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Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 19 January 2012 at 10.00 am
County Hall

Membership

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

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

Notes: ***There will be a pre-meeting at 9.00 a.m. for members of the Committee only***
Date of next meeting: *8 March 2012*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk
Committee Officer - *Claire Phillips, Tel: (01865) 323967*
claire.phillips@oxfordshire.gov.uk

Peter G. Clark.

Peter G. Clark
County Solicitor

January 2012

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 18)

4. Speaking to or Petitioning the Committee

5. Public Health (Pages 19 - 56)

10.15

Dr Jonathan McWilliam, the Director of Public Health for Oxfordshire, will present his fifth Annual Report. The presentation will be followed by questions from HOSC members. The Director's Annual Report is attached. **(JHO5)**

6. Community Mental Health Teams; update on progress and future plans (Pages 57 - 84)

11.00

In 2010 the then Oxfordshire and Buckinghamshire Mental Health NHS Trust consulted on plans to restructure community mental health provision. The aim of the restructuring was to ensure continued delivery of high quality effective patient centred mental health care to the adult population of Oxfordshire. That aim would be achieved "by basing service organisation on patient need and ensuring that the service model delivers:

- Simplicity of patient pathways with the removal of artificial barriers
- Accessibility
- Continuity of care
- Robust teams with the skills to meet the majority of patient needs from within the team, thus avoiding multiple onward referrals
- Clarity of clinical responsibility
- Clinical Leadership
- Optimal utilisation of resource
- Management locally and corporately which support the delivery of optimal care and reduce the burden of bureaucracy"

The following officers from what is now Oxford Health NHS Foundation Trust will provide an update on progress made since the reorganisation and on future plans for community mental health provision;

David Bradley – Chief Operating Officer
Jackie Thomas – Head of Service and Business Development
Eddie McLaughlin – Divisional Director, Mental Health

The original report, excluding appendices, setting out the proposed changes and an update report are attached **(JHO6a and b)**

7. Early Intervention Hubs and health matters (Pages 85 - 90)

11.45

At the November 2011 meeting members of the HOSC asked to be informed of how the County Council's new Early Intervention Hubs will deal with health issues relating to young people.

Maria Godfrey, Early Intervention Manager, Children, Education and Families will present the attached paper **(JHO7)**, and answer members' questions.

8. Quality, Innovation, Productivity and Prevention (QIPP) programme and planned care disinvestment (Pages 91 - 94)

12.15

QIPP is "a large scale transformational programme for the NHS", instigated by the Department of Health. The intention is to improve the quality of healthcare delivered by the NHS in England, while at the same time making up to £20billion of efficiency savings by 2014-15. The savings are expected to be reinvested in frontline care.

The attached paper **(JHO8)** titled, 'Quality, Innovation, Productivity and Prevention - how the NHS can protect and promote quality while releasing savings across the health system' will be presented by Dr Stephen Richards and Alan Webb from the Oxfordshire Clinical Commissioning Group (OCCG) and Francis Fairman, Clinical Effectiveness Principal from the NHS Cluster (PCT).

They will provide background to the QIPP programme and explain how QIPP will affect services and the planned care disinvestment programme.

9. Oxfordshire LINk Group – Information Share (Pages 95 - 96)

13.00

The regular update from the Oxfordshire LINk is attached **(JHO9)**. Sue Butterworth, Chair of the Oxfordshire LINk, and Adrian Chant, LINk Locality Manager, will attend to answer questions. In addition Lisa Gregory from the Strategy and Performance team in Social and Community Services will attend to update members about the HealthWatch consultation and procurement for Local HealthWatch in the light of the decision of the Department of Health to delay implementation on HealthWatch until April 2013.

10. Chairman's Report

13.20

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

11. Close of Meeting

13.30

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 10 November 2011 commencing at 10.00 am and finishing at 1.25 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Jenny Hannaby Councillor Don Seale Councillor C.H. Shouler Councillor Val Smith Councillor Keith Strangwood Councillor Lawrie Stratford Councillor Susanna Pressel District Councillor Rose Stratford Dr Harry DickinsonDistrict Councillor Martin Barrett District Councillor Elizabeth Gillespie
Co-opted Members:	Dr Harry Dickinson
Other Members in Attendance:	
By Invitation:	
Officers:	
Whole of meeting	Roger Edwards Jonathan McWilliam
Part of meeting	
Agenda Item	**Officer Attending** See agenda

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

62/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from District Councillors Christopher Hood and Hilary Hibbert-Biles and Mrs Ann Tomline.

Councillor Elizabeth Gillespie substituted for Councillor Hood and Councillor Martin Barrett substituted for Councillor Biles.

63/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillors Rose Stratford and Lawrie Stratford declared an interest as members of the Bicester Hospital League of Friends.
Councillor Dr Peter Skolar declared an interest as a member of the Townlands Hospital League of Friends.
Councillor Jenny Hannaby declared an interest as a member of the Wantage Hospital League of Friends.

64/11 MINUTES

(Agenda No. 3)

The minutes of the meeting held on September 15th 2011 were agreed and signed as a correct record of the meeting.

The following points were made:

Item 56/11 – Councillor Strangwood commented that nobody from the NHS had been present at the meeting and so it was not possible for HOSC members to ask questions about changes to the gynaecology service at the Horton General Hospital.

Councillor Hannaby asked when the proposed review of Alcohol services was likely to begin. The reply was, as soon as possible.

65/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There were no requests to speak or petitions to present.

66/11 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health for Oxfordshire presented his report on the development of the new Health and Wellbeing Board (H&WB). Dr McWilliam stressed that the Board would provide an excellent opportunity for providing joined up solutions to health and social care issues. The Board must not be allowed to become a talking shop but must deliver change and set and ensure the achievement of realistic and meaningful targets.

The HOSC would have a key role in scrutinising the work of the Board and ensuring that the focus on improving healthcare for the residents of Oxfordshire was maintained and that positive outcomes were achieved.

It is expected that the Board would have three main themes:

i. Prevention
ii. Breaking the cycle of deprivation
iii. Joining up finances

Of the four supporting Boards three; Children and Young People, Adult Health and Social Care and Health Improvement, would meet before March 2012 and clarify their membership, terms of reference and aims. The Public Involvement Board, to be chaired by the Chair of HealthWatch, would be developed over the next year. It would be important to take care to involve as wide a range of stakeholders as possible in the development of the Board.

Finally Dr McWilliam stated that the Boards would not be adding layers of bureaucracy but would use existing mechanisms wherever possible.

During the subsequent question and answer session the following points were made:

- Minutes of the H&WB and supporting boards should be made available to the appropriate scrutiny committees and H&WB minutes should be included with the HOSC agendas.
- Dr McWilliam would be invited to a future HOSC meeting to give a presentation on "prevention".
- To ensure that the Board is effective it should be expected to produce a work programme containing "practical deliverables" with local targets that could actually make a difference. The programme should contain the names of accountable officers/members together with dates for achieving targets.
- The HOSC should examine the programme and monitor the achievement (or not) of the targets.
- Concern was expressed over whether or not the Board was fully representative of the whole County. It was explained that the membership of the Board had been decided by the County Leaders' Group (the Leaders of the County, District and City Councils).
- Concern was also expressed that the new set up would lead to increased costs with more meetings and officer and member time and resources being used. It was pointed out that the level of bureaucracy should not be increased as the Children's Trust and the Health and Wellbeing Partnership would be abolished and the Adult Health and Social Care Board would use existing management groups to undertake much of the work. Members remained sceptical.
- It was noted that the Leader of the County Council was to chair the H&WB. Members of the HOSC questioned whether this was appropriate in view of the level of work that would be entailed on top of the Leader's already heavy workload. Would it not be more effective to have a Cabinet Member for Health?

  It was pointed out that the Cabinet Member for Adult Services was responsible for both social care and health issues. However it was questioned whether, bearing in mind the additional level of responsibility that the County Council would have in future for health issues, one person could successfully combine responsibility for both.

Following the discussion members **agreed**:

i. In view of the large workload involved, the HOSC would recommend that, at a future date, a new Cabinet post would be created of Cabinet Member for Health.
ii. The HOSC would wish to see a report in twelve months time that would indicate the level of resources being devoted to the bureaucracy then compared with now.

Dr McWilliam was thanked for his presentation and members wishes the new Board well.

67/11 APPROPRIATE CARE FOR EVERYONE (ACE) PROGRAMME

(Agenda No. 6)

Prior to the presentation of the report Councillor David Turner, member for the Chalgrove Division asked a question specifically related to Watlington Care Home. Cllr Turner wished to know when the proposals in the ACE report were likely to be developed such that it would be possible to identify specific implications for parts of the community, e.g. Watlington Care Home. He also asked whether the private sector should be represented on the Programme Board.

Mr Sinclair replied that there was no timetable set but that regular reports are being made to the Creating a Healthy Oxfordshire (CAHO) Board and that Councillors would be kept informed of progress.

With regard to the Board; the aim had been to have a small and effective group that included commissioners, providers and clinicians.

Mr Sinclair then presented his paper. He stressed that the aims of the ACE programme were for more people to be cared for at home with a consequent reduction in the number of beds in use in both acute and community settings.

Beds need to be used more effectively and there is a substantial piece of work being done to identify how this could happen. Work is also being done to identify ways in which people could be helped to maintain their independence, to improve the use of pooled budgets and to improve communications.

Delayed Transfers of Care (DTOC) has no single cause and the present situation of high numbers of blocked beds could get worse before it gets better. Extra investment is not yet delivering change and new services which are being developed have yet to show benefits. However, rather than just concentrating on getting numbers down, the ACE programme is aiming to deal with the fundamentals that cause the delays.

Partners are now working more closely together to achieve common standards and criteria that all can subscribe to. There is also a common aim to bring about a change to the present risk averse attitudes that prevail.

The system needs to be simplified and clarified so that the understanding of GPs and others working in the field can be improved.

The intention is to concentrate on people and the quality of service rather than just numbers. What services should be provided within the funding available and where those services should be to provide the most good are overriding criteria.

Following the presentation members asked a large number of questions. Mr Sinclair and Ms Trevillion undertook to produce a written summary of the questions and to provide answers to them. The answers have been provided and are shown below:

Councillor David Turner

1. **Bed based intermediate care (Watlington specifically). When will we and providers know (particularly the Watlington care home) what the intentions of the Council and the PCT are in relation to the intermediate care beds?**
   As part of the ACE programme we are reviewing the type, volume and position of community beds that will be required to support the population of Oxfordshire for the future. This will not be a quick job to do and we will let you know how and when this work will happen.

   We also know that we currently have not got good use of the existing community bed services and we are aiming to do a short piece of work to improve this and we will be expecting to talk to you and the providers involved very soon.

2. **Why are the care home sector not represented on the ACE Programme Board?**
   The ACE Board membership consists of senior managers from the four statutory organisations Oxfordshire County Council, Primary Care Trust/Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust, and Oxford University Hospital NHS Trust. These are the four organisations that have statutory responsibility for the delivery of services for older people. It is not the intention to extend the membership or this partnership to a range of other providers including the care home sector because the board consists only of statutory providers. If we included the care home sector we would need to include all the other health and social care sectors and the voluntary sector. It is the Boards intention that the range of health and social care providers alongside patients and the public and the voluntary sector will have the opportunity to be engaged and be involved in the work of the programme over the coming months and an engagement and communication plan is being developed.

Councillor Charles Shouler

3. **Definition of who goes into an Intermediate Care Bed?**
   The majority of people who use an intermediate care bed are people who are being discharged from acute or community hospitals who will benefit from a

period of support and rehabilitation before returning home (for the majority of people) or going into a care home.

They are also used to support people to avoid admission to acute hospital where people require additional support and rehabilitation to be more independent at home.

4. **On point 3 of the report what does 'adjusting present capacity levels in acute and post-acute care' mean?**
   As part of the review of the number of beds – acute (the JR and the Horton) and post-acute (community hospitals and intermediate care beds) we will be reviewing whether we have the right number in the right place delivering the right type of service for the older population of Oxfordshire. The general view at the moment is that we have more beds – both acute and community – than our comparator areas and their level of delays are not as high as Oxfordshire's.

Councillor Jenny Hannaby

5. **Why have these actions not happened before now?**
   Our view is that Delayed Transfer of Care (DTOC) is a symptom of system not working well and therefore we have changed the approach to addressing it as a whole system issue. In essence this means starting with how the patient/service user experiences services and making sure that the services in place enable that person to get back on his/her feet and return home as effectively as possible. This will require us to ensure the care pathways are appropriate, coherent, accessible and delivered to the right capacity for the population.

Councillor Rose Stratford

6. **What is hospital at home service?**
   Hospital at home provides a service that rapidly responds to patients who need extra support and care and they can be treated in their own home, rather than being admitted into a hospital. Patients who require extra care will be assessed in the community for example by a GP, or by a unit such as the Community based Emergency Medical Unit in Abingdon Community Hospital, and if appropriate they can then be referred to Hospital at Home.

   The Hospital at Home team will also support the early discharge of patients from hospital who require sub-acute care (more intensive care) in the home. This care is provided on an average for seven days, but can be up to fourteen. The service aims to support efforts to tackle DTOC by reducing not only the need for patients to be admitted into hospital but also supporting them to return to their homes. The Hospital at Home service is currently running across the whole County.

7. **What is the role of the end of life care matrons?**
   Their role is to proactively identify people who may be within the last year of their life who have had three or more unplanned admissions to hospital and to work with people on

crisis planning thus reducing disruptive emergency admissions. In addition, the matrons educate, inform and support primary care professionals about End of Life Care and act as champions for equitable access from areas of deprivation, minority ethnic communities and patients with non-malignant conditions who are at the end of their lives.

8. What do the community beds provide? Do they provide respite?

The Community beds currently provide:

- Community hospital services – a range of sub-acute medical support for people who no longer need acute hospital services but still require some medical support and support to improve independence before either going home (for the majority) or move onto a care home.
- Intermediate Care Services – in nursing homes with additional rehabilitation support for a period up to 6 weeks to support people to increase and improve their independence at home. This is mostly as people are discharged from hospital before going home but can be an admission from home.

They are not normally used for respite as there are other specific respite care services available.

Dr Harry Dickinson

9. What alternatives are there for housing for older people?

There are a range of alternative housing options that are being looked at for older people but the main area of development is Extra Care Housing (ECH) and the County Council is working with the district and city council to increase the number of extra care facilities that will support people who can no longer manage in their own home but who do not need to go into a care home.

Most of these are new build facilities where people have the option to buy or rent a single or double self-contained flat with communal areas, often with optional meal facility, on site minimal care support and the option of increasing this care support as people's needs change.

There are 277 ECH flats currently in operation in Oxfordshire and this will rise to 407 by April next year. Eight further, new schemes have recently been awarded HCA (the Homes and Communities Agency, the national housing and regeneration agency for England) capital grant and we are confident this will increase ECH capacity to a total of 880 flats by 2015. In addition there are good prospects for further schemes which do not have HCA grant but can be supported by OCC grant which could add a further 275 units by 2015. This would give a grand total of over 1,000 ECH flats being developed between 2007 and 2015 although planning permissions, etc. still need agreement.

The provision of equipment and adaptations in peoples own homes is also critical here and both the PCT and the Council see this as a priority area of work and investment.

Cllr Keith Strangwood

10. What about the standard of and quality of care workers?

This is a critical area and as more people choose their own care workers via the use of a personal budget this becomes even more important. The ACE Board will be looking at this as part of its work and the new Joint Commissioning function in the County Council will be looking at this area as part of its new responsibilities.

There is some evidence that shows where people are able to choose or be supported to choose the people who come into their home to provide their care support that this is a more positive relationship for both the carer and the cared for.

Jonathan McWilliam

11. Would be good to have an analysis of why the DTOC figure is so high and has not been resolved yet? Why are there all these 29 services? What are we doing about long term solutions?

The way that the NHS has traditionally approached the 'hot spot' areas such as long waits for care, high emergency admission rates etc has been to bring in solutions to address those specific problems. Where problems have not been solved, other initiatives have been introduced sometimes not taking in to account the whole picture and creating a layered effect on service provision. This has resulted in a number of service overlaps which from the point of view of GPs and patients/service users seem confusing and not easy to access.

More often than not when planning care for people, because of the complex web of services available, it has led clinicians to default to the quickest and easiest solution, that is, to admit people in to hospital rather than find services to support them at home. Once those people have been treated in hospital the default option has been to discharge people to community hospitals. This has created a bottle neck of people who then become delayed in acute hospitals and then again in the community hospitals. From the community hospitals, people are all too easily admitted from there in to care homes.

The unintended outcome has been the provision of a bed based service with a number of delays at various points in the pathway leading to an aggregated high number of delays.

Councillor Susanna Pressel

12. Why could the DTOC figure get worse before they improve?

We are committed to making a sustainable change to a care pathway that provides the right care at the right place at the right time for people. This will take time as the care pathways need to be changed and delivered differently with the appropriate workforce. Sustainable well planned change takes time to implement. In the interim we expect the figures to get worse firstly due to 'winter pressures' and secondly with the transition to a much more integrated service, the numbers are unlikely to drop dramatically in the short term. We are, however, of the view that the number of delays will reduce slowly, in a sustainable way.

13. Why is it taking so long to resolve this?

The three main providers of services Oxford University Hospitals Trust (OUH), Oxford Health NHS Foundation Trust (Oxford Health) and Social and Community Services (SCS) currently work together but not in an integrated way. These three providers of care have now given their commitment to a single approach to addressing the problem. They have submitted an 8 point plan which predominantly focuses on delivering the right services in the right place that are integrated at the point of delivery to the patient/service user. This will result in fewer people going in to hospital and when people are admitted there will be a reduced number of people delayed.

Councillor Lawrie Stratford

14. Need to make sure that accommodation is suitable for people?

Yes agreed and the new Joint Commissioning service in the Council will be aiming to prioritise accommodation and housing options for people with care needs within its work.

15. Who determines the number of community beds that are needed?

As part of the review of this area it will be the commissioners from the PCT and the Council who will be undertaking the work and making the recommendations for any changes to the relevant NHS and Council governance bodies. And depending on the scale of these changes will mean different governing bodies will need to be involved.

Councillor Val Smith

16. How can two people get very different support – one coming out of the JR and the other from the city community hospital?

We know this different level of support is happening far too often across the county. The ACE Programme is aiming to achieve a consistency of approach and ways of working across the county.

17. And why is that when people want to go home this does not happen?

For the majority of people supporting a move home from hospital is the main aim. For some people where the risk of moving home is too great then the professionals involved will work with a patient and their family to find a suitable alternative –either care home or extra care housing.

What we do know is that there are far too many people working in health and social care who are too risk averse about supporting people to go home and are waiting for everything to be perfect for a patient to return home – but what that means is that people are delayed and we all know that any period longer than necessary being in an acute hospital is not beneficial particularly for older people and that getting people home to their home environment once the medical intervention is completed is the best thing for them.

Councillor Dr Peter Skoler

18. Are we comparing like with like with the counting of DTOC between different areas? Are we all measuring the same thing?

We have set plans in place to bench mark ourselves against Buckinghamshire services and establish whether or not we are counting delays in the same way. This will go some way in answering that question.

19. Can you comment about the position of Continuing Health Care?
This has been addressed in full at the Adult Services Scrutiny Panel on 6th December, 2011.

68/11 OXFORD UNIVERSITY HOSPITALS NHS TRUST - STRATEGY UPDATE
(Agenda No. 7)

At the start of the item the Chairman read out the following statement from Councillor Ann Bonner, member for Banbury Grimsbury & Castle;

"I have been asked by a number of my constituents to contact you to express concern about developments at the Horton General Hospital. In particular they are worried about the proposed changes to gynaecology services and the effect that they could have on single sex accommodation; bed closures and the possibility of the loss of training recognition.

People in Banbury believe that the conversion of G Ward to day cases and the consequent move of patients into E Ward could, as it would be a mixed sex ward, compromise women's privacy and dignity. Furthermore the closure of a number of beds might be seen to increase the threat of the withdrawal of training recognition. Furthermore the views of the staff on the ward are concerned about the whole idea of splitting up the service by locating the inpatient beds in a different area. Local people would like to receive a confirmation that the 6 beds concerned will be protected in that they cannot be used for other purposes without the consent of the Gynaecology Department.

In view of these concerns I would ask you to seek a public statement from the Chief Executive of the Hospital Trust that everything will be done to protect the privacy of women patients. Furthermore a statement should be made that changes to service configuration and bed closures will not lead to any reductions in services provided at the Horton and that they intend to fully honour the IRP requirement to do more to develop "clinically integrated practice" across the whole Trust."

Following this Councillor George Parish Chair of the "Keep the Horton General" group introduced a number of members of the group. Charlotte Bird, Vice-Chair of the group, then read out a statement and asked a number of questions. The statement and questions were as follows:

Statement for HOSC

Can I ask that any questions that are asked, and any answers given, are minuted please?

1. **Gynaecology.** Whilst we acknowledge that the enhanced range of day and outpatient procedures will be of benefit, we remain concerned about the effect

of splitting up services by locating inpatient beds in a different area. This is based on the views of the staff on the ward (formally expressed in their published response) who are best placed to judge the practicalities of the safety or quality of the service.
The Horton Obstetric Group on 19th October was informed that, contrary to previous statements, the 6 beds to be allocated to Gynaecology **will** be ring-fenced, i.e. cannot be used for other purposes without the consent of the Gynaecology department. **In view of earlier conflicting statements, this position needs to be confirmed.**
We have raised the question of whether the changes would have any adverse effect on future recognition for training purposes – of vital importance in relation to the linked service of Obstetrics. Whilst the enhanced range of procedures is likely to be viewed positively, the lack of a dedicated ward for inpatients could have the opposite effect.
We are aware that responsibility for such recognition is passing from Royal Colleges to Deaneries and is likely to change again in the future. **However, we would urge that before irrevocable changes are made an opinion on this matter be sought from whichever body is currently responsible.**

2. **Consultation.** Although at its last meeting HOSC did not feel that the Gynaecology changes required the full consultation process, the manner in which they have been introduced was criticised.
This was debated at the CPN meeting on 27th September when an alternative was proposed and agreed. The essential features were that in future, if the ORH managers identified an area of actual or potential problem, they should seek opinions first from interested parties, the staff, general practitioners and public through structures which have been established, **before** producing a plan. **We would ask the assistance of HOSC in ensuring that this change of practice is maintained in the future as it would favour more cooperative working and help avoid negative reactions.**

3. **Cumulative changes.** We are concerned at the possibility of a series of measures, none of which is individually considered sufficient to trigger full consultation but which taken together represent a major change. We are now aware of major changes with orthopaedics. Cllr Keith Strangwood can enlarge upon this now or later during the course of the meeting. However it is an issue that we believe will require a full consultation.
In addition to the Gynaecology changes mentioned earlier, we are aware of proposals to reduce radiology cover at weekends. Since we know that the number of births is increasing, the need for scans is also increasing – obviously!
We wish to know how the HOSC plans to deal with such a situation of incremental change.

