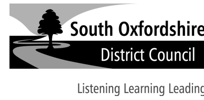
Notice of Meeting Public Document Pack



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 5 September 2013 at 10.00 am
County Hall

Membership

Chairman - Councillor Lawrie Stratford
Deputy Chairman - District Councillor Alison Thomson

Councillors:	Kevin Bulmer	Mark Lygo	Alison Rooke
	Pete Handley	Laura Price	Les Sibley
District Councillors:	Martin Barrett	Susanna Pressel	
	Christopher Hood	Rose Stratford	
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *5 December 2013*

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 Lawrie Stratford
E.Mail: lawrie.stratford@oxfordshire.gov.uk

Policy & Performance Officer - *Claire Phillips Tel: (01865) 323967*
claire.phillips@oxfordshire.gov.uk

Committee Officer - *Julie Dean Tel: (01865) 815322*
julie.dean@oxfordshire.gov.uk

Peter G. Clark
County Solicitor

August 2013

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 4 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.

recycled paper

AGENDA

1. **Apologies for Absence and Temporary Appointments**

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

3. **Minutes** (Pages 1 - 8)

   To approve the minutes of the meeting held on 13 June 2013 (**JHO3**) and to receive information arising from them.

4. **Speaking to or Petitioning the Committee**

5. **Healthwatch Oxfordshire** (Pages 9 - 10)

   10:15

   The Director of Healthwatch, Rosalind Pearce, will update the Committee on the progress of the establishment of Healthwatch and Sara Livadeas, Deputy Director, Joint Commissioning, OCC, will set out the future plans for Healthwatch. A progress report is attached at **JHO5.**

6. **Clinical Commissioning - Update** (Pages 11 - 14)

   10:30

   Dr Mary Keenan, Medical Director, OCCG, will present the regular progress report from the Oxfordshire Clinical Commissioning Group. A progress report is attached at **JHO6.**

7. **Falls in Oxfordshire** (Pages 15 - 24)

   10:45

   Fenella Trevillion, Head of Integrated Commissioning, OCCG; Sylvie Thorn, Senior Commissioning Manager, Older people, OCCG; and Suzanne Jones, Head of Countywide Services, Oxford Health will set out the strategy for falls prevention in Oxfordshire and will explain current performance. A report is attached at **JHO7**.

recycled paper

8. How the NHS in Oxfordshire is responding to the Francis Report and Sir Bruce Keogh's review (Pages 25 - 50)

11:05

Dr Richard Green, Director of Clinical Quality, OCCG; Ros Alstead, Director of Nursing & Clinical Standards, Oxford Health; and Professor Edward Baker, Medical Director, Oxford University Hospitals NHS Trust will inform the Committee about how they are responding to recommendations made in the Francis Report and in the recent publication of Sir Bruce Keogh's review. Responses from the Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust and Oxford Health FT are attached at **JHO8.**

9. Public Health - Update

11:55

The Director of Public Health for Oxfordshire, Dr Jonathan McWilliam will provide the Committee with his regular report on matters of relevance and interest and will give a specific update on matters discussed at the Oxfordshire Health & Wellbeing Board which held its inaugural meeting as a statutory body on 25 July 2013.

10. Director of Public Health (DPH) Annual Report and to canvass views in advance of the next DPH Annual Report' (Pages 51 - 98)

12:10

The Director of Public Health will present his Annual Report for 2012/13 and will canvass Members for their early views on issues of concern to the Committee which may be included in the next report. His report is attached at **JHO10.**

11. Chairman's Report and Forward Plan (Pages 99 - 100)

12:30

The Chairman will give a verbal update on meetings attended since the last formal meeting of the Committee. There will also be an opportunity for members to discuss the Forward Plan. A proposed Forward Plan is attached (**JHO11**).

12. Close of Meeting

12:45

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

recycled paper

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 13 June 2013 commencing at 10.00 am and finishing at 13.35 pm

Present:

Voting Members:

Councillor Kevin Bulmer
Councillor Pete Handley
Councillor Mark Lygo
Councillor Laura Price
Councillor Alison Rooke
Councillor Les Sibley
Councillor Lawrie Stratford
District Councillor Martin Barrett
District Councillor Dr Christopher Hood
District Councillor Susanna Pressel
District Councillor Rose Stratford
District Councillor Alison Thomson

Co-opted Members: Dr Keith Ruddle and Mrs Anne Wilkinson

Officers:

Whole of meeting: Claire Phillips (Chief Executive's Office)

Part of meeting: Sue Whitehead and Julie Dean (Chief Executive's Office)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with an additional document entitled 'Review of the Midwifery Led Unit in Chipping Norton 2008 – 2012 – Update for HOSC meeting' and agreed as set out below. Copies of the agenda, reports and additional documents are attached to the signed Minutes.

100/13 ELECTION OF CHAIRMAN FOR THE 2013/14 COUNCIL YEAR
(Agenda No. 1)

Councillor Lawrie Stratford was elected Chairman for the 2013/14 Council Year

101/13 ELECTION OF THE DEPUTY CHAIRMAN FOR THE 2013/14 COUNCIL YEAR
(Agenda No. 2)

District Councillor Alison Thomson (Vale of White Horse District Council) was elected Deputy Chairman for the 2013/14 Council Year.

102/13 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

An apology was received from Dr Harry Dickinson.

103/13 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Councillor Alison Thomson declared an interest in Agenda Item 13 - Chairman's Report and Forward Plan on account of her being a Trustee of Vale House care Home, Botley.

104/13 MINUTES
(Agenda No. 5)

The Minutes of the last meeting on 25 April 2013 were approved and signed subject to the second sentence of the final paragraph in Minute 92/13 being amended to read as follows (amendment in bold italics):

'Jonathan McWilliam agreed with the Committee that data around ethnicity was very valuable ***and noted that Members felt it was sadly lacking.'***

There were no Matters Arising.

