who use Adult Social Care services with their carers, friends and family members. The first report from the March 2010 event produced some significant recommendations, with those attending able to speak directly to SCS Directors and other staff. Clients told the LINk what was working well, if something wasn't right or if something was missing that would really help. Officers from Social and Community services have been working on an action plan throughout the last year to achieve improvements, with quarterly updates being sent to all those who attended or gave feedback and posted on the LINk website. At the 2011 event, the audience will hear if the quality of services people receive has improved, be given an update from the 2010 key recommendations, explore what further the LINk and Social and Community Services can do to change or improve services and to set further goals and recommendations for 2011-12. All updates since the March 2010 event and report can be obtained from the LINk office or
http://www.makesachange.org.uk/cms/site/news/oxfordshire/hearsay-update.aspx

'Enter and View' visits to Care Homes
The LINk has been carrying out a series of visits to 31 Care Homes initially, the criteria being size, locality to evenly cover the County and a range of service providers. LINk authorised visitors (in pairs) are writing reports based on two questionnaires which have been supplied for guidance purposes. An initial report will be made available once this first series of visits has been completed.

Drug Recovery Project
The LINk DRP Project Group had it's final meeting in public on 18th February 2011. Attended by a very broad spectrum of the community this was an opportunity to report back to those who have taken part over the past two years and also gave Howard House staff an opportunity to answer any questions. The LINk will be arranging, in collaboration with the service provider, an 'Enter and View' information gathering visit later this year.

Other projects (ongoing or concluding):

Community Mental Health Services
Following the announcement of some significant reprovision of 'Talking Therapies' nationally and the forthcoming results of a local consultation, it is proposed that this project, which has been carrying out research into delays in appointments and receiving appropriate treatment through CMHTs, should be put on hold until details of any service changes become known. An interim report will be available at the beginning of March.

GP appointments (extended hours)
The next step with this project is to engage in further communications with GP practices and Consortia with a view to making the LINk available to Patient Practice Groups and other PPI channels, within Oxfordshire's pathfinder status in the transition to GP Commissioning.

Podiatry
An information resource, comprising an attractively designed booklet, website pages and other means of communicating comprehensive local information about Foot Care is being assembled. This will be available by the end of March and widely circulated. The PCT, Age UK and local Podiatry & Chiropody practitioners are supporting the project.

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

Oxfordshire Unlimited
The membership project is making progress to help develop this User Led Organisation for those with physical disabilities in Oxfordshire. This project is providing Unlimited with the ability to increase its membership and become better known throughout the county and hence to offer to the community a key reference base for information and services in the future. A report on progress will be made at the end of the current service agreement on 31st March.

Oxfordshire Neurological Alliance
LINk is providing ongoing support for the local branch, supporting ONA to publicise its work and raise public awareness, the LINk is helping to produce promotional materials, publish a website and to provide additional channels of contact with local people. The LINk has funded the facilitation of an initial business planning workshop, hosted at Headway, from which a plan for the next stages of development will be taken forward.

Community Chest / 'Have a Say' Fund
Following an interesting and varied response to this grant fund, the LINk has awarded 11 grants to local organisations to assist in their engagement with service users, carers and the public. The LINk is putting together a booklet to promote the project work made possible by the grants. A verbal update on these projects will be provided at the meeting.

Current and past LINk newsletters and bulletins can be found at www.makesachange.org.uk/cms/site/news/oxfordshire/latest-oxfordshire-link-newsletter.aspx

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