4. **Overall bed numbers at the Horton.** Reductions have already been made of 10 medical and 7 surgical beds. To this must be added the closure of the Gynaecology ward to inpatients and their relocation elsewhere which reduces the total available by a further 12. We have been made aware of other changes which adversely affect the bed total.

The justification for this is usually that medical practice is changing so that less beds are required and more recently in the case of the Horton, that these beds to be closed represent those which are occupied by "delayed discharges" and that there are plans in hand to deal with the latter problem. This ignores the lessons of history, that the problems of delayed discharges has been with us for decades and has defied many attempts at its solution. New attempts and new initiatives are to be welcomed but to expect them to produce rapid results is overoptimistic, particularly at a time when local authority spending on community support services is coming under severe pressure. Moreover the additional funds allocated to the PCT for this purpose are strictly time limited.

To make the reductions in advance of any evidence that the problem is lessening is to invite severe difficulties as we approach the Winter period. At our request, the OH has agreed to carry out regular monitoring and make reports on admissions which have to be refused. Patients who have to be diverted elsewhere, booked admissions cancelled etc.

Bed shortages could involve the Horton incurring penalties for breaching the target for time spent in A&E and this also needs to be taken into account and monitored regularly.

HOSC is requested to help ensure that such monitoring is carried out and the results made public.

These questions were followed by a further series of questions from Rob and Jenny Jones, members of the KTHG group, as follows:

- How many more beds are to be closed throughout the Horton General?
- Where is money being spent in OUHT and how will savings be made? I hope that we will be given relevant details of where money is actually being spent within OUHT and what and how savings are to be made at each site and in which areas, Social care, General Acute Care and Specialist Services.
- In the list of the Trust's Strategic Objectives, the second objective is :-
  To provide high quality, specialist services to the population of Oxfordshire and beyond.
  The Trust's first strategic objective is :-
  To provide high quality, general acute healthcare services to the population of Oxford.
  In view of this, does the Trust provide care to all of Oxfordshire or just Oxford?
- Residents in the south of the county also have hospitals on the county boundary at Swindon and Reading, in addition to Oxford, at which they can choose to receive treatment. So the services at the Horton are extremely important to provide choice for residents in the north of the county and beyond. Perhaps the residents in the north of the county are seen as a captive market and do not count. How are acute services for the residents in the north of the county to be provided and developed?
- The phrase *'Reshape "local" services.'* used later on the page sounds ominous, particularly in light of the proposals of 2006. How will the idea of *'seeking to maximise the use of the better accommodation across the Trust.'* affect the Horton and will it continue to provide "Patient choice" or is this an empty cliché?

- The [Trust's] strategy appears to be pulling in opposing directions. On one hand it talks of treatment closer to home while on the other of services being concentrated in fewer and fewer locations. Does this agree with the concept of Patients' Choice and when there is so little capacity system what choice does the person taking the last place have, and the one after that?
- Milton Keynes has its own acute hospital and presumably it also has its own strategy to deal with the any population growth. Why is it a factor in OUHT's strategy? Or is this the next target for take over and closure?
- The capacity of the Horton Gynaecology Day Case Unit will be around 3000 cases per year. What is the minimum capacity level at which the operation of the unit will be considered viable?
- What is the Plan B if this level is not reached?
- As we go into the winter months with increasing demand for emergency admissions we are told that beds are 'flexed' to address the problems. Is it not the case that no additional beds can be brought into play at the Horton, so 'flexing' just means cancelling elective procedures?
- In point 10 of the strategy the aim is to close beds once the issue of delayed transfers of care (DTOC)has been resolved. Beds have already been closed at the Horton on the expectation that DTOCs will be reduced. How many more are intended to go?
- In view of the mooted major changes in orthopaedics at the Horton, how do the finances work in currently loaning staff to the ISTC? Does it generate a healthy profit? What are the implications of the loss of this profit?

Following the statement and questions the Chairman made four points:

i. That the HOSC accepted in good faith that gynaecology services at the Horton would improve following implementation of the Trust's proposals and that more patients would be treated there. However the Trust would be held to account if these expectations were not to be realised.
ii. That the HOSC expected that consultation would improve through the development of a protocol between the Trust and the Community Partnership Network (CPN). It was expected that service changes would happen only once proper informal consultation had been undertaken with all interested and relevant parties.
iii. The role of the HOSC is to ensure that services are maintained and/or improved. It is not the role of the Committee to seek to protect bed numbers. The HOSC recognises that procedures and methods of treatment are changing with, for example, developments in keyhole surgery. That could well lead to reductions in bed numbers with fewer people having to stay in hospitals and the HOSC understands that.
iv. Management must be allowed to manage and it is not part of the HOSC's job to "micro-manage" the local NHS. However the Committee expects meaningful consultation to be undertaken by the Trust over proposed changes and for commissioners and providers to explain to the public why change takes place.

Sir Jonathan Michael then commented in response to Councillor Bonner's statement that the Trust is fully committed to protecting the privacy of all patients at all times. He also reiterated that the proposed changes to services at the Horton would not

lead to any reductions in services and that the Trust intends to honour the IRP requirement to do more to develop “clinically integrated practice” across the whole Trust.

Sir Jonathan also accepted the importance of developing good communications with people in and around Banbury and agreed to answer the questions raised by the Keep the Horton General group through the CPN.

Sir Jonathan then presented the paper on the Trust’s updated strategy. He explained that the main factors driving change are:

- Quality standards, e.g. single-sex accommodation, that must be met
- The financial position requires savings of 5-6% this year and in the future
- Public expectations and choice.
- Epidemiology and demography
- Commissioner strategies
- Workforce issues
- National and local service reconfiguration
- Any Qualified Provider (AQP) and a more competitive environment
- Shorter stays in hospital due to changes in procedures

He stated that the most useful question to ask is not how many beds are there but are services getting better.

Ian Davies, Chairman of the Community Partnership Network, then spoke to the Committee. Mr Davies explained that the role of the CPN is to look across the wider issues of health in Banbury and the surrounding area – not just the Horton. The CPN will act as the consultative body for changes in health services including those relating to the Horton. Change will be looked at in the broader context of health services in the north of the County. The CPN will monitor what happens at the Horton and will liaise with the HOSC as necessary.

The nature and timing of consultation must, Mr Davies said, be got right in the future. The CPN will wish to be closely involved in developing a consultation protocol and discussions are already going on with the Trust over the best way to do this.

Councillor Keith Strangwood then asked the following questions. He also asked that the questions and answers should be recorded in the minutes.

Q. Are bed numbers relevant to staff availability? A. Yes, insofar as staff numbers relate to the nature of the unit and the safe and proper care of patients. Staff numbers are monitored regularly.
Q. Does the flexi bed system work? A. Beds have to be used flexibly e.g. more would be used in the summer for elective procedures than in winter when they would be needed for e.g. flu.
Q. Are staff being reduced via retirement etc, i.e. natural wastage and not being replaced? A. It is inevitable that staff numbers have to be looked at in meeting financial targets. However the safety of patients is always paramount.
Q. I have recently received reports that there are in the pipeline changes at Banbury Horton re Pathology? Can you confirm or deny this? A. Changes are being

considered to provide some services more cheaply. However the service will be retained at the Horton.
Q. Can you confirm or deny that 2 weeks ago the ORH PCT awarded a contract to Ramsey Healthcare, to the disappointment of the Nuffield, who were unsuccessful in their bid? A. The commissioners decided to award the contract to Ramsey in preference to the OU Trust which now includes the NOC.
Q. Can you also confirm or deny that ORH chief executive and team, have now decided to terminate the secondment of all staff to the TC at Banbury Horton? A. Following the awarding of the contract to Ramsey Healthcare secondments have been terminated in order to strengthen service provision in Oxford.
Q. If this is so? Then has this not been a stand alone decision by ORH/OUH with no proper consultation? A. The orthopaedic service provided to patients will not be affected; it is a staffing issue and so there is no need for consultation.
Q. Can you also confirm or deny? The alleged withdraw of secondment will take place from Jan 1ST 2012? A. Yes
Q. If these alleged changes are planned? will any orthopaedics be carried out at Banbury Horton? A. There will be no change to the pattern or level of service.
Q. If this is true? It would not be possible to maintain Trauma without Orthopaedics, no Trauma means no full cover A and E? Hence, minor injuries unit only? A. See previous answer

There then followed a series of questions from members. In response to a question about mixed sex wards Sir Jonathan Michael stated that the Trust continues to work hard to eliminate mixed sex accommodation and is being successful in their aims.
A question was then asked about whether there were sufficient female obstetricians at the Horton General to be able to deal with the numbers of Muslim women giving birth there. Andrew Stevens replied that all women who wish to have a female doctor attend to them would be able to do so.
Sir Jonathan the responded to a question about nutrition and dignity of older patients by accepting that there had been some criticism in a recent CQC report on nutrition at the hospital. The CQC had found that the John Radcliffe Hospital was meeting the standard relating to treating people with respect but that some improvements were needed around the provision of food and drink. A strategy for improvement is now in place and a system of regular ward visits is occurring to ensure that patients are able to get access to their food and drink.
The following points were then made in response to a question about the reablement programme. Discussions are ongoing with Oxford Health and the Nuffield Orthopaedic Centre in order to develop further the reablement programme. The OUH Trust is also involved in the ACE programme and the trust will provide more support at home for patients as part of an enhanced discharge programme.
On the subject of the national consultation on paediatric cardiac surgery, Sir Jonathan expressed some disappointment that the result of the consultation has been delayed by the recent court decision in the case brought by the Royal Brompton Hospital. The link with Southampton is working well and they are now developing a joint paediatric neurosurgery service with the centre in Oxford.
A comment was then made welcoming the suggested enhanced monitoring role for the Community Partnership Network in the north of the County. It was hoped that this would lead to more light being thrown onto positive developments rather than concentrating on negative aspects. Sir Jonathan agreed with this and stated that the Trust is committed to open communications and transparency.

Two questions were asked about the possible outcome of the strategic review. One asked whether there would be any changes in the provision of drugs. Andrew Stevens sated that, while the Trust always looked for the most economical means of providing drugs such as by using generic rather than branded medicines, patients would always continue to receive the drugs that they needed.
The second questioner commented that they were fortunate to live in Oxfordshire with the high quality of care available and asked whether patients would notice any difference following the formation of the new trust. Sir Jonathan replied that the strategic review was looking at services not costs although they always had to consider carefully how money was being spent. Patients should notice no difference immediately but it was hoped that care should improve as a wider range of skills became available throughout the new trust. Furthermore, with more staff available, the out of hours care should improve.
Finally assurance was sought that there was sufficiently close working between the OUH and the mental health trust and that patients with physical symptoms and who are also mentally ill are having their multiple needs recognised and treated accordingly. Sir Jonathan stated that there is close co-operation and that a new appointment has been made within the University of a Professor of Psychological Care with a particular emphasis on engagement.

The item ended with the Chairman thanking everybody who had contributed to the discussions.

69/11 CHIPPING NORTON HOSPITAL STAFFING

(Agenda No. 8)

The Chairman reminded the Committee that the issue they were now dealing with related to whether or not a review of the service provided at the new Chipping Norton Hospital should take place two or three years after the opening of the hospital; i.e. in June 2013 or 2014. The original agreement had been that the review would be after three years and that any staff employed during that time would be given the option of being employed under NHS terms and conditions of service rather than those of the Orders of St John (OSJ) who manage the hospital. The PCT had sought to remove that condition altogether but, following objections from the HOSC, were now offering a review after two years with all new recruits, if they wished, being on NHS conditions during that period.

Alan Webb, representing the commissioners of the service, opened the discussion by stressing that the quality of care had to be the paramount consideration; that there was no intention to downgrade services at Chipping Norton and that managers from the OSJ were talking to local GPs about the type of service that they, the GPs, would wish to see provided. Since the hospital opened there had been no complaints recorded and a number of compliments.

The commissioners were committed to the review of care quality and the service specification. They would wish to work with HOSC members on the terms of reference and specification for the review. The review findings would be applied to all community hospitals in Oxfordshire.

Olga Senior, from NHS South of England (the clustered SHA), stated that they share the view of the PCT. They had undertaken their own survey since the hospital opened and had also found no complaints about the present service. They consider that the contract and specification that the OSJ was working to was “robust” and would help to ensure a high quality of service provision. It was clear that in future GPs, via the Oxfordshire Clinical Commissioning Group (OCCG), should have a pivotal role in deciding on what level of service should be commissioned. Quality must come first.

During the subsequent discussion the following points were made:

The commissioners would always ensure that staff at the hospital, regardless of who employs them, would be properly trained, qualified and supervised. There should be no difference between the safety and quality of the service provided at Chipping Norton than that provided in any other Oxfordshire hospital.
The service specification is part of the contract with OSJ and that enables the commissioner to have quite a measure of control.
Staff are managed by a clinical manager.

At the end of the discussion the Committee **AGREED** to the two year period for the review; i.e. the review would take place in June 2013. It was further **AGREED** that Councillors Hilary Hibbert-Biles and Lawrie Stratford should represent the HOSC in working with the commissioners on the review.

70/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 9)

The regular LINk report was presented by Adrian Chant. There were no questions.

Alison Partridge then updated the Committee on the latest position vis a vis HealthWatch. She explained that the County Council had a responsibility to establish HealthWatch by October 2012. It would have a wider remit than the LINk and the HealthWatch role would, by 2013, include advocacy and complaints. A widespread consultation process is going on to agree a commissioning model.

Ina answer to questions about the scrutiny and governance of HealthWatch Alison Partridge told the Committee that the contract would be with the County Council which would therefore monitor the quality of service and activities undertaken by Oxfordshire HealthWatch. HealthWatch England would also have some role but the finer points of the governance arrangements have yet to be worked out.

71/11 CHAIRMAN’S REPORT

(Agenda No. 10)

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

- Toolkit meeting on gynaecological services at the Horton General Hospital
- A meeting with the PCT to discuss the provision of a new Townlands Hospital in Henley

- Oxford Health – informal “catching up” meeting with the Chief Executive and others
- A meeting with Nicola Blackwood MP for Oxford West and Abingdon and Simon Burns MP Minister of State for Health Services to talk about health services in the area

72/11 CLOSE OF MEETING
(Agenda No. 11)

The meeting closed at 13.25.

..... in the Chair

Date of signing .....

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT V

Reporting on 2010-2011
Recommendations for 2011-2013
Produced: November 2011

Director of Public Health for Oxfordshire
Annual Report V

Purpose of this report

This is an independent report produced by the Director of Public Health for Oxfordshire.

Its purpose is to use the best available science to point the way forward to better health and wellbeing for Oxfordshire.

This report reviews the previous four years of Director of Public Health annual reports, re-assesses priorities and makes recommendations for change.

This report reanalyses the scientific information in the Joint Strategic Needs Assessment (JSNA) and other key data*, and draws conclusions about:

- **Is this topic still a priority for Oxfordshire?**
- **What progress has been made against recommendations in the previous four annual reports?**
- **What further recommendations need to be made to improve health and well-being in this county?**

It is appropriate to review the previous four years of annual reports because we stand at the point of change: The advent of a new government and the prevailing economic situation means that all public sector organisations are undergoing fundamental change.

The planned abolition of PCT's and Strategic Health Authorities and their replacement by GPs in a leading role fundamentally changes the way health services are driven. We are also accommodating radical change and significant cost reductions in local government. In addition, more emphasis is placed than ever before on local people driving local change. At the same time local hospitals and community services are merging to form large NHS Trusts which are more independent and have more freedoms than ever before.

Throughout all this change public health is 'coming home' to local government after a three decades sojourn in the NHS.

We stand at the point of change, and yet at the same time we serve the same population whose problems and issues change only gradually from decade to decade.

Amid so much change, it is highly appropriate to take a fresh view of old problems, review progress and set out clearly and concisely where our efforts need to be placed.

This annual report aims to carry out these tasks.

It is intended that this report is used by planners of services across the County. Its production has been timed explicitly to influence the new Health and Wellbeing board as it sets its priorities. It is therefore deliberately pithy, brief and concise yet wide ranging: it is intended to be used, not to gather dust on shelves.

I hope you enjoy it and more importantly, use it.

Dr. Jonathan McWilliam
Director of Public Health for Oxfordshire
November 2011.

* *(there is a list of the sources used at the end of the report.)*

Contents

Chapter 1 - The Demographic Challenge.

Introduction

The previous four Director of Public Health annual reports have highlighted the challenges posed to services by the growing number and proportion of older people in Oxfordshire. It is a blessing that long lives and good health are increasing steadily in this County, but service planners face the challenge of redesigning services to meet the needs of older people in the face of changing expectations and a harsher fiscal environment.

What does the Joint Strategic Needs Assessment say about the Demographic Challenge?

- The number of older people in Oxfordshire continues to grow as expected.
- The growth in the number of people aged 85+ is roughly in line with the England average, *But: The growth in the number of older people is not uniform across the County. It is markedly higher in our more rural districts than in the City. West Oxon has the highest rates, followed in descending order by Cherwell, South and Vale with the City far below. This is shown in the figure 1.*
- The *proportion* of older people in the population also continues to increase, which means that every pound spent from the public purse has further to go.
- The cost of caring for older people increases markedly with age, rising into the last year and month of life. This is true for both health care and social care. This is shown in figures 2.
- Older people rightly demand and expect a flexible range of services built around their individual needs so that they can maintain independence and stay close to home for as long as possible. A new generation of services is required to meet these needs.
- An increasing number of people are engaged in caring for elderly friends and relatives and many more volunteer their help. Many of these people are elderly themselves. We are dependent upon these friends, relatives and volunteers. Support to enable carers to care and the framework which makes volunteering possible must be husbanded.
- These challenges are faced by the whole of our society. The predicament we are in as a nation and our ability to fund the services as a country have been spelt out clearly in the recent Dilnot report.
- There are wide variations in referrals for older people in all parts of the NHS and social care systems. This lack of standardisation warrants further investigation.
- Access to services for the elderly population living in rural areas is a continuing cause for concern.
- There is a growing number of people with dementia in the County who require access to new emerging treatments.

Key Data.

The following charts tell the whole story. Figure 1 shows the number of people aged 85+ rising into the future. Note the different experiences of the Districts within Oxfordshire, with West having the greatest increase and the City far below the rest. The fact remains that the overall rate of growth is just above the national average.

Figure 1 - Projected population - England, Oxfordshire and districts - estimated percentage growth from 2008 in those aged 85 years and over

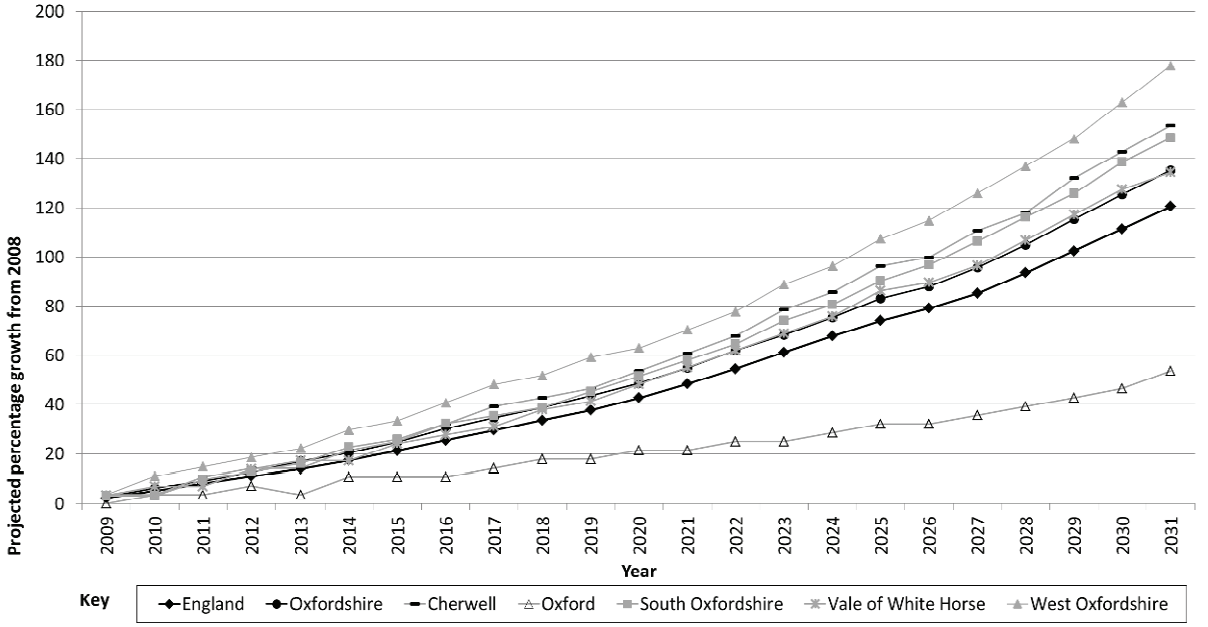
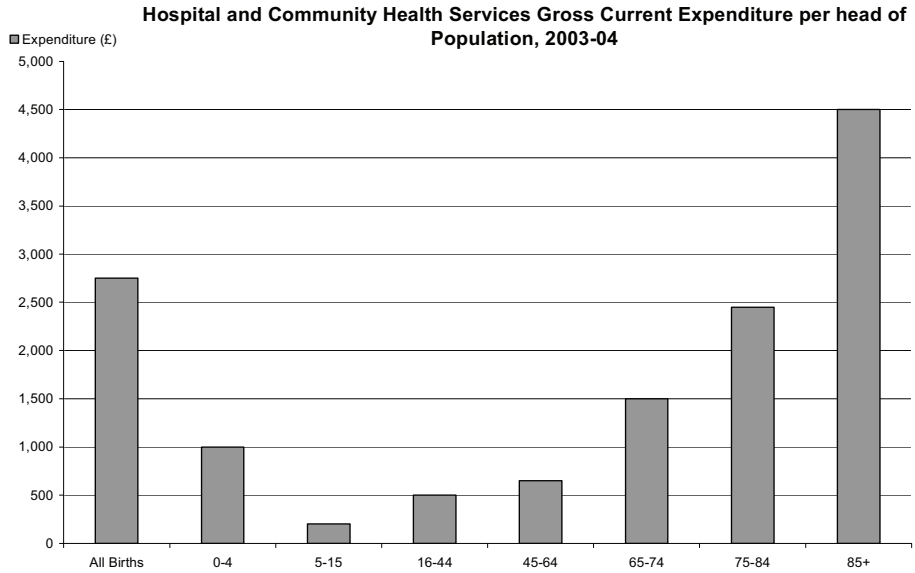


Figure 2 - Department of Health data showing how the cost of health care rises rapidly with increasing age.



The same picture is true of social care and this puts extra pressure on Local Authority budgets. For example, the average age of a person entering a care home in 2011/12 is 86 and the average age of a person starting a care package is 84. Compared with a person aged over 65, a person aged over 85 is 3.5 times more likely to require a new care package and 4 times more likely to require a care home

placement. A person over 90 is 4 times more likely to need a care package and 5 times more likely to need a care home. As the number and proportion of older people in the population grows, the pressure on health and social care to find new ways of doing things will increase. The only solution is to work together as one, particularly with the NHS.

Is 'The Demographic Challenge' Still a Priority for Oxfordshire?