105/13 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 6)

There were no petitions submitted or requests to speak agreed. The Chairman referred to a request to speak that he had received from Unison Health. Although he was unable to agree the request he invited them to contact Members directly and undertook that if they wished to write to him he would ensure that the issues were dealt with appropriately and this could include an item on a future Joint Health Overview & Scrutiny Committee agenda, if after further consideration of the issues it was considered appropriate.

106/13 DIRECTOR OF PUBLIC HEALTH UPDATE
(Agenda No. 7)

The Director of Public Health was unable to attend the meeting due to sickness and the Deputy Director of Public Health, Jackie Wilderspin, attended in his place.

It was noted that the Director of Public Health's Annual Report was going to OCC Cabinet that month. Members asked that the report be circulated and scheduled for the next meeting and that in future years they comment on the report in advance of it going to Cabinet.

107/13 HEALTH AND WELLBEING STRATEGY

(Agenda No. 8)

Oxfordshire's Joint Health & Wellbeing Strategy had been adopted by the Shadow Health & Wellbeing Board in July 2012 following extensive consultation. The Health & Wellbeing Board had considered the latest information on the health of the population, as set out in the Joint Strategic Needs Assessment. The needs identified in a report to the Board in March 2013 had confirmed that the current priorities set out in the Strategy were still relevant.

Since then the Partnership Boards (ie. the Children & Young People's Board, the Adult Health & Social Care Board and the Health Improvement Board) had considered the progress that had been made in delivering the outcomes set out in the Strategy; identified unmet need on this issue within Oxfordshire and made some recommendations on the outcomes that should be set for the year ahead.

It was now proposed that new outcomes should be set for 2013 – 14 and were the subject of consultation prior to discussion and decision at the Health & Wellbeing Board meeting on 25 July 2013. These were set out in the report (JHO8) for consideration and comment at this meeting.

The Committee commented as follow:

- It would be helpful for the national targets to be indicated in the report – and some local ones could be more ambitious, for example, target 1:1 'High % of women who have seen a midwife or a maternity health care professional by 13 weeks of pregnancy' (currently 85%);

- Some of the wording is rather vague – for example, why not state a precise figure in 1:1 rather than the word 'high'?

- Some strengthening of statements in the text by means of an accompanying explanation is required , for example, why are persistent absence rates in primary schools lower than the national average but in secondary schools higher than the national average? (priority 2) and what is meant by the term 'not known' (priority 4).

- Clarification on the reasons why there is no target for young people who go missing from care would be helpful (Priority 3)

- Some of the outcomes are too modest, for example, target 4:5 'Increase the proportion of pupils attending good or outstanding primary schools from 59% to 70% and the proportion attending good or outstanding secondary schools to 75% (currently 67% primary and 74% secondary). In contrast, some are very ambitious and overly prescriptive with regard to stated numbers, such as proposed outcome 6:3 'No more than 400 older people per year to be permanently admitted to a care home from October 2012 (currently 546);

- The Committee expressed concern that the current measures for people with a severe mental illness receiving a health check are not part of national outcome

frameworks and have been difficult to measure, and do not necessarily provide the best indicators of improved outcomes; feeling that this was a major priority (Priority 5)

- They also expressed their disappointment that the ambitious target of halting the rise in childhood obesity was not met, though the Oxfordshire rate is still lower that the national rate Priority 9);

It was **AGREED** to thank the Deputy Director of Public Health for her attendance and to ensure that the Committee's comments are included within the consultation report for submission to the Oxfordshire Health & Wellbeing Board on 25 July 2013.

108/13 CLINICAL COMMISSIONING UPDATE

(Agenda No. 9)

Catherine Mountford, Associate Director of Strategy and Governance, OCCG, presented the regular progress report of the Oxfordshire Clinical Commissioning Group (OCCG). She highlighted three issues emanating from the second Governing Body meeting held on 30 May:

- The first medium term financial plan for OCCG 2013/14 – 2015/16
- The Older People's Pool and Strategy
- OCCG response to the Francis Report

The OCCG budgets were identified as broadly £600m total with £263m contracts with the Oxford University Hospitals Trust. The OCCG would be working on a 0.5% contingency and 0.5% surplus in this first year of operation which was not compliant with NHS guidance but has been agreed with NHS England.

With regard to the Older People's Pool, Catherine Mountford reported that a proposal to increase the current budget, which amounted to £30m, by 59% to include Community Services, would be considered by the OCC Cabinet on 18 June 2013.

The Committee **AGREED** to receive the update and to thank Catherine Mountford for her attendance.

109/13 PERFORMANCE OF THE 111 NUMBER

(Agenda No. 10)

At the July 2012 meeting preliminary discussion had taken place, prior to roll out, on the incoming 111 service. At that time the Oxfordshire Clinical Commissioning Group (OCCG) had noted that the key measure of success would be calls dealt with correctly the first time and also the numbers of callers diverted from South Central Ambulance NHS Trust (SCAS) emergency calls. One year on, the Committee had requested a report on how this had progressed in Oxfordshire, in light of adverse national coverage on the performance of the 111 number since its launch.

The 111 number had a soft launch in Oxfordshire in September 2012 before the national roll-out. The aim of the service was to provide a single point of access to the

public for NHS services where callers can talk to a non-medically trained call handler who would use a specifically developed tool to manage issues.

Committee welcomed representatives from the constituent organisations involved in delivering the service. These were Catherine Mountford, Christine Hewitt and Kate Holburn (OCCG); Peter McGrain (Oxford Health) and John Nicholls (South Central Ambulance Service. Members also had before them a progress report (JHO10) which included a survey prepared by the OCCG. The representatives stressed that this was an expanding service from new, which was growing out of partnership and out of a continuing understanding of what was required, in terms of improving quality of experience.

Questioning from Members of the Committee and responses received, centred around the following issues:

- The numbers transferring from 111 to the Ambulance Service. Response – the pass rate was good;
- Opinion taken from anecdotal evidence that people had generally lost confidence in the service nationally and had found a difficulty in finding an avenue to complain. Response – Options were currently being considered. In the event that there was a need to retender, care would be taken to have one which suits Oxfordshire best. The current Oxfordshire specification went beyond the national specification in that it included, for example, the Out of Hours Service. This added both time and cost to the service provided. The Oxfordshire providers were disappointed that the national media had not been reflective of the service provided locally, as it had received a considerable amount of accolades, not least because it was a partnership venture;
- Training given to call advisers. Response – nationally accredited training was undertaken though they were not clinically trained. However, there were qualified nurse clinicians present in the room;
- Has there been an increase in patients going to Accident & Emergency due to a lack of confidence in the 111 number? It is difficult to understand why more patients were coming to Accident & Emergency and further work was being undertaken on the issue.

The Committee **AGREED** to thank the representatives of Oxford Health, the Oxfordshire Clinical Commissioning Group and the South Central Ambulance Service for their attendance and for responding to questions on the performance of the local 111 non-emergency number.

110/13 ALCOHOL ADDICTION: A REVIEW OF ISSUES, CHALLENGES, SOLUTIONS AND POSSIBLE MEANS FOR IMPROVEMENT

(Agenda No. 11)

The Deputy Director of Public Health, in her capacity as the Chair of the Alcohol Strategy Group, a sub group of the Oxfordshire Community Safety Partnership, presented the briefing report (JHO11) pointing out that the Director of Public Health for Oxfordshire had highlighted concerns about alcohol consumption in his Annual Report for several years now, adding also that this issue involved not only policy, but

also an individual's behaviour, choice and responsibility. She introduced a panel of commissioners and managers representing different stages of involvement ie. in prevention, screening and advice for harmful drinkers, referral for treatment, treatment for addiction and finally recovery and post recovery network:

Rob Whyte – Consultant Nurse (Community Service Practitioner) – Oxford University Hospitals NHS Trust Accident & Emergency Department. His role is to undertake screening work, team liaison and has direct contact with Accident & Emergency attendees;

Mandeep Novak – Oxford Health Harm Minimisation Services – Works with clients on two different levels – on prevention and assessment of patients' vulnerability and home environment;

Dr Alistair Reid – Consultant Psychiatrist in Addictions, Oxford. Focused on harm reduction treatments using psycho – social interventions;

Dee Dee Wallace – Lifetime Recovery Service – Referral to this service following a decision to stop consumption. Involves liaison with psycho-social Team to ensure client suitability. Risk assessments are taken at home. Clients then attend a series of detox programme for 7 – 10 days.

Jodie McMinn – SMART – Howard House - Secure residential care for clients with a serious level of addiction undertaking detox. Maximum 12 week programme for up to 10 residents. Intervention psycho-social work carried out and clinical and medical screening.

Anna Penn – Young Addiction Service – Employed by the County Council as part of the early intervention hub. Works on an outreach basis for young people aged 11 to 18 in their home and school environment and with the Youth Offending Service. Holistic assessments are performed and a recovery plan agreed including various motivational techniques such as CBT coping strategies.

Glenda Daniels – Oxfordshire Recovery Network – Service focussed on assisting with career and employment opportunities; education and academic work; helping to rebuild a social life and assistance with sustaining treatment via peer support. A second aim of the Service is to promote growing awareness of recovery within the local community, for example, a recovery café has been opened in Oxford, staffed by people in various stages of recovery. Another example is an enterprise hub is held in the local job centre.

Issues emerging from discussion and questioning were:

- The potential for reducing alcohol admissions
- The potential to widen the scope of the role of the A & E nurse to further the reduction of alcohol misuse reduction;
- A keenness for Public Health to undertake more school interventions in the form of a general information talk;
- Licensing issues;

- Only 50% of patients in GP surgeries undertake a Health Check – more information should be put into GP surgeries;
- More dual diagnosis required when screening for alcohol related health problems following self harm and overdose attempts with the Mental Health services.

The Committee congratulated the Panel on the considerable amount of work being done in this area, and its variety. The Panel were asked what major messages would they like to see taken up by the Committee. Jackie Wilderspin responded that the Department of Health needed to be challenged as often as possible on the policy on the sale of drink as there was considerable tension between contribution to the Exchequer of drink sales and the cost of services for alcohol addiction.

Following a full discussion it was **AGREED** to request the Senior Policy Officer to:

(a) write to the Department of Health urging that more resources be directed to partnership working to combat alcohol addiction because it impinges on so many problem areas such as teenage pregnancy, crime and anti-social behaviour;

(b) write to the Home Office urging that the manner in which alcohol is labelled be unified in order to avoid the current confusion. In addition that steps be taken to ban cheap alcohol being sold in local small shops in light of the difficulty experienced by people in recovery being faced with temptation each time they enter the shop;

(c) urge the Police Commissioner for Oxfordshire not to take resources away from this very important area;

(d) support the Public Health initiative contained in the third national strategy to take steps to encourage individuals who may be exceeding safe levels of drinking to feel able to ask for help at an earlier stage; and

(e) request the Deputy Director of Public Health to circulate the list of where the United Kingdom is in the world with regard to alcohol addiction and at the same time advising where it should be on the list.

The Committee thanked the panel of experts comprising commissioners and service managers for attending the meeting and for their useful contributions to the discussion.

111/13 HEALTHWATCH
(Agenda No. 12)

Alison Partridge, Public Engagement Manager, OCC, updated the Committee on progress in relation to the establishment of a local Healthwatch. She expressed her confidence that the interim arrangements involving the Oxfordshire Rural Community Council (ORCC), were going as well as they could be and reported arrangements as follows:

- most of the staff team had now been appointed;
- nominations for members of the Healthwatch Board would be sought shortly. The first Board meeting would take place in the first week of August;
- an event had taken place in May for the public to inform priorities to which the Director of Public Health, Social & Community Services and the Chief Executive of OCCG had attended;
- officers were in the process of setting up a procurement process to take place in April 2014. An additional Stakeholder Advisory Forum had been set up involving independent colleagues to assist . Some market development was also taking place in order to shape the best option. A time line was also in place.