Most certainly, IT IS.

This is the absolute immediate priority and it dwarfs all other priorities in this report. New approaches to the care of older people must be found if the public sector is to remain solvent: we cannot wait.

The recipe for success is becoming clearer all the time. The basic principles bear repeating here. They are:

1. Preventing disease where possible in the middle decades, investing in services backed by scientific evidence.
2. Minimising the impact of disease once it has begun e.g. through early detection programmes and expert patient approaches.
3. Having a single set of service priorities and goals across Oxfordshire's public sector so that public spending in this County is properly aligned (expressed as clear outcome measures and explicit targets).
4. Finding solutions which treat health and social care as though they were a single service.
5. Working hand in glove with the public at all stages.
6. Creating a smooth 'flow' of services from prevention through treatment-and-care and on into rehabilitation.
7. Balancing 'everyday' services for the common conditions faced by the vast majority with 'specialist' services for those with rarer conditions and commissioning these specialist services selectively and with great care.
8. Balancing services which are 'closer to home' while delivering modern, high quality services.
9. Commissioning services using tight specifications based on outcomes, the best evidence and delivery of explicit results.
10. Looking intelligently at wherever REFERRALS are made from one part of the 'system' to another and reducing those which are unnecessary. The decision to refer is the decision to open the public purse, this includes all types of referrals. These include
    - Self referrals by the public to A&E or to GPs.
    - GP referrals to consultants.
    - Referrals from community specialists to consultants.
    - Referrals from one consultant to another (a particular worry in Oxfordshire).
    - Referrals and applications for social care.

    (NB looking at referrals *is* a two-edged sword, as the same careful analysis *can* also result in some increases in referrals where quality is found wanting).
11. Working in partnership with private providers of care.
12. Caring for Oxfordshire's carers and supporting volunteers.

13. Working with older people to put their care into their own hands wherever we can afford to do so.
14. Focussing on high quality end-of-life care.
15. Creating a climate in which communities can draw on their own resources to help themselves.
16. Identifying and using the contribution other organisations can make – not just the NHS and adult social care. Issues like transport, housing, the fire and rescue service and trading standards, are crucial.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

In summary:

- This topic is now well-recognised as being of prime importance.
- Oxfordshire has made good progress in recognising this challenge early on.
- Partnership working is strong and scrutiny committees have made a valuable contribution. We have the opportunity to strengthen this further through the new Health and Wellbeing Boards.
- The importance of good care for our carers has also been recognised and there has been a welcome increase in resources used to fund helpful initiatives such as carers' breaks. This work needs to be further strengthened.
- Preventative services such as screening services (e.g. the new bowel screening programme) and immunisations services (e.g. 'flu jabs') continue to perform well.
- The care of people with dementia is also improving steadily since a specific group was formed to take this forward. This needs to be maintained.

However:

- We have not been immune from structural challenges which are part of the way England's health and social care system is set up. As the 'Dilnot Report' highlighted, it is difficult to marry seamlessly the 'free-at the-point-of-delivery' NHS system with a social care system which is gate-kept by means-testing and thresholds for care. This has shown itself in our struggles to manage the care of people at discharge from hospital into community hospitals or to other provision.
- The ***scope*** of potential joint work for older people is usefully set out in our 'Ageing Successfully' strategy, **but** this is too weak on action planning and ***delivery*** of concrete results to drive work forward. This needs to be rectified.
- We have also yet to identify and agree a set of outcome measures relevant for Oxfordshire for the care of older people for all public sector organisations. Without this we have no compass to steer by and no yardstick to measure progress. This must be a major priority for the new Health and Wellbeing Board.
- We have yet to strike the right balance in this County between 'District General Hospital' services for the majority and 'Specialist and Super-specialist' services for the few. It is a great boon to have internationally renowned hospitals on our doorstep, but it is another two-edged sword. Because we can only spend each pound of public money once, we need to look carefully at referral rates from one consultant to another all of which commit tax payer's money. We need to secure the right balance between high quality care and affordability.

Recommendations

1. Strategic Priorities for the Health and Wellbeing Board

By March 2012 Oxfordshire's Health and Wellbeing Board should establish an effective subgroup specifically designed to take forward practical work that will make an impact on all of these issues. Specifically the subgroup should:

- Be led by adult social care and clinical commissioning Group representatives working together with NHS provider trusts, other service providers the voluntary sector, public representatives and carers.
- Agree clear outcome measures and process targets for 2012, 2013 and 2014 which bind together the efforts of all organizations in a single direction.
- Set clear local trajectories for each outcome measure and performance targets. Performance against these should be monitored and reported publicly through the Health and Wellbeing Board.
- Ensure that plans are produced to correct poor performance.
- The work program should include the commissioning of practical services which will:
    - prevent disease in older people through screening and immunization programs (e.g. screening programmes such as Bowel screening health checks etc and flu jabs).
    - increase the number of carers offered help and support.
    - demonstrate evidence of effective use of the new direct payments for older people.
    - demonstrate that variations in all referral rates will be looked at systematically and action taken.
    - ensure that lengths of hospital stay are minimized while quality is kept high and the figures for delayed transfers of care are reduced.
    - strengthen the careful monitoring and control of specialist-to-specialist referrals for older people so that quality is balanced against cost.
    - show that readmission of patients to hospital or unnecessary admission of patients to nursing homes and long-term care is minimized.
    - ensure good end-of-life care and high quality care for people with dementia.

2. Strategic Priorities for the Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Clinical Commissioning Group should be fully engaged in joint planning through the Health and Wellbeing Board for improving the care of older people in Oxfordshire, and should plan a general review of the variations in self-referrals, GP referrals and consultant to consultant referrals for Oxfordshire's population.

3. Need for Strong Public Involvement

By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with older people across the County and is in a position to insert their views directly into the planning process.

4. Need to Scrutinise Plans

By September 2012 Oxfordshire's Joint Health Overview and Scrutiny Committee should scrutinize the Health and Wellbeing Board's arrangements for care of older people and should expect to be able to scrutinize a concrete plan based on the items in the recommendations above.

Chapter 2 - Breaking the Cycle of Deprivation

Introduction

Previous annual reports have made the case for concentrating the efforts of all organisations on 'Breaking the Cycle of Deprivation'.
What do we mean by this? We mean that in this County there are a relatively small number of wards where social disadvantage and poorer life chances are handed down from generation to generation. Previous reports have shown that these areas are found primarily in parts of Banbury and Oxford and larger market towns.

This message has been grasped by organisations and mainstream services ***are*** beginning to be re-shaped to focus on these areas. The overall objective has to be to level-up standards across the County where possible.

The question arises, **'is this still an issue, or have we solved it'.**

This chapter attempts to answer this question.

This question is now particularly acute as GP Commissioners arrive on the scene to invest half-a-billion pounds of public money in health services per year.
GP commissioners will build up a county plan from locality plans; it will be a challenge for them to face the need to redistribute resources to break the cycle of deprivation.

What does the Joint Strategic Needs Assessment say about Breaking the cycle of deprivation?

On this topic we can safely let the Joint Strategic Needs Assessment findings do the talking for us. Key indicators from this and companion documents show that:

Indicator 1 - Child Poverty

The County's Child Poverty Strategy shows that in Oxfordshire there are 15,660 children living in poverty, which is almost 12% of all children in the county. (Poverty is defined as living in a household with 60% less than the average household income*). The experience of poverty is not just about lack of money, it's about life chances for young people - a young person participating in a local workshop summed it up as follows "Poverty…. It's what's in your life, not what's in your bank account".

Four out of five children living in poverty live in our towns and the City and one fifth live in rural areas. (12,315 in the City, Banbury and larger market towns and 3,345 in rural areas). This is low compared to the national average, **but** variations between parts of the county tell the critical part of the story.

- **Almost one in four (23%) of children in Oxford City (5800 children) are living in poverty.**
- **Ten wards in Oxford, one in Banbury and one in Abingdon are in the worst 25% in England for levels of child poverty, these are Banbury Ruscote, Barton & Sandhills, Blackbird Leys, Carfax, Churchill, Cowley Marsh, Iffley Fields, Littlemore, Lye Valley, Northfield Brook, Rose Hill & Iffley, Abingdon Caldecott.**

* In this case, the average used is the Median which is the middle of the range of all household incomes

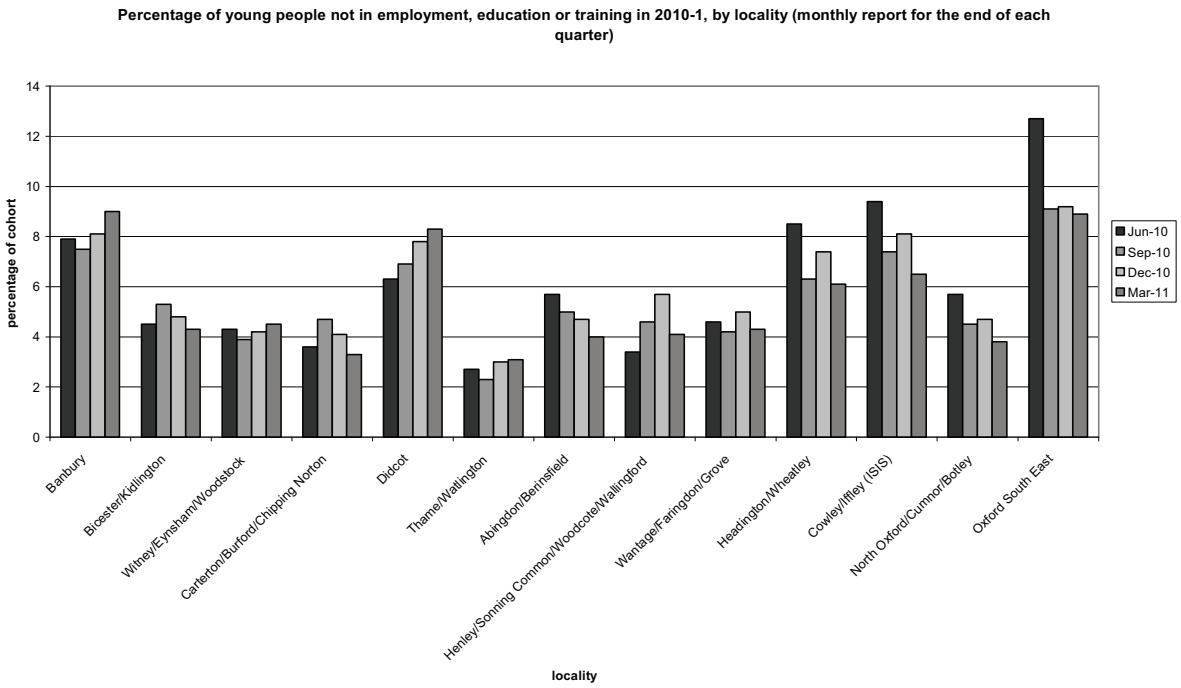
This indicator shows clearly the areas where our attention needs to be focussed to break the cycle of deprivation.

Indicator 2 - Young People Not in Education, Employment or Training

This provides a useful indicator of overall life chances for our young people. Being in education, employment and training helps to provide young people with the skills they need to step out of the cycle of deprivation. The overall picture across the County has improved since 2009 following focussed action, but a closer look within the county shows where the major problems lie. Banbury, socially disadvantaged areas of Oxford and Didcot have a higher percentage of young people who are not in education, employment or training than elsewhere in the County. Rates in Didcot and Banbury are the only places where rates are still increasing.

5.9% young people in Oxfordshire aged 16-18 were classified as NEET in 2010-11. This was higher than the South East average of 5.4% for the same period but lower than the England average, which was reported as 7.3% at the end of 2010.

Figure 3 - Percentage of Young People Not in Employment, Education or Training



Indicator 3 - Unemployment and Benefit Claimants.

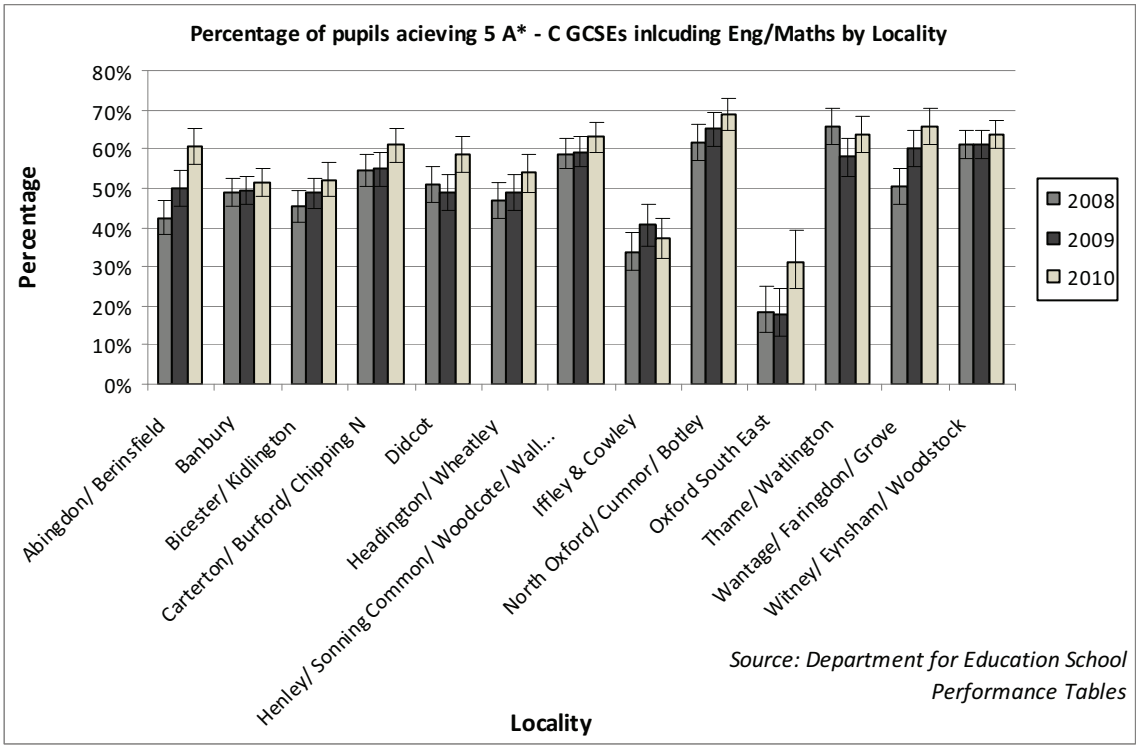
Being in regular work helps individuals and families to improve their life chances and so helps to break the cycle of deprivation. The rate of people claiming Job Seekers Allowance (JSA) in England has been declining slowly since the peak in April 2009, and seems to have levelled off during 2010-11 but is still above pre-recession levels. The number of people claiming unemployment benefits in Oxfordshire has largely mirrored national trends through the recession, and, thankfully, has always remained well below the England average.

However, some parts of the county have percentages of people claiming Jobseekers Allowance (JSA) which are well above England averages, especially in parts of the City and Banbury.

For example, 5.9% of people of working age in Blackbird Leys are claiming Job Seekers Allowance, 4.6% in Northfield Brook and 4.8% in Banbury Ruscote, compared with an Oxfordshire rate of 1.8% and an England rate of 3.7% (figures from Dept for Work and Pensions, April 2011).

Indicator 4 - Educational attainment

Figure 4 - GCSE Attainment

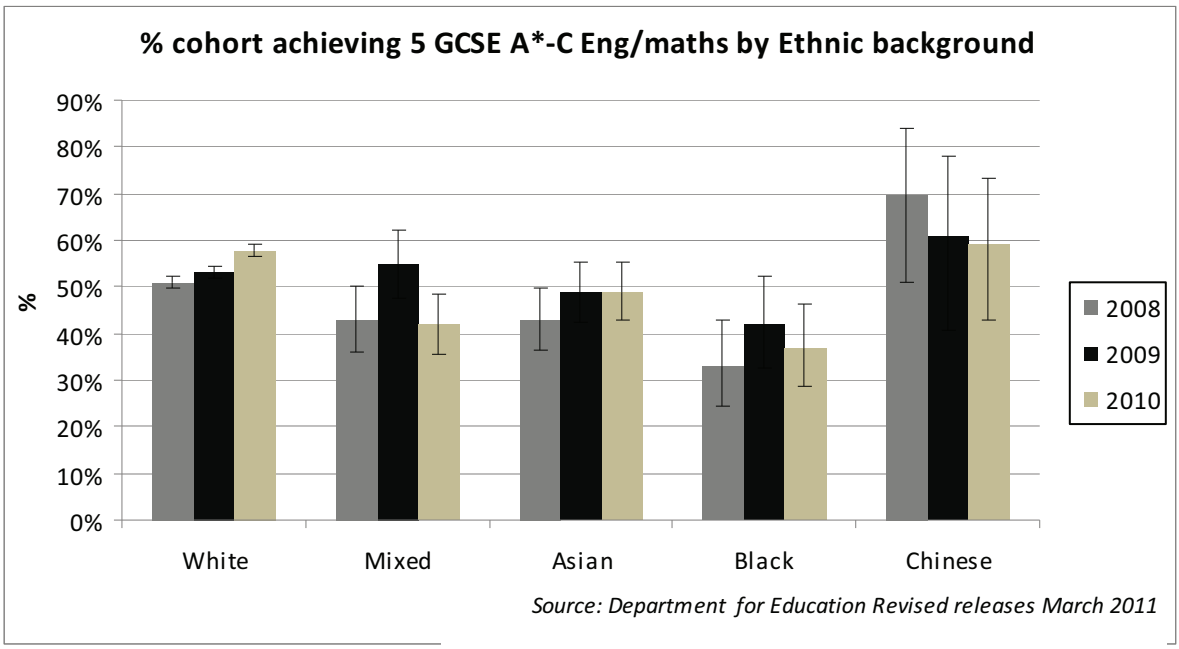


In 2010 the number of young people achieving at least 5 GCSEs with grades of A*-C including English and Maths has risen in almost all areas of the County since 2009. The only exception was the Iffley/Cowley locality in Oxford which will feature in next year's annual report. The 2011 data still awaits full analysis but shows a small fall against national trends.

As the chart shows, there are still stark differences between different areas of the county. Achievement rates in North Oxford/Cumnor/Botley are more than twice as high as those 5 miles away in South East Oxford area which covers the wards of Blackbird Leys, Rose Hill and Iffley, Littlemore and Northfield Brook.

There are also some remaining inequalities in achievement rates by ethnic group. These are shown in figure 5 which shows that results for black, Asian and mixed ethnic children were significantly poorer than their white counterparts.

Figure 5 - GCSE Attainment by Ethnic grouping



Indicator 5 - Teenage Pregnancy

In terms of the 'cycle of deprivation', teenage pregnancy is both a challenge and a success - there are still inequalities across the County, **but targeted action has shown that previously very high rates in the City have fallen steadily over the last 5 years.** This is a major success.

Overall the Oxfordshire under 18 conception rates is decreasing, broadly in line with rates in England. Oxfordshire has the 17th 'best' rates for all Local Authorities in the Country and those Local Authorities with lower rates tend to be smaller authorities in leafy shires with few areas of deprivation.

For Oxfordshire teenage pregnancy remains a useful and relevant measure of social disadvantage and poor life chances for children, young people and families. The most recent analysis shows that **Oxfordshire has 8 hotspot wards with particularly high rates**; hotspots are defined as those wards with more than 60 conceptions per year per 1,000 females aged 15-17 years. This is a cause for concern, but is also an improvement thanks to the attention we have given to this problem: the 8 current hotspots compares with 10 last year and 18 the year before that. The 8 current hotspots include 5 wards in Oxford, 1 in Banbury (the highest) and 1 each in Witney and Didcot. The wards with the highest rates are:

- Grimsbury and Castle (the highest), Banbury
- Northfield Brook, Oxford.
- St. Mary's, Oxford.
- Iffley Fields, Oxford.
- Barton and Sandhills Oxford.
- Blackbird Leys, Oxford.
- Didcot Park, South Oxfordshire.
- Witney Central, West Oxfordshire.

Indicator 6 - Crime

Overall crime rates in all districts of Oxfordshire continued to fall throughout 2010-11. The total number of crimes reported in the County fell by 4% in 2010-11 with violent crimes falling by 20%, Criminal Damage by 9.4% and burglary by 13%.
The picture here is once again uneven across the County. The greatest number of crimes occur in Oxford City, though crime rates there have been falling at proportionately higher rates than that in other parts of the county. Public order offences are more prevalent in the city centre while incidents of domestic burglary and domestic violence are more scattered. A summary of local crime figures highlights crime rates which are higher than the national average is included below.