On behalf of the Committee, the Chairman wished ORCC well with the above arrangements and looked forward to the input of the formal Healthwatch.

112/13 CHAIRMAN'S REPORT AND FORWARD PLAN
(Agenda No. 13)

The Chairman's report was noted. This included a written update on the Chipping Norton Midwifery Led Unit which was due to re-open in early July.

Possible topics for the Forward Plan were suggested. These were:

- Obesity Strategy – Oxford Weight Loss (OWL)
- Community Responder service – criteria volunteers have to work to and training
- Nutrition in hospitals – ongoing item
- Quality of care of the elderly in Level 7, John Radcliffe Hospital – How are patients suffering from dementia handled? What training is available?

113/13 CLOSE OF MEETING
(Agenda No. 14)

The meeting closed at 1.35 pm.

.... in the Chair

Date of signing ....

BRIEFING PAPER: HEALTHWATCH OXFORDSHIRE

August 2013

This Briefing Paper aims to update key stakeholders and partners about the planned approach to delivering Healthwatch Oxfordshire for Years 2 and 3 of the grant period, from April 2014 – March 2016.

1. Context
Under the Health & Social Care Act 2012 all local authorities were required to commission a Healthwatch for their areas by 1st April 2013. They were also required to commission an NHS Complaints Advocacy Service, which could be part of, or separate from, local Healthwatch. (In Oxfordshire this is separately commissioned through a regional consortium).

Local Healthwatch organisations are the independent 'local consumer champion for patients, service users and the public' and must be established as a 'body corporate and social enterprise'. They are supported nationally by Healthwatch England, which was established in October 2012, as a committee of the Care Quality Commission.

2. Healthwatch Oxfordshire
Oxfordshire Rural Community Council has been contracted to deliver Healthwatch Oxfordshire for one year. It was launched in May 2013; a new Healthwatch Board was elected in August 2013, and a small staff team has been appointed.

3. The vision for Healthwatch Oxfordshire
The vision for Healthwatch remains true to the original one that was created following widescale consultation in 2011. The vision is for Healthwatch Oxfordshire to be a strongly led, independent, well known and highly reputed organisation. It will act as a strong champion; raising issues based on robust evidence and making a tangible difference to health and social care in Oxfordshire.

The organisation will have a slim infrastructure, but a widespread local 'presence'; utilising expertise and networks through commissioning functions from existing voluntary and independent sector organisations; thus stimulating and encouraging innovation. It will work towards establishing itself as a sustainable organisation.

4. The delivery approach
Oxfordshire County Council will use a 'Grant-in-Aid' agreement to fund Healthwatch Oxfordshire for Years 2 and 3 of the grant period. This will allow greater independence, while ensuring robust accountability. A Funding

Agreement will specify expectations, outputs and outcomes, and the principles of the Compact will apply.

The current contract runs for 1 year, so a fair, open and transparent process will run in the autumn 2013, to achieve the optimum solution in the longer term.

An open invitation will be placed on the SE Portal in September 2013, inviting interested individuals and bodies to apply to deliver the outcomes outlined in 3 above. This could include:

- An individual
- The current Heathwatch Board
- The current contract holder
- Any other provider

We will be particularly keen though to hear from any individuals who are interested in applying.

5. Timeline

Briefing information sent	August 2013
Invitation to apply to deliver Healthwatch Oxfordshire	September 2013
Interviews for shortlisted bids	October 2013
Final decision-making	December 2013

Alison Partridge, Public Engagement Manager **August 2013**

NHS
Oxfordshire
Clinical Commissioning Group

Update from Oxfordshire Clinical Commissioning Group

1. Strategy update

Oxfordshire Clinical Commissioning Group (OCCG) is currently developing its Commissioning Strategy. This will be a five-year Strategy setting out the vision for health services in Oxfordshire and how they will be delivered. GP practices, as members of OCCG, are contributing their ideas through the Localities and it is anticipated that wider engagement with interested organisations and the public will take place later in the Autumn.

The Strategy is set in the context of the demographic and disease changes which are described in the Joint Strategic Needs Assessment. It will recognise the aims set out in the joint Health and Wellbeing Strategy and the recommendations set out in the report from Oxfordshire's Director of Public Health. It will consider the provider landscape, the rise in demand for acute care services and the challenges of providing healthcare in isolated rural areas. It will also recognise the financial position of Oxfordshire's health economy and the constraints that this will mean.

The Strategy will not to describe in detail all of the specific developments which might take place in healthcare over the next five years but will set out and seek to reach agreement on the underlying principles and strategic themes which should underpin any decision making.

Cross cutting themes will include:

- Fairness and equity and a need to tackle health inequalities
- The need to balance the needs of the individual patient with those of the whole population
- The need to respond to all sections of the community and be aware of those seldom heard
- The need to encourage clinicians to be proactive in identifying people at risk of developing further complications from their diseases and working with them to try and take remedial action before a crisis develops.
- The importance of prioritising areas where we can make maximise impact for patients.
- Working to prevent ill health and encourage health and wellbeing

Specific themes will include

- A shift to commissioning for outcomes and for patient centred services. This includes actively involving patients at an individual level in their own care and also patients and the public at a collective level in helping to shape health care services

- Integrated care through joint working
- Moving care closer to home
- A proactive and strategic approach to quality and safety

OCCG would like an opportunity for further discussion on the Strategy with the Health Overview and Scrutiny Committee in October.