Figure 6 - Local Crime figures 2010/2011 showing offences per 1,000 resident population. Rates which are higher than the national average are larger and in bold

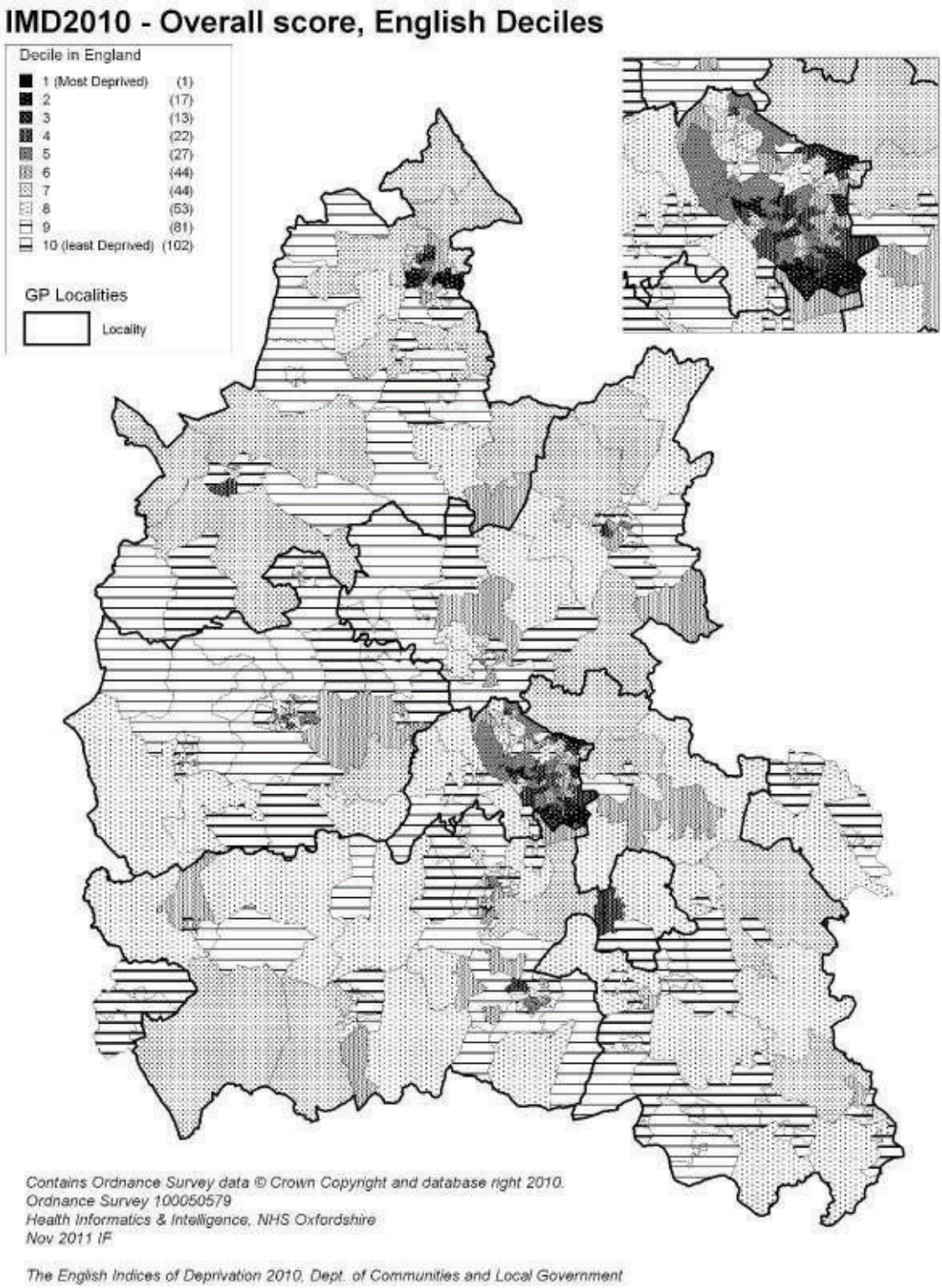
	OXFORD CITY	SODC	WODC	VALE	CHERWELL	England AVERAGE
Burglary	**9.7**	7.6	5.0	4.4	5.4	9.6
Criminal damage	**15.4**	9.7	9.1	7.9	10.7	12.7
Drug offences	**6.6**	2.1	1.2	3.1	3.1	4.2
Fraud and forgery	**5.2**	**4.2**	2.1	2.1	**4.7**	2.7
Offences against vehicles	7.7	5.1	3.4	3.0	4.0	8.2
Other offences	**1.7**	0.6	0.5	0.4	0.9	1.2
Other theft offences	**49.7**	14.1	12.8	11.2	18.2	19.3
Robbery	**1.7**	0.2	0.2	0.1	0.4	1.4
Sexual offences	**1.5**	0.7	0.6	0.7	0.9	1.0
Violence against the person	**23.0**	9.1	9.7	9.2	14.8	14.8

Data supplied by Home Office based on data collected by police forces in England and Wales between 2010 and 2011

Indicator 7 - Index of Multiple Deprivation (IMD)

The Index of Multiple Deprivation 2010 combines a number of indicators (such as the income deprivation affecting children index used above), chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area (called Lower Super Output Areas – LSOA) in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Figure 7 - Map showing Index of Multiple Deprivation 2010 by Small Area (LSOA)



The 2010 IMD scores confirm that in general Oxfordshire is, for most, an affluent place to live. 324 out of 404 small areas are in the top 50% of most affluent places within England. However, on closer examination, the typical picture of disadvantage confined to small areas persists. Northfield Brook is the small area of Oxford which is the most deprived, the next 17 small areas which are most deprived all fall within Oxford City, Banbury and one small area of Abingdon.

Indicator 8 - Early Death and Areas of Social Deprivation

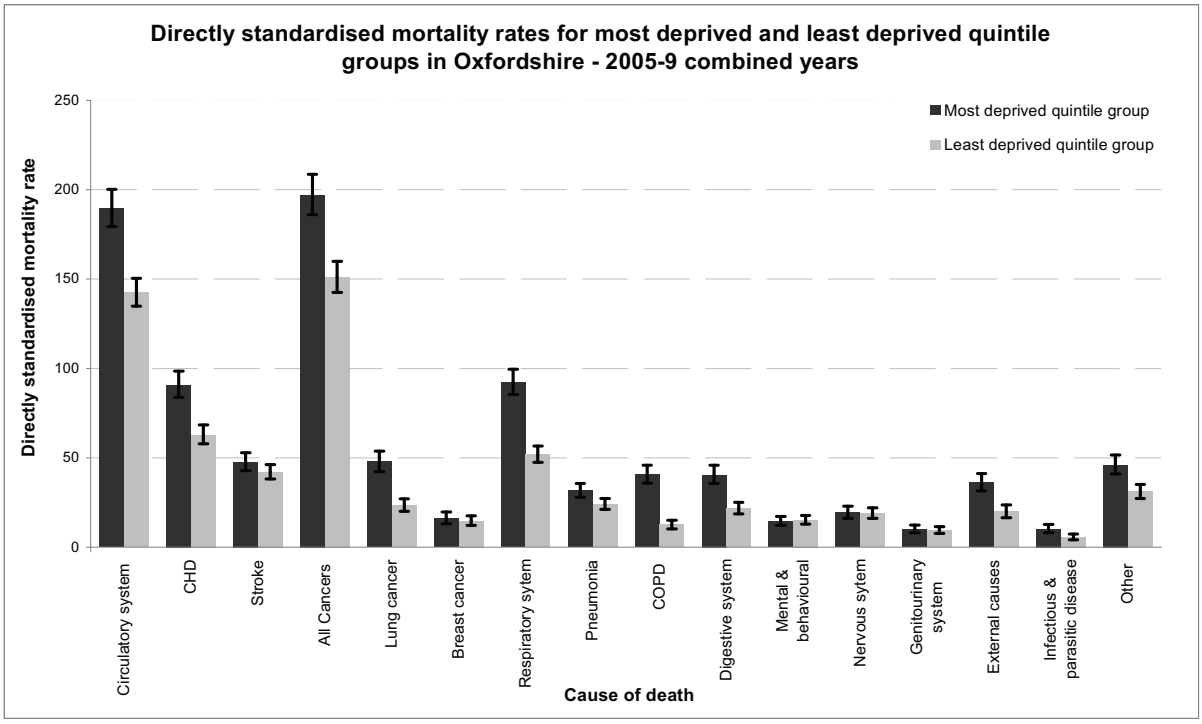
The chart below shows death rates across the county and the causes of death from 2005 to 2009.

For each cause of death the left hand column shows death rates in the 20% most socially deprived wards and the right hand column shows death rates in 20% most affluent wards.

The chart shows clearly that:

- Death rates in socially deprived wards are higher across the board than in affluent areas (i.e. the chances of dying at a younger age are higher).
- This is particularly apparent in the most common causes of death - circulatory diseases (e.g. coronary heart disease (CHD) and stroke and cancer).

Figure 8 - Comparing Mortality Rates in deprived and affluent wards



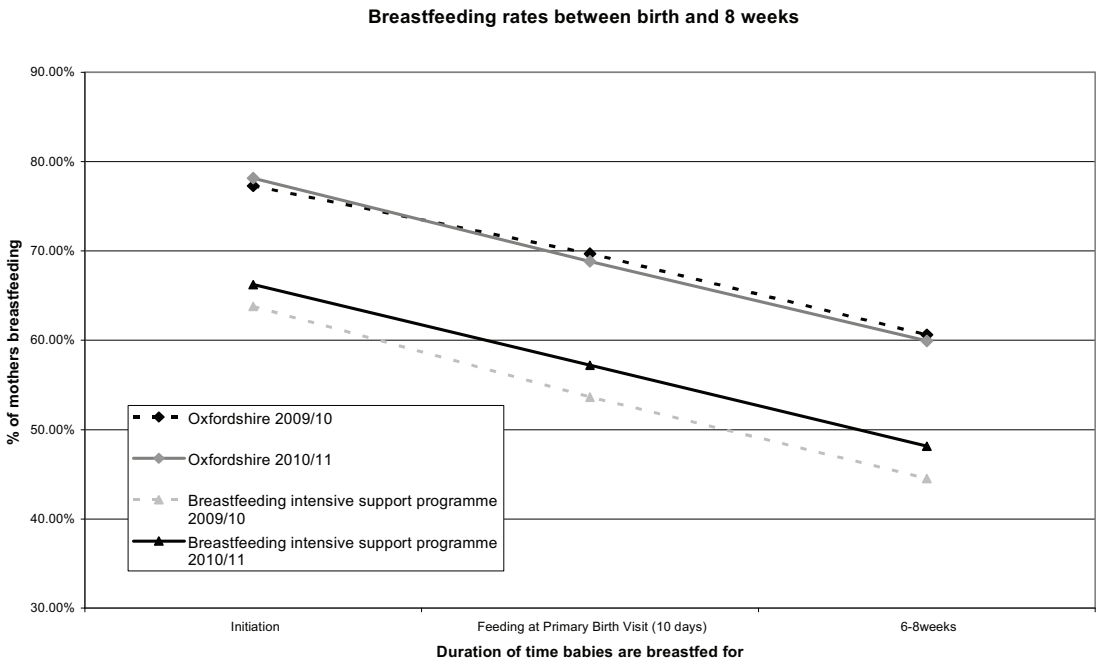
Indicator 9 - Breast Feeding Levels

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire is high (79%) compared with national levels (74%), this is a good result. However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children. In 2009, areas of Oxford and Banbury were identified as having significantly lower breastfeeding rates than the rest of Oxfordshire. An intensive support service was set up, working out of general practices serving the populations with the poorest uptake. The practices were Blackbird Leys Health Centre - Oxford, both Donnington Health Centres - Oxford, Windrush Surgery - Banbury, 12 Horse Fair - Banbury, West Bar Surgery – Banbury

and The Orchard Health Centre - Banbury. The service was designed to support mothers in choosing to breastfeed and then provide practical help to continue feeding during the first weeks of life

Figure 9 shows that as expected, breastfeeding decreases as time goes by. The two top lines show breastfeeding rates for the whole county for the last two years. The bottom two lines show breastfeeding rates for the practices in Oxford and Banbury serving the areas with the lowest rates. This shows that, whilst the county average has been static, the extra support offered in the most deprived areas has improved rates across the board by about 4 percentage points. This is a good result.

Figure 9 - Breastfeeding rates between birth and 8 weeks, for 2009/10 and 2010/11



Indicator 10 - Obesity in Children

Being obese* in childhood puts your health on the back foot throughout life, and any obesity is a cause for concern (see chapter 4, dedicated to this topic). In *this* chapter we look at obesity rates in children in different parts of the County as a marker for where our effort is most needed to break the cycle of deprivation.
In Oxfordshire we measure obesity carefully in schoolchildren at two ages: reception year (around age 4 to 5) and year 6 (around age 10 to 11).
Figures 10 and 11 compare levels of obesity between the Districts within Oxfordshire and with the national average.

* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

In reception year, all Districts are below the national average. The City has the highest rates, followed by Cherwell and West Oxfordshire. (The very high figure for 2008/9 in West Oxfordshire is almost certainly inaccurate, due to a data recording error).
By year 6 however the picture changes, with Oxford City significantly higher than the national average with almost 1 in 5 (almost 20%) children obese with the other districts comfortably lower than the national average grouped around the 14-15% obese mark.

Figure 10 - Obesity amongst children in Reception Year 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire

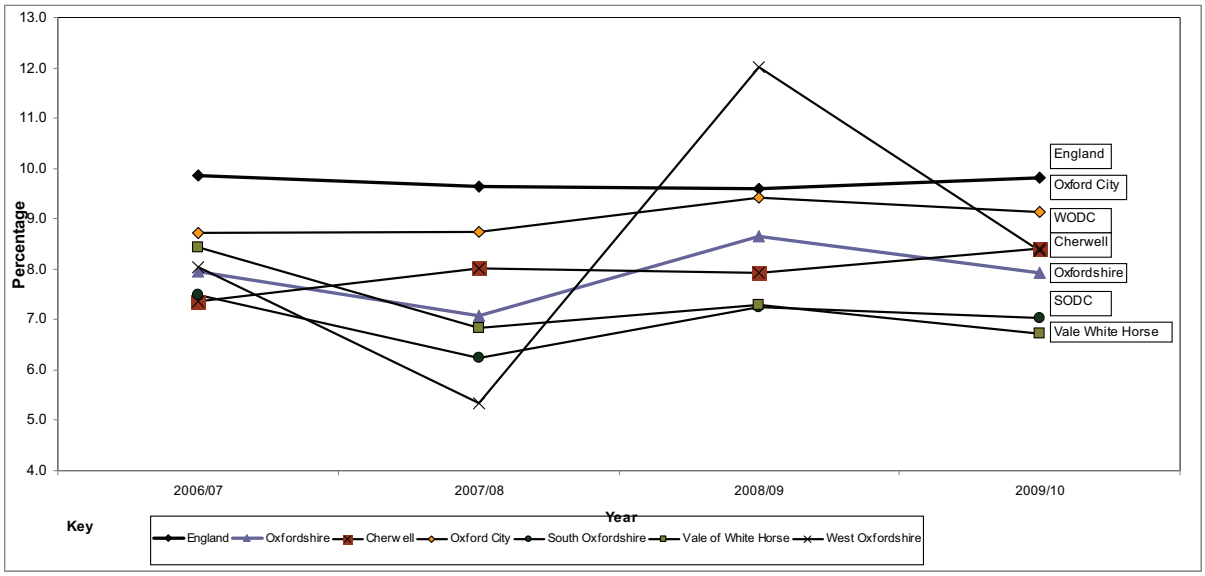
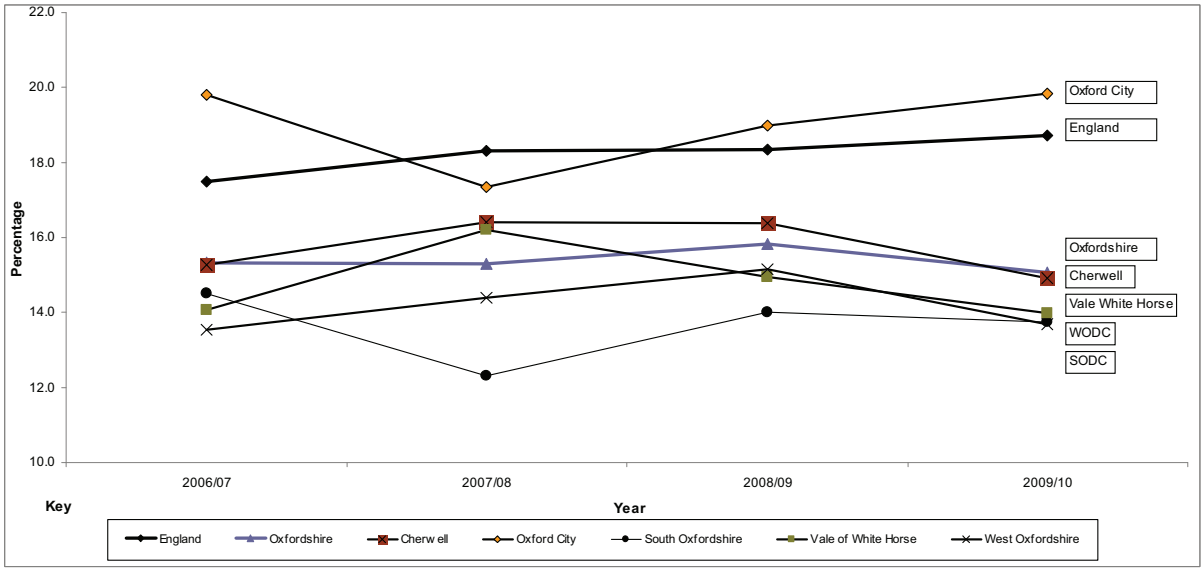


Figure 11 - Obesity amongst Year 6 children 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire



Is Breaking The Cycle Of Deprivation Still a Priority for Oxfordshire?

Unquestionably yes.

The statistics quoted above paint the picture eloquently:-

Breaking the cycle of deprivation is *the* major long-term social challenge facing Oxfordshire.

As a problem overall, its impact on health is only surpassed by the demographic challenge posed by an ageing population.

We **HAVE** recognised this challenge over the past 4 years and we **HAVE** begun to make a difference and this is a great step forward, but it is clear that efforts will need to be maintained over successive decades if we are to beat this problem.

The issue still overwhelmingly affects the most socially disadvantaged parts of Oxford City and Banbury and consequently, this is where the focus for action must lie. Since we have recognised this issue as a major problem in this County, promising work has begun. It is vital that these green shoots are nurtured with care.

We seem to get the best results when we focus on:

- **making a difference to *specific families in specific areas*** through direct contact and action
- **Re-designing existing *mainstream* services at the margin** to give a slightly enhanced focus on deprived areas as opposed to designing stand-alone, short term initiatives. Stand-alone initiatives are always harder to sustain in times when finances are under pressure, and sustainability has to be the watchword.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Breaking the cycle of deprivation is now recognised as a major plank in Local Authority and NHS policy in Oxfordshire. This is a major achievement and all organisations should take credit for this. The altruistic use of the Local Area Agreement reward grant on this topic bears witness to this and is to be applauded. Important new initiatives and new ways of working have sprung out of this recognition, in particular:

- The family intervention project which has targeted help to the specific families who need it the most
- Work to target schools with poor educational attainment
- Reductions in teenage conceptions in the “hotspot” areas
- Fewer young people as a whole Not in Education, Employment and Training (NEET)
- Job Clubs linking with local employers to offer opportunities
- Apprenticeships, internships and volunteering opportunities for young people.
- Benefits advice available from Citizens Advice Bureau advisors in GP practices in Banbury as well as Oxford
- Further Local Area Agreement reward funding being made available for skills development and improving employability.

However the watchword here is <u>persistence</u>. This means persistence over time despite changes in fiscal policy, and organisational change.

The most pressing challenges in Oxfordshire are to:

- Ensure that the new Oxfordshire Clinical Commissioning Group is fully supportive of Breaking the Cycle of Deprivation as a policy and that their locality structure will enable them to focus on these areas in the County when the need arises.
- Ensure that 'Breaking the Cycle of Deprivation' continues to be a very visible major plank of policy across all organisations in Oxfordshire as partnership structures are reviewed and renewed. This should incorporate the implementation of the Child Poverty Strategy. It will be vital for the Health and Wellbeing Board to adopt this topic as a major priority and it will also be vital for the Community Safety Partnership and the Local Enterprise Partnership to play their parts also.

Recommendations

1. A Strategic Priority for the Health and Wellbeing board

By March 2012 the Health and Well-Being Board should have adopted Breaking the Cycle of Deprivation as a major priority for the public sector in the County.
A Children and Young People's Board should have been set up to continue the work of the Children's Trust on this topic and should report regularly on a basket of outcome measures and key performance targets designed to show progress to the main board. This should include setting specific local trajectories for 2012, 2013 and 2014. The Health and Wellbeing Board should require improvement plans to be in place where progress is not on target.

2. A Strategic Priority for Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Oxfordshire Clinical Commissioning Group should be a fully signed-up partner to programmes of work designed to break the cycle of deprivation in Oxfordshire under the auspices of the Health and Wellbeing Board.

3. A Strategic Priority for the Community Safety Partnership and Local Enterprise Partnership

By June 2012 the Community Safety Partnership and Local Enterprise Partnership should have identified focussed action that they will oversee to play their part in Breaking the Cycle of Deprivation.

Chapter 3 - Mental Health: Avoiding a Cinderella Service

It is appropriate to conclude that services combating mental illness and promoting mental wellbeing HAVE improved over the last four years in Oxfordshire.

Four years ago mental health was definitely a 'Cinderella issue' - this is no longer the case. The challenge will be to sustain this improvement during a tough fiscal climate, especially as the impact of recession works its way through peoples' personal circumstances.

The analysis below shows why this conclusion is drawn.

What does the Joint Strategic Needs Assessment (JSNA) say about Mental Health?

Measuring and assessing mental health and wellbeing is difficult. Why? Because mental health is such a complex thing - it is so complex and so tied in with peoples social circumstances that it is hard to define. It isn't neat and tidy like diabetes.

Having said that, the JSNA sheds very useful light on the subject -
For example, we know that:

- Mixed anxiety and depression is the most common mental disorder - it is estimated to affect around 35,000 people in Oxfordshire at any one time (9% of adults). It isn't possible to say whether this level is rising or falling, but we DO know that more people than ever before are now receiving treatment for these common conditions.
- Levels of major mental illnesses like schizophrenia recorded by GPs are stable and are not rising.
- Oxfordshire's suicide figures show a decrease to bring County levels in line with national averages after a worrying upward trend.
- Rates of Accident and Emergency attendances for deliberate self-harm such as overdoses have fallen steadily over the last 4 years.
- National data shows early signs that people with mental health problems are becoming less stigmatised. The National 'Attitudes to Mental Illness survey 2011' shows that:
    - the percentage of people agreeing that 'Mental illness is an illness like any other' increased from 71% in 1994 to 77% in 2011.
    - the percentage saying they would be comfortable talking to a friend or family member about their mental health rose from 66% in 2009 to 70% in 2011.
    - the percentage saying they would feel uncomfortable talking to their employer about their mental health fell to 43%, compared to 50% in 2010.

What Evidence is there of service improvement?

The consensus among local professionals is that:

- The need to improve services which help to get people back into work and achieve independent living has been recognised, and these services are now being strengthened.
- Mental health service commissioning is much improved. Services are specified in contracts in much more detail.
- Much better services are in place for common conditions - e.g. more counselling in general practice and improved access to 'talking therapies'.
- The commissioning of dementia services is much improved in line with the national dementia strategy.
- Carers for people with mental health problems are benefitting from a welcome increase in GP-referred carers breaks.
- Joined up early intervention services for children and families will help to spot psychological problems early and will make treatment more accessible.

Is This Still a Priority for Oxfordshire?

Absolutely. The sea may be calmer, but it is by no means all plain sailing from here on. The next raft of challenges includes:

- Maintaining what we have achieved with tightening resources.
- Untangling the way we pay for NHS services within the 'payment by results system'. This tries to fix a standard price for standard treatments and works fine for physical illness…… mental illness however is much more complex as it resists being packaged up and neatly priced. It is hard to see how this will work smoothly.
- The move to join up all mental health services cradle to grave as part of the national 'No Health Without Mental Health' initiative.
- GP Commissioners will be taking the reins of NHS commissioning fully over the next year or so. We will need to keep focus and direction during this change.
- The long term impact of the recession will filter through to increase common psychological conditions - this is an inequalities issue as areas of social disadvantage experience higher levels of unemployment and other stresses.
- The recently created Oxford Health NHS Foundation Trust has now expanded into the physical health arena from its traditional base in providing mental health services. The impact of this is as yet unclear, but it will be important to keep focus here too.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Good Progress has been made:

- Mental health is now firmly on the agenda as a major concern - it is no longer such a Cinderella service.
- There is a much improved focus on older people and on dementia services.
- The creation of a large pooled budget for mental health services will help to 'glue' together the NHS and Local Authorities in commissioning services.
- More emphasis has been given to carers for people with mental health problems.

BUT

- We have struggled to set authoritative outcome measures for mental health - an issue that is currently being wrestled with at national level.

Recommendations

1. Strategic Priority of this Topic
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that a cradle to grave strategy is in place for mental health in Oxfordshire. It should ensure that all of its sub-groups are playing their part to commission integrated services for children, adults and older people.

2. Need to Review Pooled Budgets
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that the pooled budgets for mental health are reviewed and are working effectively to implement mental health commissioning.