2. Outcomes based commissioning

As outlined above, OCCG is developing a new approach to commissioning services with a stronger focus on outcomes for patients. There are a variety of ways of developing this approach from simply including more outcomes based measures within current contracts to moving to a completely different commissioning/contracting mechanism that is entirely outcomes focused. The outcome based commissioning work in Oxfordshire is drawn from the COBIC model. COBIC stands for Capitated and Outcome Based Incentivised Contract, and is an exciting example of commissioning innovation that focuses on outcomes rather than activity.

Traditional healthcare commissioning in the NHS has tended to focus on processes: numbers of appointments, attendances, operations and procedures. But, with static funding levels, growing demand and unexplained variation in clinical care between providers, we need a new mechanism that instead rewards both value for money and outcomes that are important clinically and to patients. Outcome based commissioning is one such mechanism.

Each outcome based commissioning area covers all care for a given group of people – e.g. frail elderly. Each related budget is based on an understanding of the needs of that population and includes significant financial rewards for achieving specified outcome measures. To deliver those outcomes and make the efficiency savings necessary to stay within the allocated budget, providers must collaborate and problem solve.

Outcome Based Commissioning is a vehicle to:

- concentrate on outcomes
- better reflect public and user values
- properly engage clinicians in service design.

OCCG is working on three areas (maternity, mental health and older people) to introduce outcomes based contracts form April 2014. OCCG would like the opportunity to update the Health Overview and Scrutiny Committee on outcomes based commissioning on a regular basis.

3. Urgent care update

In line with national guidance, NHS and partner organisations in Oxfordshire have formed an urgent care board and developed an urgent care recovery and improvement plan. The board includes representation from all the key

health and social care services in Oxfordshire and our remit is to work together to deliver excellent urgent care in Oxfordshire. Our plan includes moving care close to home where it is safe and in patients' interests to do so – for this reason we are putting a lot of investment into developing our community based services and supporting people to stay at home. We are also ensuring that more services are provided on a 24X7 basis and are available when people need them. We are seeking external validation of our plans so that we can ensure we are following best practice and doing the things that will really improve the delivery of care when people need it.

Last winter was particularly hard and the urgent care system was under a lot of pressure – we are planning early to ensure that we are better prepared this winter. We anticipate receiving additional funding from NHS England targeted at dealing with 'winter pressures' as has been widely trailed in the press. We have agreed our priorities and how we would propose spending such money to deliver the best possible care. The proposals include things like extra investment around the processes and systems which enable people to be discharged in a timely way and not 'blocked' in a hospital bed

4. Thames Valley Priorities Committee

CCGs must have in place a process for agreeing priorities for funding treatments and drugs. It is recognised that CCGs should work together to reduce the potential of a 'postcode lottery'. The approach was previously managed across the region by Milton Keynes, Oxfordshire, Buckinghamshire and Berkshire Priorities Committee which was abolished, with the PCTs, on 31 March 2013. The CCGs across Oxfordshire, Berkshire and Buckinghamshire have since agreed to establish a new Thames Valley Priorities Committee and are in the process of agreeing the terms of reference for this group. NHS England is now responsible for commissioning specialist services. Much of the work of the previous Priorities Committee related to specialist services and so it is anticipated that the work of the new Priorities Committee will be much reduced.

OCCG has agreed to adopt all previous PCT policies which remain relevant. These policies will be reviewed over the coming months and the process for doing this is being agreed across the other CCGs.

The new Thames Valley Priorities Committee will have lay membership as well as a range of clinicians and other expertise. Decisions about existing policies and new treatments and drugs will be made based on evidence reviews.

Until the new arrangements are in place, it was necessary to establish an interim committee to consider a review of the Assisted Conception Policy. There was an urgent need to do this following the change in the equalities duty in relation to age discrimination and revised guidelines from the National Institute for Health and Care Excellence (NICE). A revised policy was agreed at the July meeting of OCCG's Governing Body. It is not anticipated that the

interim committee will need to meet again before the new Thames Valley Priorities Committee is properly established.

5. Emergency abdominal surgery at Horton General Hospital

Following concerns raised by a local GP last year and an internal audit, Oxford University Hospitals asked the Royal College of Surgeons to review the emergency abdominal surgery at the Horton. It was agreed that until the findings of the review could be considered, emergency abdominal Surgery would be suspended at the Horton and patients would be transferred to the John Radcliffe Hospital in Oxford for treatment.

From the Banbury area, approximately 20 people per week are referred for investigations with five of these patients needing emergency abdominal surgery per week. The Oxford University Hospitals have been putting in arrangements for assessing patients in Banbury and then transferring those requiring further investigations and surgery to Oxford.

It has taken longer than anticipated to establish the assessment clinic at the Horton and so most of those requiring investigations have needed to be referred to Oxford.

The report from the Royal College of Surgeons is about to be published (with redactions). This will highlight where improvements need to be made and we will be discussing the recommendations with the Trust.

August 2013

Oxfordshire
Clinical Commissioning Group

Oxfordshire's Falls Prevention Service

Report for Oxfordshire Health and Overview Scrutiny Committee

August 2013

Purpose of this paper

This paper is to inform the Health and Overview Scrutiny Committee on the current status of delivering fall's prevention across Oxfordshire in line with the Older Peoples Joint Commissioning Strategy.

Context

In 2013 the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council agreed the Oxfordshire Older People's Joint Commissioning Strategy 2013-16. This was developed from extensive consultation with members of the public, carers, commissioners, providers and partners. The strategy sets out the vision for supporting older people in Oxfordshire to live independent and successful lives, what success will look like as described by older people and the main priority areas:

1. I can take part in a range of activities and services that help me stay well and be part of a supportive community.
2. I get the care and support I need in the most appropriate way and at the right time.
3. When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
4. As a carer, I am supported in my caring role.
5. Living with dementia, I and my carers receive good advice and support early on and I get the right help at the right time to live well.
6. I see health and social care services working well together.