3. Need for Outcome measures
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that meaningful outcome measures and trajectories are agreed for mental health services in Oxfordshire.

4. Strengthening the Public Voice
By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with mental health service users and carers and is in a position to put forward their views forcefully into the planning process.

5. Strategic Priority for Oxfordshire Clinical Commissioning Group
By June 2012, Oxfordshire Clinical Commissioning Group should have agreed to make the further improvement of the commissioning of NHS mental health services a priority, and they should be doing this through playing a full role as strategic partners in Oxfordshire's Health and Wellbeing Board.

Chapter 4 - The Rising Tide of Obesity

Previous annual reports highlighted the importance of halting the advance of obesity* in our society. This is important because:

- Obesity is on the increase in epidemic proportions in affluent Western society.
- Once obesity is established in childhood it is very hard to shake off in later life.
- Obesity reduces lifespan by around nine years.
- Obesity can lead to high blood pressure and long term conditions such as diabetes heart disease and stroke and cancer which lead to premature death and drive the costs of health and social care which we cannot afford.
- The risk of getting diabetes is up to 7 times greater in obese women and up to 5 times greater in obese men.
- The risk of developing diabetes is up to 20 times greater for people who are very obese (Body Mass Index over 40*).
- Obesity adds £1 million **every year** to the cost of the NHS in Oxfordshire alone.
- 10% of all cancer deaths among non-smokers are linked to obesity.
- Obesity decreases mobility making independent living harder.

A **reduction in 10% of body weight** gives the following benefits, even if you do not return into a normal weight category:

- a 20% fall in death rates overall.
- a 30% reduction in deaths related to diabetes.
- a 40% reduction in obesity-related deaths from cancer (e.g. bowel cancer).
- a 90% decrease in the symptoms of angina.
- a significant reduction in blood pressure and cholesterol levels.

What does the Joint Strategic Needs Assessment say about Obesity?

The key facts from the JSNA are:
For Adults:

- Levels of obesity in over 16s are gradually increasing nationally, but levels in Oxfordshire are not quite so high in comparison (22% for Oxon compared with 24 % nationally).
- National rates for adult obesity continue to creep up around 1-2% per year, but the most recent figures for Oxon show a slight fall - enough to be welcomed cautiously but this could be just a 'blip' in our favour.

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* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30
- a BMI greater than or equal to 40 is morbidly obesity - that is a 6 foot man weighing 21 stone 1 has a BMI of 40, whereas a female who is 5 foot 4 weighing 16 stone 9 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

For Children:

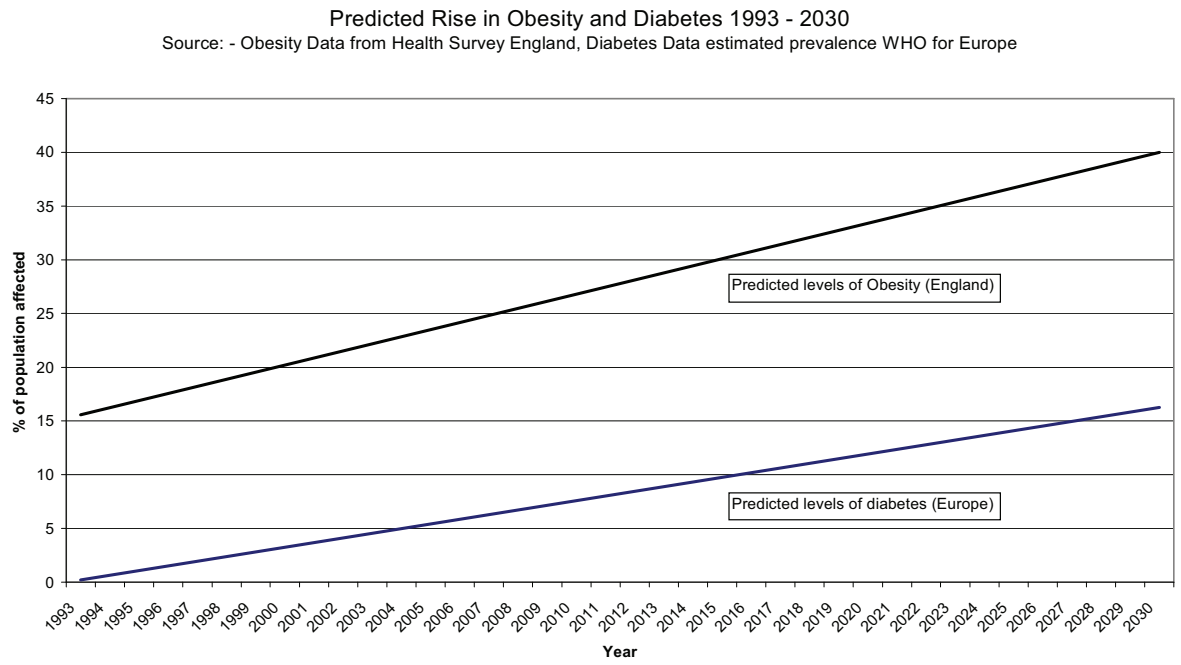
- Among children, levels of obesity are too high at around 8% of reception year children, rising to 15% of year 6 children. This shows that eating too many calories and taking too little exercise gradually increases weight year on year, with year 6 levels being almost double reception levels. This feeds through into ever increasing levels of obesity in young adults.
- The relatively 'good' county average masks the familiar pattern of social deprivation - Chapter 2 has already drawn attention to the fact that obesity levels are significantly higher in the City compared with the rest of the County.

However, that said, it isn't all bad news

- The trend in levels of childhood obesity has been pretty static both nationally and in Oxfordshire in recent years (2006-2010). This is good news as our aim is to halt the rising tide as a first step.
- Also, Oxfordshire's children do have lower levels of obesity than their National counterparts, with Oxon reception year levels around 1% lower than nationally (8% compared with 9%) and year 6 levels around 4% lower (15% compared with 19%).
- Oxon can take further comfort from recent data on exercise levels in adults. It transpires that **Oxfordshire is the sportiest and most active county in England according to the latest Active People survey results released by Sport England** earlier this year. Since 2005 the percentage of people in Oxfordshire participating in regular activity each week has risen year on year to 26%, **the highest in England**, with an increase of 514 people participating regularly compared in the last year. GO Active (Get Oxfordshire Active) is one of the projects in Oxfordshire that has contributed to this increase as a good example of Local Government and the NHS working in partnership. For example, since January 2009 over 13,000 people have taken part in GO Active activities such as Dance, Nordic Walking and Rounders across the county and independent research has shown that 84% of those involved are leading a more active lifestyle as a result.

Trends in chronic disease associated with obesity continue to show an upward trend. Figure 12 shows a worst case scenario for diabetes which we may face based on the "Foresight Report" which looked in detail at obesity levels using data from England and World Health Organisation predictions of worse case scenario diabetes levels across Europe.

Figure 12 - Predicted rises in Obesity and Diabetes



Is This Still a Priority for Oxfordshire?

The fight against obesity is the most important lifestyle challenge for the population of Oxfordshire. We are doing well as a County, but *can* do more to tackle this problem.

The risks of obesity are obvious. The benefits of losing weight are very clear, and yet, on the whole the trend is still going up. Why? Because, on the whole, in Western society as it stands, just by living an 'average' life, it is easier to become obese than it is to maintain a normal weight.

There is some comfort in the data for Oxfordshire, but not enough to justify taking our foot off the accelerator for a second. If we do not continue efforts to turn back the "rising tide" we may not be able to afford to treat the ensuing chronic disease and high levels of physical disability which will result. It is imperative that we continue to tackle obesity as a partnership, with each partner playing a full role.

There is huge scope here for District Councils to link the efforts of GP commissioners, road and transport planners public health staff, health visitors and schools to continue the fight against obesity. It is particularly important to take a cradle-to-grave approach to try to prevent people becoming obese in the first place - an approach which starts before the birth of the child and continues throughout life.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Progress against recommendations has been generally good. The calls for stronger partnership working have been heeded, and obesity was taken seriously as a priority by the Health and Wellbeing Partnership, a body that will be subsumed with the new Health and Wellbeing Board. These actions have helped us to be in a strong place in Oxfordshire going forward.

However:
It has proved difficult to measure reliably levels of adult obesity and physical activity in the general population. It was hoped that reliable information might be available through general practice but this has run into practical and statistical difficulties and is probably beyond our scope currently. We will need to continue to use national estimates and one-off surveys as a proxy to measure progress.

Successful work on obesity depends on good joint working between organisations. **Following the major re-structuring of public sector organisations over the last year, the major task facing us is to maintain, re-vamp or re-create the strong partnership work we traditionally enjoy in Oxfordshire.** It will be particularly important to connect District Councils, GP Commissioners, County Council, schools and the new Public Health Team as it transits to the County Council. The new Health and Wellbeing Board will have a pivotal role to play in driving this work forwards.

Recommendations

1. Strategic Priority for the Health and Wellbeing Board and its Health Improvement Board

By March 2012, Oxfordshire's Health and Wellbeing Board and its subsidiary Health Improvement Board should adopt the fight against obesity as a major priority, should set local targets for Oxfordshire and should regularly monitor progress against these targets. As part of this process, all Local Authorities, GP Commissioners and Healthwatch are recommended to adopt the fight against obesity as an important corporate priority.

2. Requirement for a re-vamped County Strategy

By June 2012, the new Public Health Team should agree and coordinate a cradle-to-grave strategy to prevent and treat obesity, on behalf of all organisations in Oxfordshire. This should include working together with all Local Authorities and GP Commissioners. This should be adopted by the Health and Wellbeing Board

3. Need to Retain Strong Partnership Working of the Sports Partnership Board

By June 2012, the Sports Partnership Board which has instigated and co-ordinated the “Go Active” project (that allowed countywide co-ordination of physical activity initiatives between District Councils and Health Services) should ensure that the scheme is made sustainable going into the future.

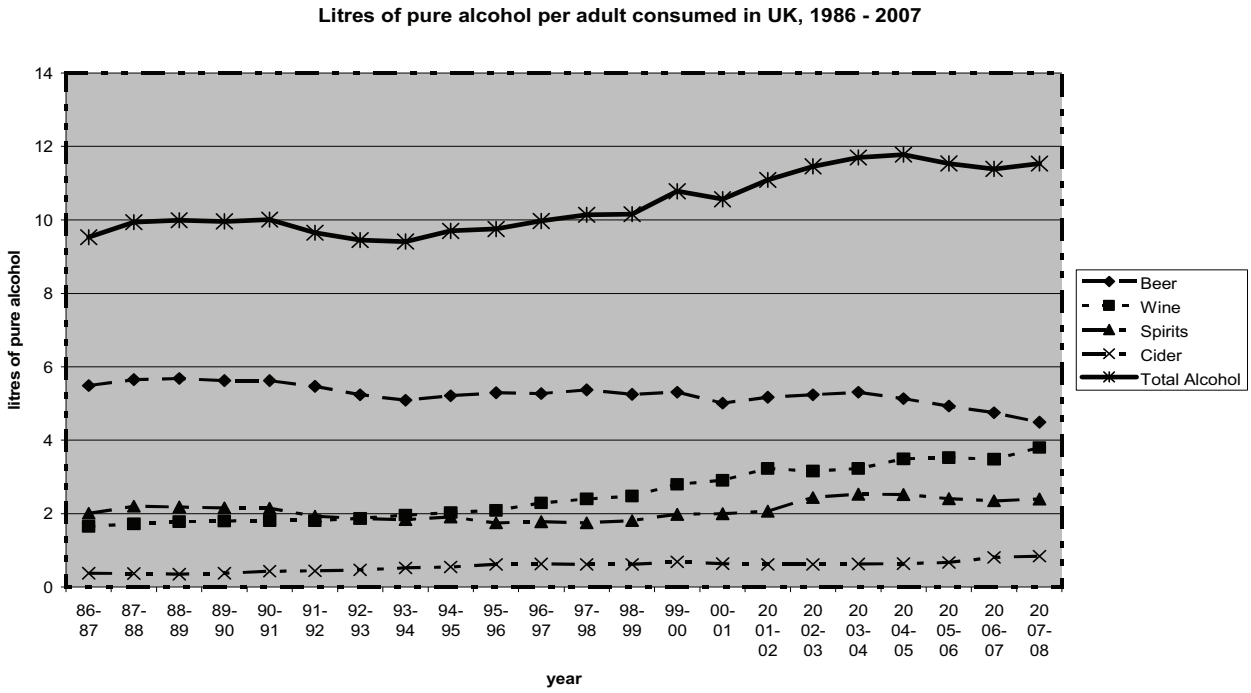
Chapter 5 - Alcohol: What's Your Poison?

Last year's Annual Report established that drinking too much alcohol was a cause of major concern for the future of health in Oxfordshire for the following ten reasons:

1. **Alcohol consumption has risen in the last 40 years**

   In England, average adult alcohol consumption has risen by 40% since 1970. The graph below shows the recent trends in consumption.

Figure 13 - Alcohol Consumption in the UK



Source: Institute of Alcohol Studies Factsheet "Drinking in Great Britain" www.ias.org.uk

2. **Many Adults exceed recommended drinking levels** and one in five drinks at hazardous levels
3. **Alcohol consumption in young people has increased** with heavy drinking and binge drinking a concern in this group. Consumption among young women has been increasing rapidly.
4. **Alcohol, without doubt, causes disease** and early death. It is a poison.
   - In England in 2006, 16,236 people died from alcohol-related causes.
   - The number of deaths from alcohol-related liver disease has almost doubled in the last decade.
   - Alcohol causes cancers of the liver, bowel, breast, throat, mouth, larynx and oesophagus; it causes osteoporosis, reduces fertility and causes accidents of all kinds.
   - Alcohol is responsible for around 950,000 unnecessary admissions to hospital nationally per year, and this is rising (an increase of 70% in the 6 years between 2002/03 and 2008/09).
5. **Alcohol is getting cheaper and more easily available**

The real cost of alcohol has fallen: a unit of alcohol cost 67% less in 2007 than in 1987.

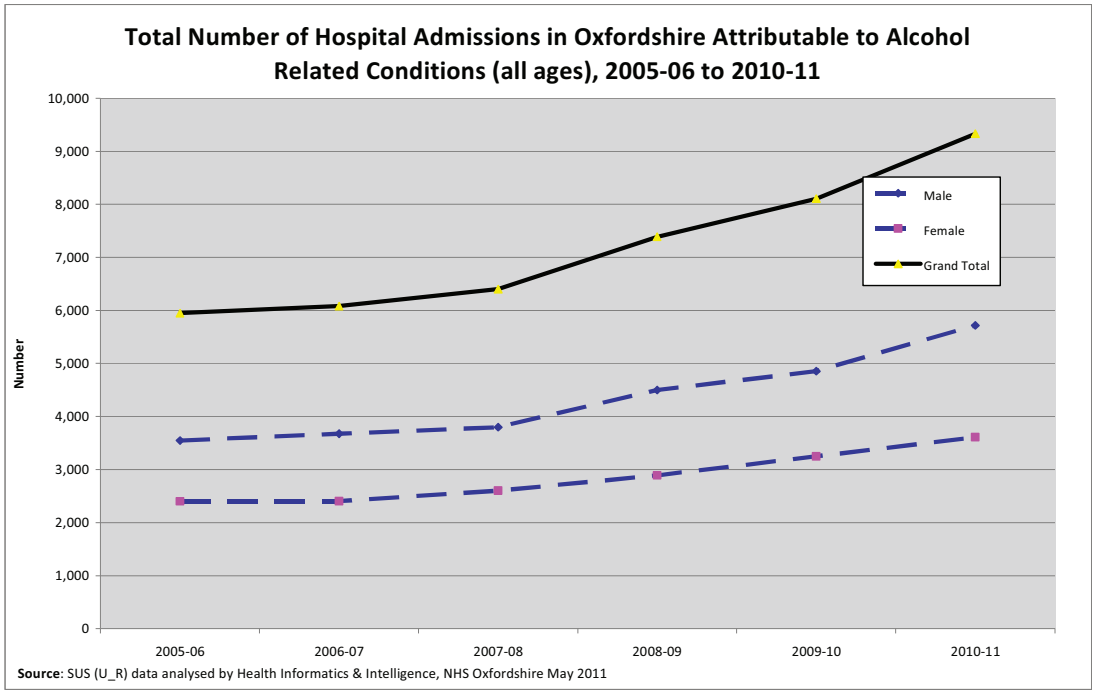
6. **The health benefits of alcohol are overstated**

Despite recent media coverage, attempts to define a 'safe' level of drinking are fraught with difficulty. Although above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke. For those who drink above this low level, and for those under 40 years who drink any amount, alcohol **increases** the risk of heart disease and stroke. For those of any age, drinking any amount of alcohol increases the risk of cancer, there is no safe limit. Across England, for every hospital admission that alcohol 'prevents', alcohol causes 13 people to be admitted.

7. **Alcohol damages the family and social networks**
8. **Alcohol fuels antisocial behaviour** and changes the character of our towns, especially in the evening at weekends
9. **Alcohol damages front-line services** and the economy and places a huge financial burden on the taxpayer.
10. **Hospital admissions for alcohol related harm in Oxfordshire are rising**

Local statistics show the burden of disease related to alcohol in Oxfordshire. The graph below shows how hospital admissions due to alcohol related conditions are rising steeply and the position is worse than last year.*

Figure 14 - Hospital Admissions attributed to Alcohol



* This calculation takes into account health conditions and other causes of admission to hospital (i.e. accidents) that are either wholly or partially attributable to alcohol. The greatest proportion of alcohol related admissions to Oxfordshire hospitals in 2010-2011 related to the following health conditions;

- Breast cancer, Cataracts, Heart rhythm problems, Unspecified chest pain, Urinary tract infections

What Does the Joint Strategic Needs Assessment say about Alcohol?

Last year's report set out the scene fully:
There are two main points to make.
1) The trends in Oxfordshire mirror the national trends well -
All indications are that levels of drinking are gradually rising and that services are expending more and more effort to respond to the results in terms of ill health, accidents and crime.
2) Although the trend is going up, on the whole, Oxfordshire's levels are better than the England average.
In short, we do have a big problem to deal with even though other's have it worse.

Is This Still a Priority for Oxfordshire?

This topic *SHOULD* be a priority for Oxfordshire and the real solution is through prevention - that means persuading people of all ages to drink sensibly.

However, it is often said that “there is a tide in the affairs of men”, and all the indications are that society as a whole is not yet ready to hear this message. It is highly unlikely that in the current climate the public sector can push back against the wave of cheap booze, relaxed licensing laws and a culture which subtly condones drinking.
As with the early years of public awareness campaigns regarding smoking and seat-belt legislation, the public are not yet prepared to hear the 'prevention' message when it comes to alcohol. It is even more of a tricky issue because, unlike smoking, alcohol in modest doses causes minimal harm, and it is also deeply embedded in social activity…. But then, 20 years ago so was smoking…….

This leaves us with a two-edged strategy:
1) Do what we can to chip away at public attitudes which support drinking to excess through education of all age groups.
2) In the meantime continue to apply sticking plaster to the symptoms through 'harm minimisation' approaches.

We are good at harm minimisation in Oxfordshire and we should be proud of what our blue-light services have achieved working with Local Authorities, the NHS and other partners. Some of the good work done is showcased in the next section.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Last year's recommendation was a clarion call to strengthen our harm minimisation strategy for Oxfordshire. This has been achieved well. A new strategy is in place and it is being actioned by a well-organised strategy group working across many organisations.

Here are 3 priority areas giving examples of good progress:

1. Community safety
   - Violent crime rates have continued to fall and our cities and town centres are safer. Latest figures for July – Sept 2011 show a decrease of 23% in the number of violent crimes compared with the same three months last year. This is a total of 169 fewer crimes just in those 3 months. The City had the biggest reduction, with 104 fewer violent crimes than in this period last year. This continues a long term trend for falling crime rates across the County. In addition, offering targeted advice to the most vulnerable people in A&E who are injured because of their drinking people has shown a 70% reduction in repeat attendances. The advice is offered to those who have already attended A&E several times and everyone aged under 18 with alcohol related conditions.
2. Health
   - Comprehensive guidelines have been produced for GPs and other practitioners to help with offering advice or referral for help to reduce alcohol related harm. The first step is to use a simple set of questions to get an idea of alcohol intake and then the practitioner can offer help and support accordingly.
3. Children and Young People
   - Lesson plans and follow-up activities for the school curriculum are available for teachers so that the issue of alcohol can be raised for discussion with young people. Work is also underway to help young carers whose parents may be misusing alcohol.

Recommendations

1. Strategic Priority of this topic

By March 2012 the Oxfordshire Community Safety Partnership and The Oxfordshire Drug and Alcohol Action Team should confirm the Alcohol prevention and harm minimisation remain priorities. Within this framework, the multi-agency approach of the Alcohol Strategy Group must be maintained and continually developed.

2. Strategic Alignment and clarity of who-does what

By March 2012, the Oxfordshire Community Safety Partnership and the Oxfordshire Health and Wellbeing Board should have reached agreement that the Oxfordshire Community Safety Partnership will take a lead role on setting outcome measures for alcohol and achieving progress. This progress should be reported to the Oxfordshire Health and Wellbeing Board via its Health Improvement Board.

3. Prevention and Education

By June 2012 an authoritative 'set' of public messages should be widely used throughout Oxfordshire tailored to different audiences, to help people to understand the personal implications of drinking alcohol. This is intended to help people make their own informed choices. These messages should be planned and promulgated through the Oxfordshire Community Safety Partnership working with Oxfordshire's Public Health Team.

4. Harm Minimisation

By June 2012 work the Oxfordshire Community Safety Partnership should conclude work with the Oxfordshire Clinical Commissioning Group to find the best means to develop the offer of brief advice through primary care and other settings, not just targeting those who are drinking at harmful levels but also using the AUDIT screening tool to help everyone understand their current level of drinking and whether there is reason to be concerned.

5. Moving gradually 'upstream' from harm minimisation towards prevention

By June 2012, the Oxfordshire Community Safety Partnership should ensure that essential reactive services are maintained to minimise alcohol related harm, (for example, through Nightsafe initiatives), **And** continue to move towards prevention in all this work. Specific plans should be drawn up to enhance the preventive element of all harm minimisation programmes. Examples of these approaches are:

- Promoting the work of Street Pastors who provide an important preventive element in keeping the night time economy safe.
- Finding new ways of reducing under-age sales.
- Enforcing licensing conditions.

Chapter 6 - Fighting Killer Diseases

Communicable diseases can have a major impact on the health of a population. A communicable disease is one which spreads from person to person through the air, water, food or person to person contact.

Over the last four years, most of the major killer infectious diseases have been in decline across Oxfordshire. However, these diseases remain a threat but their impact can be reduced further by good surveillance and information, early identification and swift action basic cleanliness, hand washing and good food hygiene.

This chapter reports on the most important diseases one by one.