The strategy sets out plans that will achieve this including encouraging healthy lifestyles, reducing ill health through early identification of problems and intervention and investment in community services to achieve better outcomes for people and reduce the need for hospital and inappropriate residential care.

The Oxfordshire Falls Prevention Service is key in supporting the delivery of some of these outcomes by enabling older people to live independently, preventing ill-health and admission to hospital.

1.0 Why is fall's prevention important?

1.1 Why do older people fall?

Maintaining balance is the key to preventing falls, but as we age the balance system as a whole is less sensitive, less rapid, less accurate and weaker thus increasing our falls risk.

The causes of falls are divided into two groups: intrinsic factors which are things to do with the person and extrinsic factors which are those things to do with the environment.

A. Intrinsic factors:

- Reduced sensory input- this is believed to be the most significant.
- Medical conditions that commonly affect sensory input such as stroke and Parkinson's disease.
- Medications. Antidepressants and sleeping tablets affect sensory input. Older people also often take medications that affect the blood supply to the brain by causing a reduction in blood pressure which can result in a fall.
- Weakness to joints and muscles and pain from arthritis, damage to nerves will also increase the incidence of falls.
- Anxiety, depression and dementia can prevent a person from concentrating properly and they can fall as a result.
- An infection or any illness that makes a person feel unwell can increase their likelihood of falling. It is well recognised that falling can be a clear indicator of failing health.

B. Extrinsic factors:

- Cluttered environment,
- Rugs which are a trip hazard
- Equipment that is in a poor state
- Furniture such as the bed and chair at an inappropriate height.

1.2 Consequence of a fall

A fall or injury can have a devastating effect on the older person's life, leading to personal costs include, fear, isolation, pain, loss of independence, depression and death. The estimated burden of falls in the over 65 population in Oxfordshire now and over the next 20 years will rise due to the increase in the population 'at risk of falling'

It is well documented that effective fall prevention has the effect on reducing emergency department visits, hospitalisation, nursing home placements and functional decline.

The NICE 'clinical guidelines 21' on falls prevention were first published in 2004 and update in June 2012 as NICE 161. The Oxfordshire falls prevention service works to these NICE guidelines.

2.0 Oxfordshire Fall's Prevention Service

Oxfordshire has had a Falls Prevention Service since June 2004. It is jointly funded by Health and Social Care, and delivers a comprehensive fall prevention and intervention countywide service which has grown and developed over the last nine years.

The service strives to improve the health and wellbeing of the local population by the early detection, management and treatment of risk factors that can lead to falls. The underlying principles are:

- To treat all our patients with compassion and respect
- Provide services in the community close to home in a safe and secure environment
- Provide accessible high quality, personalised, safe and appropriate health care, were we listen to our patients and strive to provide the best service and aim to continually improve
- To maintain independence and improve the quality of life of those who fall or who are at risk of falling
- Reduce avoidable admissions to hospital
- Identify and treat common conditions
- Reduce the incidence of falls amongst older people
- Support our patients to remain living safe and independently at home
- Manage the demands on our services ensuring timely intervention
- Support carers/families and all clinicians in the early detection and management of risk factors that can increase the risk of falls through education, training

2.1 The Service Delivers:

- Falls assessments and treatment plan, in patients' homes in clinics and in care homes – *2012/13 total 2,308 undertaken, plus 1,939 non-conveyed fallers assessments in the last 21 months*
- Home based exercise programs - *2012/13 total 89 people supported*
- Education and Training – to both health and social care practitioners, private providers and to the general public – *2012/13 total of 1,391 individuals*
- Support to community and older people's mental health wards - *Daily*
- Health and wellbeing advise to community groups – *2012/13, 461 people attended exercise groups and 11 information fairs attended*
- Integrated delivery with the Fracture Prevention Service - *part of pathway*

2.2 Role of the Falls Prevention Practitioner

The fall's prevention practitioner is in most cases a registered nurse, trained as an extended scope practitioner to carry out a comprehensive gerontology assessment and put in place a treatment plan to reduce the risk of further falls, see Appendix A.

A patient treatment plan is discussed and implemented together with the individual and their carer as appropriate. Treatment recommendations and referrals to other services such as exercise classes are made and a copy of the plan is shared with the patient's GP.

3.0 Integration in the whole system of older people's care

3.1 Falls Prevention in Community Hospitals and Older People Acute Mental Health Wards

The service supports Local and National drivers by leading the fall prevention work throughout Oxford Health NHS Foundation Trust (OHFT) bed based care to reduce the number of falls in community hospitals and older people's mental health wards

The service has delivered training to the front line clinical staff since 2004. It has now developed an e-learning falls training package which takes about one hour to complete. This can be accessed in the workplace and replaces the three hour classroom based training. that was previously necessary. This improves the efficiency of both the falls prevention service and the ward staff by releasing more time for patient care.

3.2 Non-conveyed fallers

A non-conveyed faller - is a person who has fallen in their home and needed the assistance of the ambulance service but did not require transport to a minor injury unit or the emergency department

In 2010 the service piloted the impact of ambulance staff referring all non-conveyed fallers in the Didcot area to the Oxfordshire Falls Prevention Service. The initial findings clearly demonstrated that this cohort of patients were high risk fallers. The number of hospital admissions among this group was high at 46% within the first 3 months of the first ambulance call out. The service saw a reduction in admission of 9% in the patients seen in the pilot are verses patients in the rest of the county. Following the pilot the service was commissioned to deliver an extended service to non-conveyed fallers countywide which has continued to demonstrate a significant reduction in hospital admissions and cost savings.

Findings in the last 21 month: 1,939 people have been seen with a reduction in hospital admissions down from 46% to 33%. Overall this equates to 249 fewer admissions over a 21 month period, equating to approximately £500k in savings to the health economy and improving people's lives.