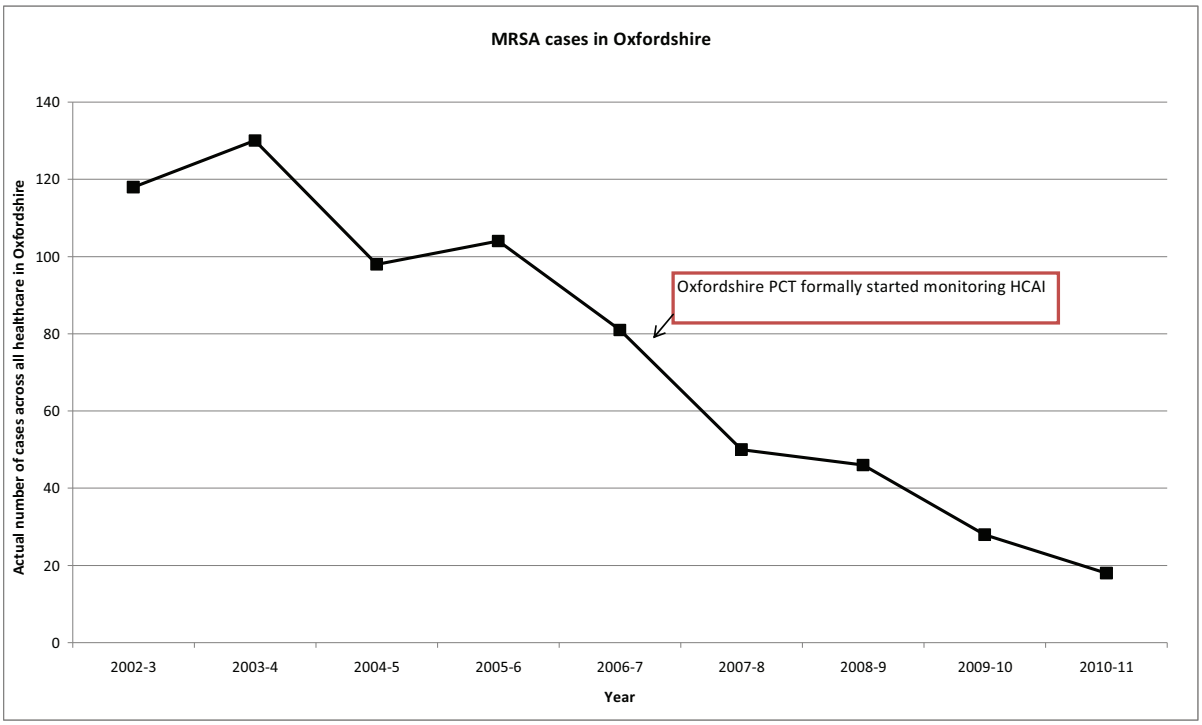
1. Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant *Staphylococcus Aureus* (MRSA) and *Clostridium difficile* (*C.diff*.) remain an important cause of sickness and death, both in hospitals and in the community. However numbers of infections **can and have been** reduced through considerable focussed effort in this County.

a) Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through invasive procedures or chronic wounds) it can cause blood poisoning (bacteraemias). It can be difficult to treat in people who are already very unwell so we continue to look for the causes of the infection and to identify measures to further reduce our numbers. The reduction in MRSA bacteraemia continued its downward trend seen since 2002-3. **This is an impressive achievement for healthcare in Oxfordshire**. Success has been due to improved detection, improved cleanliness, improved clinical procedures, focussed management action and strict surveillance.

Figure 15 - MRSA cases in Oxfordshire

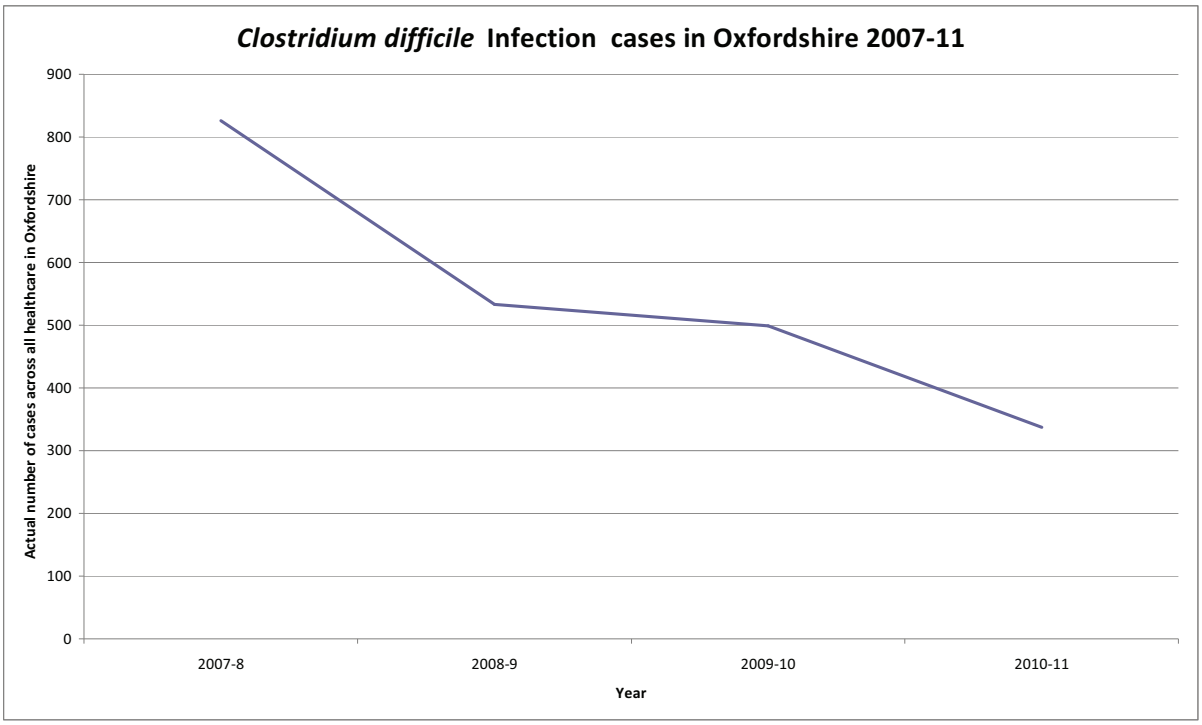


b) *Clostridium difficile* (*C.diff*)

Clostridium difficile is a bacterium that causes mild to severe diarrhoea which is potentially life-threatening especially in the elderly and infirm. This bacterium commonly lives harmlessly in some people's intestines but commonly used broad spectrum antibiotics can disturb the balance of bacteria in the gut which results in the *C.diff* bacteria producing illness.

A focussed approach on the prevention of this infection is resulting in a steady reduction in cases since 2007/08.

Figure 16 - Clostridium Difficile Infections in Oxfordshire



Work continues in the Oxfordshire health economy to reduce inappropriate antibiotic use, and in healthcare settings improve the speed of isolation of suspected cases and cleanliness of the environment.

2. Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by *Mycobacterium tuberculosis* which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If it is not treated, an active TB infection can be fatal as it damages the lungs to such an extent that the individual cannot breathe.

In Oxfordshire, the number of cases of TB in 2010 was 61 (28 with lung disease and 33 with other TB). The small increase in numbers in 2010 is related to our success in identifying TB in non-UK born population rather than as a threat to the Public Health.

Figure 17 - Tuberculosis incidence rate in Oxfordshire

Year	Number of Cases	Rate per 100,000 population
2006	53	8.4
2007	76	12
2008	56	8.8
2009	55	8.6
2010	61	9.5

Over the past 4 years the rates of new cases occurring, and the number of cases, has remained highest in Oxford City and Cherwell District Council. The county average rate for new cases is consistently lower than the UK rate. **This is a good achievement.**

Figure 18 - TB incidence rate by Local Authority, Oxfordshire, 2010

Local Authority	Cases	Population	Rate per 100,000 population
Cherwell	14	139,200	10.1
Oxford	32	149,300	21.4
South Oxfordshire	4	130,600	3.1
Vale of White Horse	6	118,700	5.1
West Oxfordshire	5	102,500	4.9
UK			13.9

Source: Enhanced TB Surveillance System
Prepared by: Thames Valley Health Protection Unit

The Chief Medical Officer has set local services a target of recording all TB cases and completing successful treatment in 85% of cases. Oxfordshire's successful treatment rates have risen to 94.5% in 2009 (above the Thames Valley average) compared with 84.2% in 2007 and 89.3% in 2008. High completion rates are an important indicator of good control. This year has seen the TB service introduce an even greater degree of accessibility helping improve the response times to TB.

3. Other Diseases Preventable by Immunisation

a) Childhood immunisations

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve, with uptake now amongst the highest levels in the country. The work which has been on-going around data collection and record keeping, involving general practice, community and PCT staff, is resulting in more children being fully immunised.

The new Child Health Information System which went 'live' in mid February 2010 is an absolutely essential tool for keeping information accurate and quality high. The small number of children who are not immunised can now be followed up individually and offered immunisation.

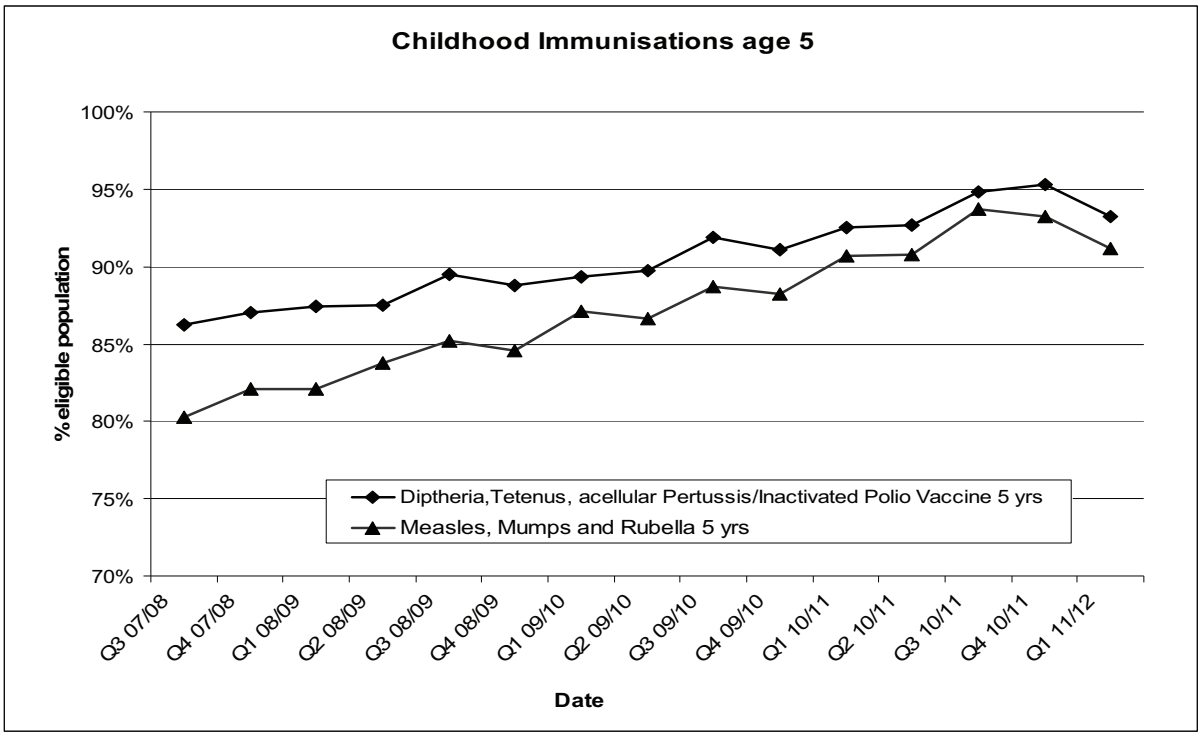
b) Measles Mumps and Rubella vaccine (MMR)

Uptake of this immunisation has risen by 6% over the last year and Oxfordshire's levels are the best in the Region. The importance of this is underlined by considering measles as an example:

In the absence of vaccination there would be approximately 8,000 cases of measles per year on average in Oxfordshire. Of these, approximately 40 people would suffer convulsions as a complication, 8 encephalitis and an average of 1 person per year would die.

The chart below shows the good success we have had in Oxfordshire overall in immunising our children against measles, mumps, rubella, diphtheria tetanus and polio. We will need to ensure that the downturn in the last quarter's data is reversed.

Figure 19 - Childhood Immunisations



c) Human Papilloma Virus vaccine (HPV): preventing cervical cancer

The problem with human papilloma virus (HPV) is that it may go on to cause cervical cancers. It is so common that at least 50% of sexually active men and women get it at some point in their lives although only a handful of the women affected go on to develop cervical cancer.

There is no treatment for the virus itself but a highly effective vaccine is available that protects against HPV types 16 and 18, the types most which between them cause over 70% of all cervical cancers. **HPV vaccination will save the lives of an estimated 400 women each year in the UK with 4 lives saved per year in Oxfordshire.**

We are currently immunising the 3rd cohort of girls with HPV vaccination – these were students in school year 8 during 2010/11 – the uptake for the whole course of 3 injections is expected to be at least 90% in this age group. The catch up programme, offering HPV to all girls up to the age of 18 years, took place during the academic year 2009/10.

This new vaccine is a significant step forward in the prevention of cancer.

4. Sexually transmitted infections

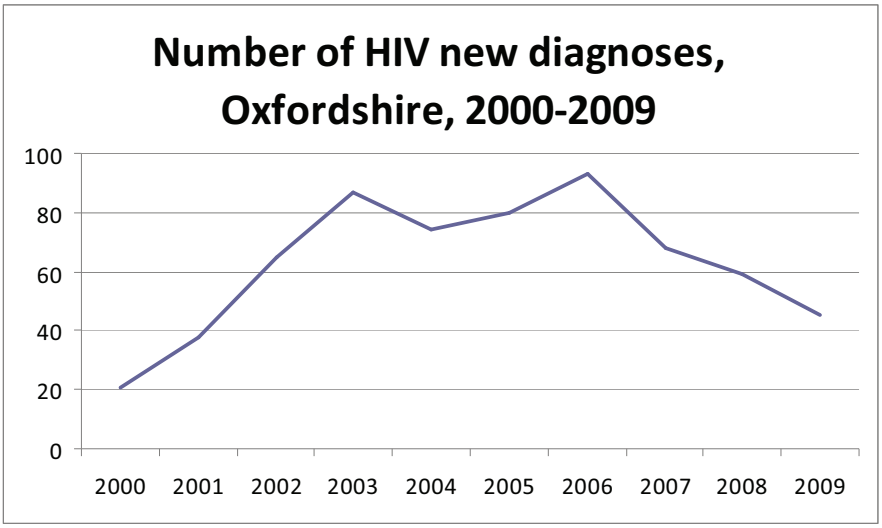
a) HIV & AIDS

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, and significant mortality.

It affects men and women, straight and gay, can be acquired in the UK or abroad and the best form of protection is still through 'safer sex' techniques.

In 2009, there were 214 new diagnoses of HIV in Thames Valley which is a 19% reduction from 2008. This is a good result. Of these new diagnoses 45 were new HIV diagnoses in Oxfordshire. The Oxfordshire figures continue to fall. We continue to work in partnership to get the prevention message across.

Figure 20 - Number of new HIV diagnosis reported in Oxfordshire, 2000-2009

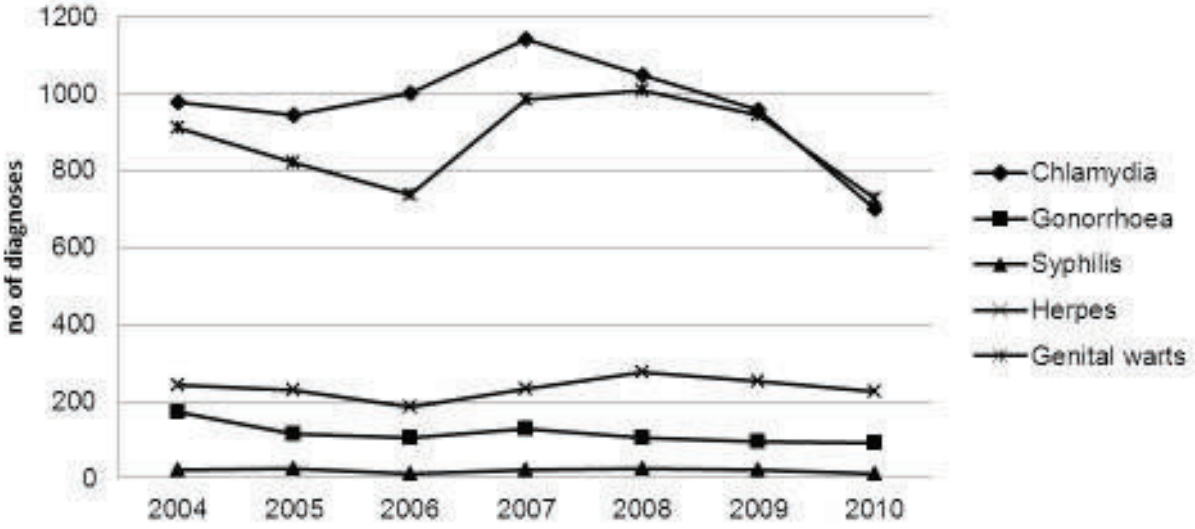


b) Sexual Health

It is important to monitor sexually transmitted diseases carefully to watch for increases in disease, the vast majority of which are preventable through taking basic 'safe sex' precautions. This is an important area to address because if Sexually Transmitted diseases are left undetected and untreated they may result in serious complications such as infertility in later life.

It is heartening to see that all the major sexually transmitted diseases fell during the last year. Chlamydia and genital warts remain the most common although there have been decreases in Chlamydia cases over both 2008 and 2009 from a highpoint in 2007.

Figure 21 - Diagnosed sexually transmitted infections for Oxfordshire residents 2004-2010



Is Fighting Killer Diseases Still a Priority for Oxfordshire?

Improved surveillance and good teamwork with the Health Protection Agency mean that all the major killer infectious diseases are in decline…...for now.

However, this is a trend that can quickly be reversed and it is imperative that we remain vigilant to the threats posed by new diseases emerging, old diseases developing resistance to treatment and peoples behaviour becoming more risky.

Killer communicable diseases are well managed in Oxfordshire but remain an ever-present threat. Constant vigilance is required and careful management will give us the best chance to keep these infections at bay.

This topic must always remain a top priority in order to protect the public health of Oxfordshire.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

All the recommendations from the previous DPH annual reports have been met. Services, surveillance and management of diseases have been steadily improving over the last 4 years.

Recommendations

1. Maintain vigilance and priority during reorganisation
The Director of Public Health and the local Health Protection Agency must work closely during the forthcoming national reorganisation of public health services to maintain surveillance of communicable diseases during 2011/12/13 and take appropriate steps to control these diseases and any new emerging killer diseases.

2. The need to Report on these figures in Public
The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.

Documents and Sources of Information used to produce this Report

Joint Strategic Needs Assessment versions 1 - 4
Public Health Surveillance dashboard
Health Protection Agency Infectious Disease data
Oxfordshire Safer Communities Partnerships Alcohol Strategy Group basket of indicators for Oxfordshire
The Child Poverty Needs Assessment for Oxfordshire
Oxfordshire Children and Young Peoples plan indicators
Oxfordshire PCT Performance data
GP Consortia Information packs – March 2011
Learned journals
Data from Govt Departments
Oxfordshire safer communities safer communities partnership performance framework

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Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

Proposal for A/OA Organisational Change Paper

September 2010

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Updated 24th September 2010 by Jackie Thomas, Locum Deputy Director of Operations (Oxfordshire)

Contents

1 Executive Summary

This paper has been prepared to inform staff of changes that the Oxfordshire Adult and Older Adult Directorate will make to its Community Services. The paper details these changes to management, community team structures and medical support to in-patient wards.

The paper details the areas of change and the new structures to be implemented to achieve the proposed model of care. It identifies the savings that will be realised through these changes and also the risks and opportunities that these changes will present. The model described draws on over 40 years of clinical and research evidence for Community Mental Health provision.

The objective for the service is the delivery of high quality effective patient centred mental health care to the adult population of Oxfordshire. This will be achieved by basing service organisation on patient need and ensuring that the service model delivers:

- Simplicity of patient pathways with the removal of artificial barriers
- Accessibility
- Continuity of care
- Robust teams with the skills to meet the majority of patient needs from within the team, thus avoiding multiple onward referrals
- Clarity of clinical responsibility
- Clinical Leadership

- Optimal utilisation of resource
- Management locally and corporately which support the delivery of optimal care and reduce the burden of bureaucracy

2 Background

The Adult and Older Adult Directorate employs approximately 1000 staff (725.5w.t.e.) and provides a wide range of services. The Directorate is integrated with Oxfordshire Social & Community Services through a Section 75 agreement.
Services for adults include: In-patient, community mental health services (CMHT), early intervention in psychosis (EIS) and assertive engagement (AOR). Services for older adults include: inpatient, specialist support to day care centres, community care, intermediate care (AES), liaison into general hospitals including a self harm service, memory clinics and in-reach into residential and nursing homes. Both care groups have crisis support and treatment provided from the same team (CRHT).

The pressure on in-patient wards, with reduction in bed numbers and increased severity of conditions presented by patients, instructs that there needs to be more support to these teams. The current model of increasing numbers of community teams admitting into the ward causes relationships between the ward and community teams to be more fragmented, blurs responsibility and has high logistical problems for the wards to serve all these teams.

This document proposes that we need to bridge the dilemma of maintaining continuity of care with developing a model of clinical leadership to the ward teams. By reinstating the CMHT as the core service to deliver treatments in the community this model reduces the numbers of teams interfacing with the wards and also creates a lead medical role to support and develop the ward team.

The current model has many small single consultant teams which makes it vulnerable to reductions in service due to sickness, vacancies and also less responsive to peaks in demand. This proposal allows the development of patch based CMHT's that can be sub-divided into robust operational teams, maintaining clear leadership and accountability with more effective cross-cover and development of wider skill sets across the patch.

3 Financial Drivers for Change

- Over the next 4 years OBMH is required to deliver Cash Releasing Efficiency Savings and provide a small surplus against any borrowing for capital developments. The impact of this on services is the need to have increased efficiency and productivity.

- In previous years the savings required by the Adult and Older Adult Directorate have been met by reductions in management costs and by reducing the in-patient bed stock. It is planned to further reduce management costs, however we are not in a position to further reduce our beds at this time.

- The current income budget of the Directorate is approximately £42m. The savings to be achieved are £5.3 million over the next 4 years. This document sets out how this will be achieved by reducing management and staffing costs.

4 Proposal for Service Change

- The proposal is to reduce community costs by £3.4m, Central Management by £250k and over time to realise savings from reviewing the number of

community bases we have in partnership with Community Health Oxfordshire (CHO). Any shortfall in savings is to be met by reductions in overheads and any other efficiency that can be realised over the 4 years.

- From April 2011 OBMH will be merging with Community Health Oxfordshire. We will work together to ensure that we use our joint estate in the most efficient way. This may assist in realising further estate savings.

- We will retain the Crisis and Home Treatment Team (CRHT), Bridge-building, the Prison In-reach Team, the Assessment and Enablement Team (AES) and our contribution to the Single Point of Assessment Rehabilitation and Care service (SPARC). This recognises the specialist competencies contained in these services which are both relevant for the most vulnerable and needy service users and difficult to provide in a more generalist team.