3.3 Fragility Fracture Prevention Care Pathway

The service works closely with the Fracture Prevention Team based at the Nuffield Orthopaedic Centre to help support the fragility fracture pathway into the community and care homes.

Historically 2003 to 2005 the hip fracture rates among care home residents increased at a rate of 37%, data from the Oxfordshire Hip Fracture Audit reported. When the falls service was set up in 2004 the service started working with 10 designated care homes and was able to demonstrate a 20% reduction in falls incidents in these homes against the county levels. This increased to 40 care homes in 2006, now through the Care Home Support Service

which work with all care homes for the over 65 in the county the number of Hip fractures have continued to decline.

The most significant change is the ratio of fractures rate to total beds which has decreased from 2.6 in 2004 to 1.8 in 2011 (taken from Oxfordshire Hip Fracture Audit)

In 2012/13 the service and the Care Home Support Service carried out a total 850 falls assessments in care homes

3.4 Training and education

The service provides both formal and informal training to other health care providers – see Appendix B for details

Internally to Oxford Health NHS FT the service has carried out 35 training sessions to a range of qualified and non-qualified healthcare staff in 2012/13.

Across the county the service in total delivered 149 sessions to 1391 people

3.5 Health and wellbeing advisor

This advisor visits community groups, day centres and WI's delivering health promotion advice on falls prevention and makes links with local seated exercise groups and services.

They also Offer taster session of exercise to community centres, care homes, day centres and link them with a tutor to encourage them to have regular sessions- See Appendix B

3.6 Home Based Exercise Programme

This is delivered via 'The Otago Programme' developed in New Zealand for individuals who are house bound. Studies using the programme show a reduction in falls of between 30-46% and fewer injuries associated with falling. This programme was designed specifically to prevent falls and consists of a set of strength and balance retraining exercises and a walking plan. The exercises are individually prescribed and increase in difficulty over a series of five home visits. During 2012/13 a total of 89 patients undertook the programme.

4.0 Benchmarking

In 2011, Oxfordshire County Council commissioned: the following study

Improving falls and fracture services in the South Central and South Coast Regions:

"A research study involving Oxfordshire, Buckinghamshire and Kent" by Dr Todor Proykov and Rachel Taylor

The report published in January 2012 made the following statements after reviewing the national picture and the three project sites:

National picture

- There is a wide range of falls pathways implemented across the country; these vary significantly in the way they are organised.

- The majority of falls services are based in acute or community hospitals, with only a few in primary care or emergency departments. Most services undertake multi-factorial assessment with the content and quality of these assessments varying substantially. Access to services relies in the majority of cases on health professional referral.
- Very few pathways make an effort to integrate social and community services components.

Research sites findings

- The falls prevention services in Oxfordshire and Buckinghamshire are *well-grounded in research evidence* and their leadership is keeping up-to-date with the most recent research and with alternative models that exist across the country.
- The number of assessments carried out by Oxfordshire is approximately three times more than in Buckinghamshire (2,246 against 730).
- The relative numbers of assessment carried out by both services compare favorably to the 2,100 assessments carried out by Greater Glasgow and Clyde—with twice as many staff as Oxfordshire.
- Both Buckinghamshire and Oxfordshire provide exercise classes that are based on research evidence of what works for people with falls. Both sites evaluate the outcomes of the classes and demonstrate significant improvement for the patients, in consistency with the research evidence of the effectiveness of these classes.
- In the period 2007-2008 the Greater Glasgow and Clyde falls prevention service, the largest one in the country at that time had roughly 2,650 referrals. In that respect although three years later Buckinghamshire had similar number (2,657) of referrals to Greater Glasgow, and Oxfordshire more (3,500). The population of Greater Glasgow and Clyde is 1,196,335; in Oxfordshire it is 687,206 and in Buckinghamshire it is 739,600. This suggests that, given the smaller staff resource, Buckinghamshire and Oxfordshire are accepting a much greater number of referrals.
- Overall costs - estimation shows that
    - UK services (2007) – 180 attendances on average with *total budget* of £171,340 on average
    - Oxfordshire (2011) – 2,246 assessments with a *total budget* of £543,000
    - Buckinghamshire (2011) – 730 assessment with a *total budget* of £258,185.

5.0 Patient feedback

The patient survey in 2012 reported that:

59% of patients rated the service as excellent

36% very good

5% good

Below are some additional comments patients completed as part of the survey;

‘A very thorough and competent examination with a useful discussion concerning my predicament.’

'Absolutely wonderful. I learned more about my health problems that have been worry me for a long time than any other health professionals I have seen before.'

'The atmosphere was friendly and relaxing. The examination was thorough. I was left feeling reassured and happy.'

'The sympathetic reception, the precise diagnosis and the very useful advice was all handled in a thoroughly professional manner.'

6.0 Next steps

The development of integrated locality teams and further Emergency Multi-disciplinary Units such as the one in Abingdon will continue the identification of people who are falling or at high risk so that they can access fall's prevention experts. These teams will also be equipped to carry out first line assessments and interventions, by improving all professionals' generic assessment abilities.

The increase of both Oxfordshire Clinical Commissioning Group and Oxfordshire County Councils pooling of resources in older peoples services, allows an increased scope for further support of services such as the falls prevention service. Which are demonstrating real change in older people's lives and improving their quality.

Appendix A:

Competency of Falls Prevention Practitioner

1.0 Medical skills
Ability to:

- take a full medical history
- a drug review (an understanding of indications and uses of drugs, their side effects and interactions, their potential to cause falls, and the ability to recommend suitable alternatives to GPs)
- A cardiovascular examination: particularly heart rate and rhythm (including basic ECG interpretation), the presence of cardiac murmurs, clinical diagnosis of congestive cardiac failure.
- Assessment of lying and standing blood pressure
- A neurological examination: detection of neurological causes of disturbed gait and balance; assessment of neurological disability; assessment of vestibular dysfunction; ability to perform Epley's manoeuvre; detection of peripheral neuropathy.
- Ability to take blood samples and interpret the results.
- Undertake the MMSE and CLOX and understand the implications of the results.