- We will restructure our Community Mental Health Teams (CMHT's) to achieve the savings required. This restructuring will involve an overall reduction in clinical and administrative staff. With the level of vacancies within the Directorate the proposal is to reduce the number of budgeted posts wherever possible in the first year to allow for a longer period of consolidation of the new model rather than further large changes year on year. The changes will include merging the existing single modular teams into a smaller number of larger teams which retain a locality connection. These changes will afford the retention of a range of shared resources and capabilities within the community service.

- We will also be introducing "hot-desking" and reducing administrative costs through more services sharing the same premises and other initiatives to maximise the efficiency of the buildings we use. This is expected to achieve a minimum of £1m reduction in service costs over time. Most of these

savings will be related to a review of community bases and will be subject to a separate proposal and consultation.

- We will reduce the number of administrative support staff by Adult and Older Adult Services operating out of the same premises and sharing the administrative resource. In addition we will be to implementing the new electronic notes system (RIO) and exploring other opportunities for technology to assist clinical staff to efficiently and directly enter and access case information.

- Savings will have to be realised from increasing the clinical contact time of clinical staff and therefore managing with fewer posts. This will be achieved through increased clinics with resultant decrease in the number of home visits, excepting when these home visits are clinically indicated. It is important to emphasise that home visits will still be necessary for some service users who are unable to attend clinics for various reasons. Also by focussing on agreeing thresholds for access to services with primary care partners. It is expected that the number of clinical contacts will increase from an average of 700 contacts per annum to 840 per annum. In the future the currency for provision of care will be based on outcomes and not on numbers.

5 How the proposal will affect operation of clinical services and posts

At previous Adult and Older Adult Senior Staff Away Days we have discussed the variance between teams in thresholds for access to our community services. The proposal is to begin to use the framework of the Health of the Nation Payments by Results (HoNOSPbR) to cluster patient groups and identify the clinical inputs to meet their care needs. From this work we will identify the core elements and

services that the new community teams will provide. This work commenced at the Adult and Older Adult Management Away Days in April 2010 where clinical and management staff began to identify and agree the core clusters that our community services should work within. In delivering the new model of service we will be clearer about these thresholds for accessing our services and make sure these are more consistent across the county.

We will review the operational practices of our community teams to minimise the amount of resource tied up within community premises. This will include utilising capacity in bases fully, increasing the number of clinic contacts, planning visits to minimise non-patient contact time, use of technology to reduce the administrative support requirements.

We are proposing that the new community teams will continue their existing remit of the care and treatment of those with functional conditions (Adults of Working Age) and functional and organic conditions (Older Adults). In addition the teams will carry the currently separate functions of Assertive Outreach, Early Intervention in Psychosis, as well as the general CMHT functions.

For Older Adults the Day Service teams, which are managed within the CMHT's, will be fully absorbed into the new community teams, with the expectation that the function of group work and support to day centres continues from within the CMHT. Memory Clinics will also remain a function of the new CMHT.

To achieve the required savings we will have to work to a set of agreed principles which will allow and require more efficient and effective use of resources. This may involve some or all of:

- more closely delineated packages of care for finite periods with regular formal assessment of changing needs,
- greater role definition within teams,
- more effective working with families,

- standardised and authoritative assessments to gate keep entry to the service using qualified staff
- reduction in reliance upon routine follow-up care, and the review of policies dictating such practice
- targeting of home visiting by teams for those where it is clinically indicated or who are unable to attend clinics,
- reviewing all cases where there has been no contact with the care co-ordinator or RC in the previous 3 months
- routine use of audit to examine and change practice
- promotion of clinical research and innovation

.

There are 725.5wte budgeted posts across the adult and Older Adult Directorate. The proposed changes will equate to a reduction of approximately 47wte budgeted posts (including management reductions) within the Directorate. This will be achieved through vacancy management and thus staff may need to move from their current localities. It is important, however, that this is done with the least amount of change and therefore for the patient as little impact as possible. Many of the current Ward vacancies are being managed by the use of NHS bank staff; therefore it expected that bank usage will reduce significantly with the implementation of the new model and that the majority of the reductions of posts will be made in the first year.

5.1 Premises Savings

Adult and Older adult services currently operate out of 12 community bases (in addition to the main hospital sites at the Warneford, Churchill, Littlemore and the Horton):

Base	Location	Services
Townlands	Henley	Adult and Older Adult
Wykeham Park	Thame	Older Adult
Charter House	Thame	Adult, CAMHS, SCAS

Mereland Road	Didcot	Adult
Ridgeway	Didcot	Older Adult
Abingdon Mental Health Centre	Abingdon	Adult and Older Adult, SCAS
Nuffield Centre	Witney	Adult and Older Adult, SCAS
Julier Centre	Bicester	Adult, SCAS, Prison In reach
Elms	Banbury	Adult
Fiennes	Banbury	Older Adult
Rectory Centre	Oxford	Adult, SCAS, Vol Sector
Manzil Way	Oxford	Older Adult, Complex Needs

In addition to the above there are CAMHS bases in Abingdon, Witney and Banbury. We also have adult community staff based in 3 areas of the Warneford Hospital.

CHO operate out of 9 community hospital bases, many situated in the same market towns as OBMH community bases.

It is proposed to work towards a reduction in the number of bases, with co-location of CHO, adult, older adult, CAMHS and Specialist Adult services wherever practicable possible. A review of the bases will be undertaken and potentials for shared bases explored and this will be consulted on separately in the future. Over the next three years it is envisaged that this will produce a premises saving of between £1m - £1.8m.

It is accepted that there may be some increase in staff travel costs, to allow for this non-pay budgets have been left at the same levels prior to the proposed decrease in staffing, which gives added headroom for this cost pressure.

Summary:
At the April 2010 Adult and Older Adult Senior Staff Away Days there was discussion about the possibilities of base reductions, particularly following the

joining of OBMH and CHO in April 2011. Therefore it is planned to intensively review the all community bases to assess the potential to share single bases where possible.

5.2 Central Management Savings

- In excess of a £250k reduction in central management costs will be achieved.

Central Management

Staff Type	Band	WTE	Total Cost - standard point
Nurse Consultant	8b	2.00	£130,000
PDL	8a	0.50	£24,551
OT	8a	0.51	£27,087
OT	7	0.40	£17,174
Admin	4	1.00	£25,565
Total Pay		**4.41**	**£224,377**
Non-Pay			**£30,000**

The nurse consultant roles have been vacant for 6 months with one nurse consultant successfully taking up the post of Deputy Director of Nursing and the other taking a leading role in the implementation of the productive ward. Two of the service managers are also lead nurses and therefore will maintain nursing leadership across the directorate. In addition the directorate now has two modern matrons in post for one year whilst the ward managers undergo a training programme with the aim of each ward having their own modern matron.

The two OT posts sit within the management cost centre and it is believed that the functions of the posts could be undertaken within the band 7 posts across the directorate therefore the band 7 posts become either practice development nurses,

Senior Practitioners or OT lead posts. This will ensure equity across the service and that all professions have leadership at this level.

5.3 Community Team Savings

- It is proposed to restructure community services from the existing model of the small modular team with access to separate modernisation teams, to larger community teams with the skills to meet the need of service users. The teams will be expected to work to a team model of service provision.

In year one the Early Intervention Service will reduce to one band 7, 8 Care Coordinators and 1 band 5 carer support worker. The management of the Early Intervention team will sit with the city west CMHT manager and the consultant input will be from the service user's sector consultant.

In year one the city Assertive Outreach Team will reduce to one band 7, 5 Care Coordinators and 4 Support, Time and Recovery (STR). The management of the team will sit with the city east CMHT manager and the consultant input will be from the appropriate city consultant for the service user.

Both, the city Assertive Outreach Team and the Early Intervention Team would be reviewed after one year to look at the further integration of the functions into the CMHT's.

- Each team across adults and older adults will have a care coordinator who takes a lead role supporting carers

- For Adult and Older Adult Services this will be reconfiguring the existing small geographically scattered teams to larger Community Mental Health Teams (CMHT). This will achieve a saving on pay costs of approx £2m.

- The CMHT will have a primary focus on the treatment of organic and functional conditions with patterns of both acute mental health symptoms and more enduring and severe mental illness, including the capacity to intervene early in psychosis and to work with difficult to engage patients.

- There will be dedicated time of 1wte for each of the 4 adult admission wards. There will be 0.5wte dedicated time for each of the 3 older adult admission wards. The Intensive Care Unit will continue to have 0.7wte Consultant time.

- We are aware that there is a PCT development group that is defining what a comprehensive memory service would be composed of. It is anticipated that a request will be made for funding of this new service. The dementia strategy is clear that the diagnostic service for dementia and assessment of challenging behaviour remains a specialist secondary care function. The older adult CMHTs would continue to undertake the functions of memory clinics which will continue to develop in conjunction with the implementation of the Dementia Strategy.

- Crisis Resolution and Home Treatment (CRHT) service will be maintained as at present. The within hours urgent response service will be carried out predominately by the CMHT. During afternoon hours there will be shared working between the CMHT and the CRHT teams. Out of hours the CRHT will provide an urgent response and home treatment based service, with increased home visits throughout the night-time period. We will continue to offer the 7 Day Crisis Day Centre in Oxford and the 5 Day Elms Day Centre in Banbury.

- The proposed model is consistent with Oxfordshire PCT's Stepped Care Pathway, with the Mental Health Community Service concentrating on specialist diagnostics, acute crisis and enduring mental health problems.

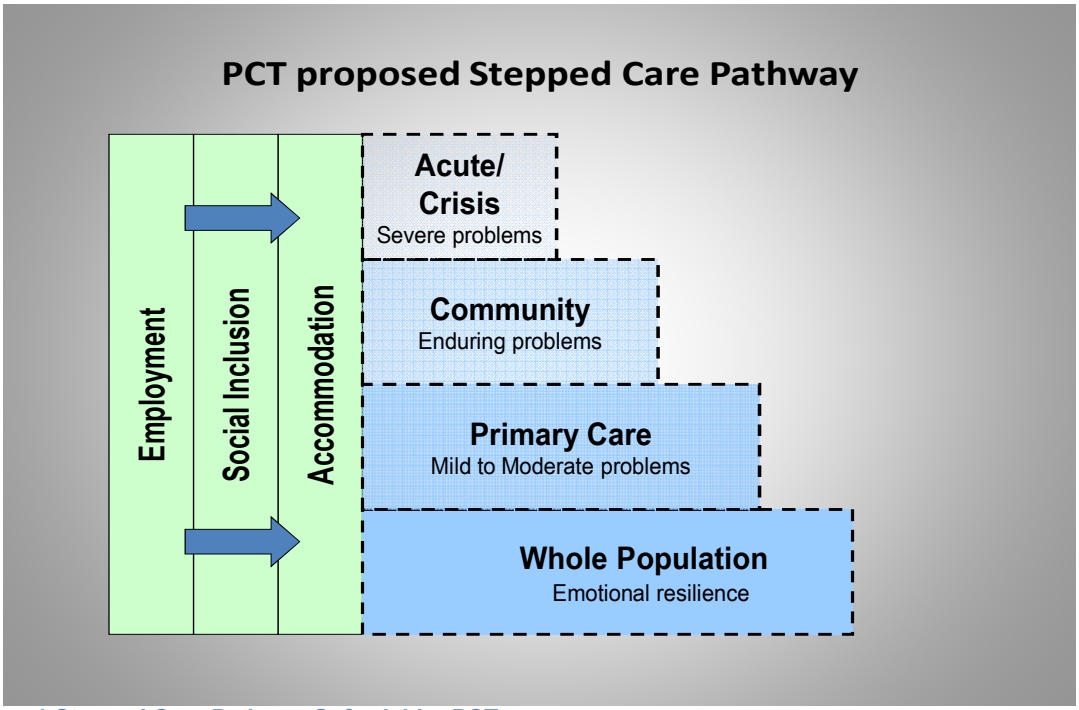

Figure 1 Stepped Care Pathway Oxfordshire PCT

- In terms of reviewing the proposed models effectiveness, we will be examining data re-activity and morbidity which will become available as we continue to collect HoNOS data and relate it to HoNOSPbR

5.4 The Community Mental Health Team Model (CMHT)

The CMHT will maintain the integrity of multi-disciplinary team working and as such will comprise medical, nursing, social work and occupational therapy as core professions. At present there are psychology staff who are managed as part of the specialist adult directorate, but they remain core members of the community teams which they are co-located with.

The CMHT will have a clinical management structure with a Clinical Team Manager and two senior clinical staff from either: Nursing, Social Work or

Occupational Therapy professions. These staff, with the consultant psychiatrists will form the senior clinical leadership group for each CMHT. In addition the Specialist Directorate Senior Psychology staff who are currently based with the CMHT's will be invited to be part of this senior clinical leadership group. Staff will be grouped to maintain links with primary care teams and to ensure that team functioning is optimised.

To enable the CMHT's to function effectively they will require access to clinical space in each of the main market towns across Oxfordshire. The teams will also need good access to clinical information, currently all community staff are using blackberry devices and we are exploring new technologies for mobile working.

5.5 CMHT Core functions

The CMHT will have the core functions of providing specialist mental health care assessment and treatment. The teams will a have clear operational policy which will detail: the thresholds for access to the service, the services offered, the model of care, the roles and responsibilities of team members and how the patient pathway/ journey is expected to be clinically managed. The policy will be developed by the teams and clinicians during the implementation phase of the changes.

The fundamental requirement of the CMHT is to provide individualised care based on diagnosis and patient need. The model of care must support continuity and be clear about the services being offered to the patient.

The larger teams will allow for greater sharing of skills. Having a wider skill mix of staff will allow for tasks to be carried out by those at the appropriate skill level, such as STR workers working on practical tasks with patients.

The CMHT operational policy must include how the team will manage the mental health needs in their patch, be clear about who is responsible for delivery of care and that the team is operating within the best evidence-based practice framework.

5.6 Adult Community Model

The proposal is to create larger teams that meet the functions of the CMHT, AOR and EIS with an initial move to a smaller EIS and AOR.

Across the Adult Services (within Adult and Older Adult Directorate) there are 490 wte staff posts. The proposed model for community services is a reduction of approximately 26wte posts.

Each new Community Mental Health Team (CMHT) will have a Clinical Manager and two Senior Practitioner/ Senior CPN posts. There will also be an increase in unregistered staff to provide more practical support to patients, freeing up qualified staff to undertake therapeutic interventions. All adult CMHT teams will have 3wte Consultant Psychiatrists with 1wte providing the senior medical input for inpatients from the teams catchment area. The operational model for the teams will ensure that key principles of effective patient centred care are delivered.

The proposal is to realign from the existing 17 modular CMHT's (and the countywide Early Intervention team as well as the Assertive Outreach teams) to have 5 locality focused teams (full GP practice figures shown in Appendix 1):

- North (Banbury and Bicester: Adult 18-64 population 104,056)
- City (Oxford West and Kidlington: Adult 18-64 population 72,769)
- City (Oxford East: Adult population 77,440)
- South East (Wallingford, Thame, Henley, Didcot, Wantage and Grove: Adult population 116,914*)
- South West (Abingdon, Witney and Faringdon: Adult population 100,002)
- *Thame data contains all population not only those under Oxfordshire PCT*

5.6.1 CMHT Team Structures Adult County

5.6.1.1 South East Adult

Didcot, Thame and Henley

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12

Band 5	1
Band 4 MHP	0
Band 3 STR	3
A&C Band 6	
A&C Band 5	1.5
A&C Band 4	5

5.6.1.2South West Adult

Witney, Abingdon and Faringdon

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12
Band 5	1
Band 4 MHP	0
Band 3 STR	3
A&C Band 6	
A&C Band 5	1.5
A&C Band 4	5

5.6.1.3North

Adults North

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12 (12 plus 1 Liaison)
Band 5	1
Band 3 STR	3
A&C Band 5	1.5
A&C Band 4	5

5.6.1.4City

City Teams - East and West

Position	Number of Posts (wte)
Consultant	6
Speciality Doctor	2
Team Manager	2
Senior Practitioner/PDL	4
Band 6	22
Band 5	2
Band 3 STR	6
A&C Band 5	1.5
A&C Band 4	10

**Care Co-ordinator is the central function in planning the delivery of service and is a post that is usually filled by a professional from either: Nursing, Social Work or Occupational Therapy. The carers support worker will be a care coordinator with a lead role in carers support.*
***STR Workers will be Band 4 if undertaking MHP training.*

5.6.1.5EIS & AOR Staffing

Position	Early Intervention Team	Assertive Outreach Team
Senior Practitioner/PDL	1	1
Band 6	8	5
Band 5	1	
Band 3 STR		4

5.6.2 Consultant input into the adult wards

The Adult services have five in-patient units, four of which are acute admission (20-21 beds) and one is the psychiatric intensive care unit (PICU) which has 15 beds and serves Oxfordshire, Buckinghamshire and Milton Keynes. Two of the four acute admission units are for male patients and two are for female patients. The city sector bed usage is approximately two of the wards (42 beds), with the rest of the county bed usage being two wards.

The consultant and nursing groups within adults have discussed the options for consultant time on the wards and have agreed the following proposal:

The City Wards (two wards) each will have the equivalent of a whole time consultant made up from two post holders working half-time on each of the two wards. This means each of the city wards will have two consultants working into it.

In the county there are three CMHT's each of which will provide dedicated in-patient consultant cover. This will be met by two consultants in each CMHT providing 3-4 programmed activities (PA's) into a ward. This means each of the county wards will have three consultants working into it.

The PICU has in place a dedicated consultant working 0.7wte in the Ward.

There will be a recorded timetable of consultant time into the wards and a clear expectation of cross-cover being in place to cover any absences. Three months after implementation there will be a review of the effectiveness of these arrangements.

5.6.3 Adult Summary

This proposal delivers some of the required savings. The core function of the CMHT is to provide care, treatment and recovery to patients with significant need and with severe and enduring mental illness, from early intervention in psychosis, severe depression, bipolar conditions, schizophrenia and resistant OCD.

In addition, the proposal includes dedicated consultant time (equivalent to 1 wte per ward) for each of the 4 admission wards.

5.7 Older Adult Community Model

Older Adults will move from the current four locality model to a three locality team model. The proposed model includes:

2.8 wte Consultant Psychiatrists in the South
2.6wte Consultant Psychiatrists in the City
2.4 wte Consultant Psychiatrists in the North

Each area has 0.5wte Consultants (within the stated wte above) per in-patient unit.

There are 235.5wte budgeted posts across the Older Adult part of the Directorate. The proposed model represents a reduction of approximately 11wte staff from those currently in post. There are vacant posts across the Older Adult care group. A detailed breakdown of the existing and proposed posts is shown in Appendix 4. This proposal represents £984k reduction in pay and non-pay.

The structure of each of the proposed Community Mental Health Team (CMHT) locality teams are shown in the following table:

5.7.1 Older Adult Staffing by team

North, City, South

Position	Posts Per Team (wte)
Consultants	2.4 North, 2.6 City, 2.8 South
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12
Band 5	1
Band 4 MHP	
Band 3 STR	3
A&C Band 5	1.5
A&C Band 4	3

**Care Co-ordinator is the central function in planning the delivery of service and is a post that is usually filled by a professional from either: Nursing, Social Work or Occupational Therapy. The carers support worker will be a care coordinator with a lead role in carers support*
***Band 4 if undertaking MHP training*

5.7.2 Consultant input into the older adult wards

The Older Adult consultant and nursing groups have agreed that each of the three wards will have 0.5 wte dedicated consultant input. The expectation is that cross cover will be in place to ensure each ward has cover throughout the year.

5.7.3 Older Adult Summary

This proposal delivers some of the required savings. The AES service will continue to operate countywide and this year will include mental health intermediate care beds. As with the adult CMHT's, the core functions are to provide care, treatment and recovery to patients with severe and enduring mental illness, in the context of presentations of functional or organic conditions. The teams will continue to provide groupwork, inreach to nursing homes and memory clinics. Each of the three in-patient wards will have 0.5wte of dedicated consultant time.

6 Adult and Older Adult: numbers of posts affected

- This represents a net reduction of 47.04wte of community budgeted posts within the Directorate
- This reduces the number of posts across the Directorate, from 725.5wte to 678.46wte

- Vacancies are currently being held in preparation for the proposed changes, with essential cover being provided through the use of NHS Bank staff
- The number of posts being reduced outnumbers the posts vacant, one to ones will provide an opportunity to discuss all options and ensure suitable alternative employment is considered, if appropriate

Risks and Opportunities Impact Assessment

6.1 Risks

RISK	IMPACTS	ACTIONS TO REDUCE RISK
Reduction in Quality of service through staff changes	Patient and carer dissatisfaction with the service. Commissioners dissatisfied and not supporting the new service model.	Patient satisfaction measures to be introduced to review how the new service is being perceived. Also this model is consistent with the approach in the Buckinghamshire arm of OBMH and there are higher levels of patient satisfaction with services there and no increase in patient non attendance rates for their centralised clinic model.
Delay in approval leading to delay in implementation	Financial savings target not met. Staff feeling unsettled and uncertain of their future.	Vacancies being held to offset delays. Staff made aware of the direction of service change through regular directorate away days.
Potential negative impact on staff from them perceiving an increase in their workload	Poorer staff retention and reduction in staff satisfaction with their role.	Increase in productivity to be realised through better use of central clinic model reducing time spent on travelling. Work with commissioners to agree a better quality currency based on clinical outcomes rather than numbers of patients seen – this should be realised through HoNOSPbR patient clustering.
Reorganisation leads to reduction in service capacity due to expected productivity	Poorer service response, patients waiting for care. Referrers dissatisfied with the service.	Staff will be engaged in delivering the changes to ensure that they assist in minimising any reduction in capacity. Productivity gain is set at a realistic

gains not being met, to compensate for the reduction in personnel	Commissioners dissatisfied with the service.	level of increasing contacts to 4.5 per wte per day over a 41 week year.
Unable to release savings in premises due to lease terms or suitable alternative clinical space	Risk of up to £1m of the savings to be achieved.	Proposal assumes that these savings can be realised with CHO over a three year period to ensure delivery.
Central Management Savings not realised	£250k identified for savings, posts already identified and savings ready to be delivered.	Posts already identified and it is likely more than £250k will be achieved.
Stakeholder disquiet about changes in thresholds for access to services	Primary care and services such as IAPT will be expected to treat more cases rather than routinely refer to specialist secondary care. Patients are likely to be discharged more quickly from secondary care services.	Clear criteria for access to services published. Service specifications agreed with commissioners.

6.2 SWOT Analysis

Strengths	Weaknesses
Larger teams are more robust. Better cross cover from having larger teams Centralised clinics allow more patients to be seen than seeing everyone at home with the additional travelling time for clinicians from d.v.'s. The CMHT structure allows for greater contribution from all professional groups into the clinical management of the team. Model is already tested as to its effectiveness in that it mirrors the approach in OBMH A&OA Buckinghamshire services.	Teams that are too large may be difficult to manage. Patients will be expected to travel to appointments when they are able to do so. Possible reduction in the quality of service with less clinical resource available. Complexity of the community bases in terms of leases, ownership and suitable replacements may delay some of the implementation of this element of change. There may be some issues with having access to good clinic space in all areas of the county.
Opportunities	**Threats**
More support for multidisciplinary working within larger CMHT's. Changes mean that teams will have to review the thresholds for access to the teams which gives the opportunity to agree common criteria for access across the teams than is currently the case.	Decreased patient satisfaction leading to poorer patient survey returns and possible patient withdrawal from care.

To increase the productivity of community staff. To work with colleagues in CHO to realise more shared working and operating out of each others community bases.	

7 Summary

The Adult and Older Adult Community Services will be delivered from fewer, larger CMHT's. The CMHT's will form the core element of the specialist mental health care pathway. To work effectively the CMHT's will work across the community and acute care pathway, including provision of specialist support and advice to the integrated CHO/OBMH teams (figure 2 below).

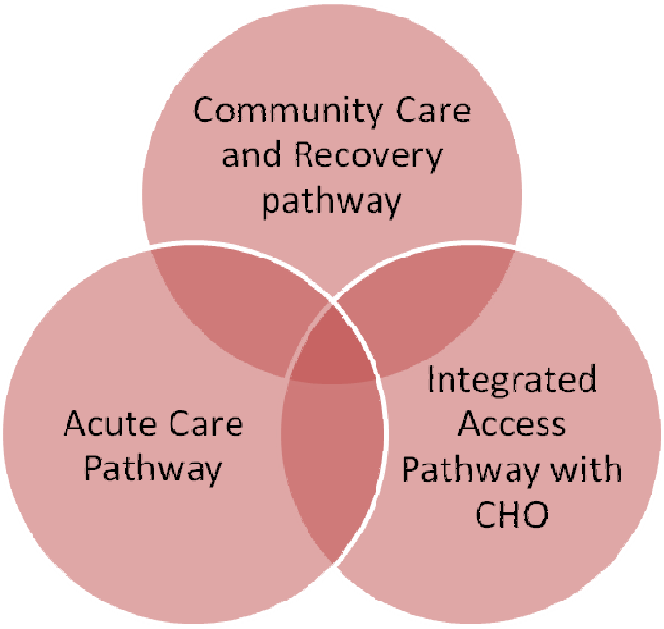

Figure 2 Integrated Pathways

Our services will work more closely with Community Health partners. Bed management will use the Acute and Older Adults Care Pathways model of practice which will afford better bed gate-keeping.
Care inputs and outputs will be based on Patient Clusters and patient and carers will contribute to assessing the effectiveness of services will better developed clinical outcome measures.

Update to Health Overview and Scrutiny Committee
3rd July 2012

1. Introduction

This paper has been written to give an update of the changes made to Community Mental Health Teams in January 2011 and the impacts this had had for Oxford Health NHS Foundation Trust, for service users and their carers and for the staff who work in the teams

2. Background

From the original consultation document, September 2010, the objective of the Community Mental Health Service is to delivery high quality patient centred mental health care to the adult population of Oxfordshire.

The original model in 2010 was provided by small single consultant teams which were vulnerable to reductions in service due to sickness, vacancies and also less responsive to high levels of referral. The new service proposal allowed for the development of larger Community Mental Health Team's maintaining clear leadership and accountability. This also allowed for more effective cross-cover and the development of wider skill sets across each of the teams.

3. Progress to date

Across Oxfordshire there are now 5 Adult CMHTs (previously 11 small teams) and 3 Older Adult CMHTs (previously 9 teams). All of the new CMHTs have a clear skill mix with a multidisciplinary team that includes consultants, other medical staff, community psychiatric nurses, social workers, occupational therapists and support workers.

Outcome for Service Users and carers

Although, initially, there was some changes in care team for some service users and their carers as the localities moved to larger teams, this was kept to a minimum by ensuring that one professional member of the service users' care team would remain in place during the changes.

The main geographical area where this was an issue was Wantage and Grove. The Wantage and Grove service users moved from a team in the South West to a team in the South East. A staff grade doctor was used to support the handover of service users and to ensure this was a smooth transition from one team to another. All changes were undertaken through the care programme approach with service users having care plans and risk assessments in place and a review of their care prior to transfer.

All service users and carers are now with the appropriate team and appropriate levels of service are now being provided.

Outcome for Staff

The smaller teams have now developed into larger Community Mental Health Teams although for some teams the issue of co-location remains a challenge.

Consultants are working towards inpatient ward provision, with the North and City Teams providing one consultant to work on the wards from the CMHT, the other teams are working towards this.

Hot desking has worked in some teams but others are finding it difficult. Team managers are looking at the issues in the teams and finding solutions to ensure staff are able to work well.

4. Metrics

Before the service changes there were between 6,000 – 7,000 cases open to the Adult and Older Adult Mental Health services. Since the change the caseload remains over 6,000 therefore there has not been a significant change. There were a number of service users on caseloads who had not had any contact with Mental Health services for 6 months and longer. These service users were seen and reviewed, and if appropriate discharged back to the GP.

Contact activity up to August 2010 was approx. 23,000 face to face contacts a year and the contact level this year has increased slightly to approx. 24,000.

Overall we reduced the Community staffing by 49 members of staff; mainly administration and management. We developed larger community mental health teams and encouraged the use of, both, seeing service users at home as well as a clinic model of outpatients. The utilisation of clinics means that the amount of time lost to travel is minimised and more time is being spent in providing interventions to service users.

5. Next Steps

To undertake a review of the Early Intervention Service and Assertive Outreach Service to analyse the impact of the changes on these services

To develop further the role of inpatient consultants and leadership on the wards

To undertake the 12Q survey to gain feedback from staff re satisfaction

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Health Scrutiny Committee

Report on Early Intervention Service and Interfaces with Health

Background

1. This paper has been prepared for the Health Scrutiny Committee so as to provide members with a brief introduction to the work of the redesigned early intervention service and to draw particular attention to the health-based aspects of the service.

2. Oxfordshire County Council (OCC) and partner agencies want all children and young people to have the best start in life and receive the on going support that they and their families need to fulfil their potential.

3. Services for all children and young people (such as schools, colleges early years settings, primary care, health visiting) have a key role in promoting well being and preventing problems. For the majority of children and young people high quality universal services will enable them to achieve good outcomes and reach their full potential.

4. However from time to time some children will become “vulnerable”. They may have difficulty making a transition from primary to secondary school, their development may be delayed, they may break the law or have emotional difficulties. Others are vulnerable because of their own development, family circumstances or environmental factors.

Issues

5. The vision in Oxfordshire was to change the way services are delivered across all agencies so that universal targeted and specialist services can work in a more integrated way to identify and work with vulnerable children and their families at an earlier stage and provide services in a way that children young people and families have said will make a difference to them.

6. The proposals included the integration and redesign of existing services to offer one early intervention and prevention service, that is capable of working locally with vulnerable children young people and families with additional or complex needs.

7. All partner agencies were actively involved in the shaping of the new service through the Early Intervention Steering Group. This group had and continues to have strategic responsibility for driving the implementation of the Early Intervention Service forward and will form the governance partnership responsible for the oversight of the new service reporting to the Children’s Trust and local Safeguarding Board as well as to the Health and Wellbeing Board.

8. Health partners were and continue to be actively involved in the design and implementation of the service. There was senior representation from Public Health, Health Commissioning and Oxford Health NHS Foundation Trust at strategic level through their representation on Early Intervention steering group. At operational level Health and County Council managers and practitioners are working together to ensure that service delivery for children young people and their families across Health and the Early Intervention Service is as seamless and integrated as possible.

9. The Early Intervention Service "went live" on 1 September 2011. The service operates from the 44 Childrens Centres and from seven Early Intervention hub sites. There are three Early Intervention managers North, Central and South responsible for strategic delivery of the service and each hub is managed by an Early Intervention hub manager.

10. The service is targeted at vulnerable children young people and families with additional and or complex needs which cannot be met by existing resources in the locality.

11. The range of services and interventions that the Early Intervention Service can deliver with partner agencies for vulnerable children, young people and their families includes:

    Support to professionals

    - Consultation and advice to professionals children young people and families through a dedicated helpline and drop in sessions
    - Contributing to and supporting integrated working processes through the provision of advice training and support to undertake Common Assessment Framework and utilise Team Around the Child / family processes
    - Support to lead professionals through provision of advice and training
    - To assist in work with other professionals and community groups to ensure that plans and interventions are complementary and families and children access appropriate services

    Support to children young people and families

    Diverse and flexible support to children young people and families covering wide- ranging issues which can impact upon family life. This may include:

    - Direct work with children, young people and their families in their home and/or alternative community setting using evidence based interventions e.g. solution focused cognitive behavioural Webster Stratton approaches
    - Group work

- Open access and targeted sessions in both the hubs and the satellites for young people to respond to the needs of the area
- Community outreach work which responds to the needs of the area
- Acting as lead professional where appropriate for some children, young people and their families
- Delivery in conjunction with children centres and partners of evidence based parenting programmes
- Diversion activities and assessments to prevent young people entering the youth justice system
- Restorative practice which focuses on the needs of victims and offenders offering support to the victims of crime and encouraging offenders to take responsibilities for their actions.
- Provision of professional counselling
- Provision of mentoring and coaching
- Access to employment, education and training opportunities

12. This range of evidenced based early interventions will help to improve outcomes in relation to:

    - Persistent absence
    - Exclusions from school
    - Number of young people not in employment, education or training
    - Numbers of young people offending including first time entrants to the criminal justice system
    - Teenage pregnancy rates
    - Levels of children and young people admitted to hospital for non-accidental injuries including self-harm
    - Improving foundation stage profile results for vulnerable and disadvantaged groups
    - Inappropriate caring responsibilities
    - Improving attendance and attainment of children looked after

13. There are seven Early Intervention delivery themes that have been identified to ensure clear responsibility for strategy, performance and delivery in relation to these key areas of work. Each Hub Service Manager together with an Early Intervention Manager has a lead responsibility for one of the delivery themes

    - Early years development and parenting
    - Health & Well being
    - Engagement in education, employment and training
    - Youth and youth justice and anti-social behaviour
    - Community development
    - Workforce development
    - Integrated processes

14. The role of the hub manager and EIS manager is to ensure the strategic direction of this area of work across the Early Intervention Service by

- Taking a lead on the relevant Key Performance Indicators for the directorate in relation to the delivery theme
- Ensuring delivery of the key theme is co-ordinated consistently across the county, to a high quality and responsive to local need

15. Themes included within Health and Well being delivery are:

    - Anti bullying
    - Substance misuse
    - Sexual health/teenage pregnancy
    - Disabilities
    - Mental health

16. To support the monitoring of performance around these issues a set of Early Intervention performance indicators are in place whereby regular reporting of the indicators helps Early Intervention staff and partners, agree, review and plan future service delivery and direction in a meaningful way.

17. The service has been operational since September 2011. There is on-going support and joint work with Health colleagues and much has been achieved in a short time span which builds on the good partnership working that was already in place including good partnership practice between Childrens Centres and Health. This is helping to ensure that Health and Early Intervention services are working well together to achieve better outcomes for children.

18. Care pathways have been agreed for children young people and their families so that where Health or Early Intervention staff identify needs for children/ families to access services from Health or Early Intervention this can be done seamlessly.

19. It is obviously early days and now that the service is up and running there is still work to do to strengthen and modify these pathways in the light of practice. To take this forward a day is being organised in March 2012 for Health and Children Young People and Family practitioners to test these pathways identify where there is good practice learn from this and modify and change as necessary.

20. A draft action plan has been drawn up around the themes within the health and well being delivery strand (described above). This plan identifies where there is good practice but also where there are issues that need to be addressed and an action plan to address these issues.

21. The implementation of the new service has also led to some new and innovative work across Health and Early Intervention Service. An example includes a nurse practitioner employed within the Early Intervention Service.

22. The service is responsible for diverting young people away from the criminal justice system. Many of these young people do have mental health needs

which in the past have not always been identified at an early stage which has sometimes meant that young people's mental health issues have not been addressed as part of an integrated support plan to help then young person.

23. Together with Health colleagues a successful bid was made for diversion pathfinder funding. Through this funding the service is now able to employ a mental health nurse whose role is to screen young people who are being diverted for Mental Health issues and do appropriate checks to see what services have already been involved. The nurse can also access and broker services for Diversion clients as required and work directly with young people.

Conclusion

24. As stated it is very early days for this new service. There is however a strong commitment across all agencies in Oxfordshire to ensure that we are providing more holistic integrated support for families. Health Services and the County Council are committed to building on the good work that is in place and continuing to work together at strategic and operational level to ensure that we are jointly delivering services that will improve outcomes for children young people and families. This will be monitored through performance management frameworks and goverance arrangements ensuring that where there are challenges, gaps in service delivery mechanisms are in place to address these issues.

Maria Godfrey

Early Intervention Manager (North)

January 2012

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Oxfordshire Clinical Commissioning Group

NHS

Quality, Innovation, Productivity and Prevention within the NHS in Oxfordshire

1. Background

Overall NHS spending will increase by 0.4% in real terms to 2015. However, the government are also seeking £20bn in efficiency and productivity savings by 2014. Despite a 2.8% increase in funding for the NHS in Oxfordshire for 2012-13, there are more financial pressures than ever because:

- the population of Oxfordshire is growing, and more people are living on into old age;
- advances in technology mean that new (and generally more costly) medicines and treatments are becoming available all the time;
- patients and the public have higher expectations of care and treatment by the NHS;
- the costs of items such as medicines, food and petrol are increasing – inflation impacts on hospitals and other health care providers, as it does on all of us.

The impact of the above factors is that the NHS in Oxfordshire has to find efficiency savings of £100m over the next three years in order to continue to provide the current level of health services an enable investment in our key priorities.

2. Quality, Innovation, Productivity and Prevention

This difficult financial situation affects health care services across England, not just Oxfordshire, and the Department of Health has initiated a programme of work called *Quality, Innovation, Productivity and Prevention* (QIPP). This approach looks at how the NHS can protect and promote quality while releasing savings across health systems. It is the responsibility of all NHS health care providers in Oxfordshire to help deliver the local QIPP plan and NHS organisations across the county are already working together to respond to this challenge.

The Oxfordshire QIPP plan proposes changes to health care services that will provide high quality services to meet the health needs of residents, and that can be delivered within available resources. The QIPP plan drives the Oxfordshire Clinical Commissioning Group's (OCCG) 2012/13 Operational Plan. It also incorporates NHS Hospital Trusts' 'cost improvement' plans.

The NHS in Oxfordshire is one of the lowest funded in the country, receiving approximately £1,300 per person per year from the Department of Health. Our population is comparatively healthy but our forward plans require that we take account of the following key factors:

a. The population of Oxfordshire is getting older – 100% increase in over 85s by 2029; 43% increase in over 65s by 2029,
b. Health inequalities exist – whilst the county is affluent there are pockets of long standing deprivation. 1 in 4 children in Oxford live in poverty with a 15 year life expectancy gap in best and worst wards within the county,
c. There is a growing number of people with long term conditions – 1 in 4 people experience poor mental health; 1 in 7 people have a long term condition and this is rising due to lifestyle factors and obesity.

3. Programme Vision

The QIPP plan has been developed to deliver the vision of improving the health and well-being of people in Oxfordshire by providing the best possible health services within the resources available. Collectively the NHS will do this by:

- Helping people to manage their own health through health promotion and ill-health prevention initiatives.
- Integrating health and social care teams in the community to ensure patients can access the right treatment when they need it.
- Reviewing the delivery of hospital care, and moving services to the community where it is clinically appropriate.
- Reviewing the provision of services that are shown to be less clinically ineffective and provide insufficient health benefits, and those that do not represent good value for money.

To deliver QIPP, the OCCG is working with other NHS Trusts, Oxfordshire County Council and voluntary organisations in Oxfordshire on a range of projects including:

- The Appropriate Care for Everyone (ACE) Programme to tackle the issue of delayed transfers of care and ensure older people are receiving the right care, at the right time and in the right place.
- Improved access to expert patient programmes for people with long term conditions so they can better manage their condition.
- Referral management within planned care for example the on-going implementation of a Musculoskeletal (MSK) Triage system which is for routine referrals for musculoskeletal problems. All referrals go through a consistent clinical triage system whereby they are assessed by a clinician; they are then either returned to the GP with advice on how to treat the patient in primary care for example their GP could be advised to administer joint injections as first line treatment; or they are referred onto a tier 2 triage which is a face to face appointment with a clinician who will look at the patient's problem and decide the diagnosis and treatment path or they are referred directly into secondary care to the provider of the patients choice.
- The introduction of an Emergency Multidisciplinary Diagnosis and Triage Unit (EMDTU) operating Monday to Friday 08.00-18.00 based in Abingdon Community Hospital. The EMDTU gives urgent care patients access to speedy investigations and diagnosis in the community. Patients would be referred via their GP, the ambulance services, emergency departments and community health care professionals. The EMDTU would make the clinical decision whether patients referred to them for urgent care needed to go into an acute or community hospital or if they could have their care at home.

4. Working with clinicians, patients, carers and the public

The NHS is involving staff, GPs, clinicians and healthcare professionals to ensure decisions about which services to continue to provide and which to replace are based on evidence of clinical and cost effectiveness, local priorities and health care needs, and value for money. The OCCG is already working with local people to get feedback on proposed changes to services.

As well as setting up a number of QIPP projects, the OCCG is also reviewing the funding of treatments that previously have been provided as a matter of routine and ensuring that doctors and health care professionals are adhering to best evidence and criteria for use of treatments and services. These reviews are essential if we are to maintain high quality, local and sustainable NHS health services for the future.

A recent example of this is the change in criteria for people to access non emergency patient transport. This service was being used by a wide range of patients many of whom could travel by bus or car. The patient transport service costs the NHS in Oxfordshire over £3 million a year and in the last financial year we spent £350,000 of this on patients who were able to use ‘walk on’ transport. That is patients who could travel by car and need no assistance in getting in and out of a

vehicle. It was estimated that we could save as much as £200,000 by tightening up on who could use this service. The NHS worked with staff and members of the public including those using non-emergency transport to seek feedback on the proposed changes to criteria. There was general consensus in favour of the proposed changes.

Another example of this work is the review of the provision of NHS prescriptions for gluten-free foods. In Oxfordshire we spend £350,000 each year on prescriptions for gluten-free foods for people with coeliac disease. Twenty or thirty years ago, only a small range of 'gluten-free' foods were available and these were relatively expensive. To enable people to manage their disease, GPs were able to provide gluten-free foods on prescription. However, in recent years there have been considerable improvements in the types of foods available in shops and supermarkets. Nowadays there is a wide range of gluten-free foods in supermarkets, eg, gluten-free pasta, pizza bases, cakes and breads; there is a good choice of various makes of gluten-free food; the cost of gluten-free foods is not as high as it used to be; non-wheat, barley or rye based foods that provide carbohydrates are readily available, eg, potatoes and rice.

It has also been argued that the NHS does not provide food on prescription for other groups of patients whose diseases are associated with, or affected by, the type of food they eat.

For these reasons, we are considering whether or not the local NHS should continue to provide NHS prescriptions for gluten-free foods. We are seeking the views of local people - adults and parents/carers of children who have coeliac disease; patient support groups; doctors, dieticians and specialists - to find out what the impact might be if NHS prescriptions for gluten-free food were no longer funded. All the findings will be considered before a final decision is made.

5. Summary

Society is changing so health and social care systems need to change to respond to rising demand from an increasing older population, patient expectations and advances in technology and medicines. The challenge is to maintain and improve the quality of care for all patients within the finite resources we have available. NHS organisations and social care in Oxfordshire are already working together to respond to this challenge by improving productivity within the NHS locally, so doing the same but more efficiently and using staff to maximum effect and working collectively with the public to change the way that healthcare is delivered.

The QIPP plan for Oxfordshire will be approved by OCCG and the NHS Buckinghamshire & Oxfordshire Cluster at the end of March 2012.

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Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting 19th January 2012

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

LINk Core Group – meeting in public

The December quarterly meeting of the Core Group, which took place in Didcot, had 21 attendees, mostly from South Oxfordshire. Main topics under discussion were: the transition to HealthWatch and new Commissioning structures in relation to public engagement; OCC consultation on the procurement of HealthWatch; Personal Budgets; Enter and View visits to Care Homes; new partnership and project work with the LINk (see below) and the two forthcoming 'Hearsay' service user and carer events.
All members are welcome to attend the next Core Group meeting in public, which will take place in North Oxfordshire (venue tba) on **15th March from 6.30pm – 9.00pm.**

Ongoing Health projects and engagement:

A Mental Health 'Hearsay' event is taking place on 12th January 2012. This is a replacement for the regular Mental Health 'Sounding Board', which has been a feature of SCS engagement over the last 2 years. In order for recommendations and comments from service users and carers, obtained through recent Sounding Boards, to have a more consistent and robust means of follow up with service providers and commissioners, it was proposed that the Hearsay model be incorporated into the existing engagement structure. Concerns and issues which have arisen from comments collected by the LINk before and during the event will be considered in partnership with Directors and Service Leads from Oxford Health, Oxfordshire PCT, Clinical Commissioning Group and Social Care. Topics have been developed in the planning round with a final report being taken forward in the form of an action plan agreed with Oxford Health and Commissioners, with a timeline of updates against progress to be agreed. *A verbal report from the event will be provided for members.*

GP Patient Practice Groups and public engagement
LINk is planning an approach, to selected GP Practices, in order to gather information about their own strategies for patient & public engagement and to offer a means of developing this in partnership, supported by the LINk and its network. A pilot proposal is currently being discussed with a Practice.

Other projects

'Enter and View' visits to Care Homes

A new information and training session took place on 9th December for 'Enter and View' participants in order to provide statutory authorisation for newly recruited visitors and an opportunity to review the process for those who carried out visits last year. A second series of visits to Care Homes, selected by provider, size and geography, will take place from the end of January 2012 onwards, followed by a second report. The emphasis will be on quality standards of reporting and sharing recommendations with the Care Home providers together with Social and Community Services.

New project proposals, supplied to the LINk Priorities and Finance Groups, have been accepted from Oxfordshire Wheel, to partner a large service user and carer-led event about Self-Directed Support being planned for 1st March 2012. The main aims and objectives of the event are: to share service user and carer experiences of SDS; to provide a showcase for related organisations to promote what they do; provide a promotion opportunity for HealthWatch; gather feedback with regards to the effectiveness of SDS so far and what would improve it in the future.

A proposal from Oxfordshire Family Support Network has been approved to continue the LINk-funded work begun last year in developing further understanding of the needs of older carers who care for family members who have learning disabilities and to investigate the best way to deliver an older carer support service.

Further applications for project work have been received from Omega (ME Support Group) and OxSun (Mental Health Service User Network) and will be considered for support shortly.

HealthWatch
Members will be aware that the Dept of Health has postponed the introduction of Local HealthWatch until April 2013. Lisa Gregory, Taking Part Team Manger, will attend to provide an update from the OCC consultation, which concluded in December and proposals for the next steps in the light of the delayed implementation.

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Update 09/01/2012