2.0 Occupational Therapy skills
Ability to assess disability and functional state; to assess the patient's home environment; to have expertise in aids and appliances that might help overcome disability; to have a knowledge of local services.

3.0 Physiotherapy skills
Ability to assess gait and balance; selection of walking aids; knowledge of gait and balance re-training – its potential and limitations;

4.0 Osteoporosis knowledge
Ability to carry out an osteoporosis risk assessment understanding risk factors and treatment options

Competency achievement is monitored by the lead gerontology consultant and clinical leads via examination, direct supervision and indirect supervision.

APPENDIX B

Falls 2012-2013	**TOTAL 2012-13**
Total seen for one to one fall assessment	2,308
Number of teaching/education sessions delivered to:	Sessions
Care home staff	20
Balance and safety group	41
Inpatient staff	34
Day centres/sheltered	2
Community groups	4
Falls awareness training	35
Other	13
Total number of education/teaching *sessions* given:	149
Total number *people* taught at Education Level 1: (medical, registered or social service)	442
Total number *people* taught at Education Level 2, (health or social care support worker)	226
Total number *people* taught at Education Level 3, (older people who have fallen)	118
Total number *people* taught at Education Level 4, (the general public e.g. people spoke to at information fairs/relative advice during clinic)	634
Number of student/professional taught in clinic	Individuals
Level 1 (medical, registered or social service)	21
Level 2 (health or social care support worker)	21

Total number of people who received education/teaching:	1391
Number of patients receiving home based exercise:	Individuals
New:	89
Follow up:	317
Number of exercise session	0
Taster:	14
Balance and Safety:	24
Weekly class:	22
Total number of exercise sessions	58
Number of people attending exercise session	Individuals
Taster:	155
Balance and Safety:	96
Weekly class:	210
Total number of people attending an exercise session:	461
Other awareness raising activity/ information fairs attended	11

Oxfordshire Clinical Commissioning Group Current Clinical Assurance Framework

1. Introduction

The first Francis report on the Mid Staffordshire NHS Foundation Trust was published in 2010. It identified extremely poor care being delivered in a number of areas of the trust. The second report was published in February 2013. This report goes further and looks at the wider responsibility of the NHS. The report makes 290 recommendations.

Following the Francis report, the Keogh report was published and looked at 14 hospital trusts, selected for investigation on the basis that they had been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Following the Keogh review, 11 Trusts were placed under ‘special measures’ by the Health Secretary.

The approach used by the Keogh Team offers a blueprint for the Care Quality Commission’s new approach to inspections. The CQC’s new Chief Inspector of Hospitals, Professor Sir Mike Richards, has already announced that he will lead significantly bigger inspection teams headed up by clinical and other experts and including trained members of the public.

The Prime Minister has commissioned Professor Don Berwick to undertake a review of patient safety. His report makes recommendations for the NHS, its regulators and the government on how to build a robust nationwide system for patient safety based within in a culture of transparency, openness and continual learning with patients firmly at its heart.

This paper describes the systems and processes with which Oxfordshire Clinical Commissioning Group (OCCG) monitors and manages the quality of provider services.

There are three aspects of clinical quality; clinical effectiveness, patient safety and patient experience. This report details the types of clinical quality intelligence collected, the methods used to collect it and the way in which it is analysed by OCCG.

Roles and Responsibilities

The primary responsibility for quality sits with frontline professionals, both clinical and managerial. Frontline staff and are responsible for their own professional conduct and competence and for the quality of the care they provide. They are witnesses when things go wrong and often have ideas about how the quality of care could be improved. It is vital that these staff are able to speak up and are empowered to act to prevent failings in care and to suggest improvements. OCCG has developed an innovative solution to gather feedback from GPs within Oxfordshire. An explanation of how this information is collected and reviewed is described under section 6.

The second line of defence against serious quality failure is the boards and senior leaders of health care providers. Commissioners are responsible for ensuring the quality of care delivered by the services they commission. Provider boards and the CCG Governing Body are ultimately accountable when things go wrong. They should address problems that arise as a result of a lack of systems and processes. It is vital that they are able to monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems. OCCG is fully aware of its role and work closely with providers to ensure an open culture where mistakes are learned from and not punished. This links to the recommendations made by the Berwick report.

The final line of defence against serious quality failure is external structures and systems. These are usually at national level and are responsible for assuring the public about the quality of care. These national bodies require organisations to be transparent and can require them to account of their performance and actions. They can also take action when local organisations fail to resolve issues. The CQC is in the process of developing a more robust and in-depth inspection process for hospitals. The CQC has a range of indicators which it uses to establish quality and conducts inspections when these indicators suggest deficiencies. OCCG monitors these indicators the providers' performance against the indicators to ensure that we are aware of possible issues as soon as they arise. Monitor also reviews the performance of foundation trusts.

2. Clinical effectiveness

In seeking to establish quality there is clearly a desire to look at things which can be measured. This is a relatively new science and methods are constantly changing and being updated.

2.1 Dr Foster, HSMR and SHMI

Oxfordshire commissioners have, since 2008, used Dr Foster software to monitor clinical outcomes at Oxford University Hospitals NHS Trust (OUH) (previously Oxford Radcliffe Hospitals). This was also one of the tools used to identify trusts to inspect in the Keogh review and is one of the triggers for a CQC inspection. The clinical outcomes measured by this software are mortality, readmissions, length of stay and day case rates. Using an algorithm, the software determines whether the expected numbers of negative outcomes (e.g. for mortality, this would be death) are exceeded by the monitored number. When any of these outcomes is statistically significantly higher than expected, Dr Foster will produce a 'red bell'. OCCG review this data and attend clinical governance meetings at the OUH where mortality is discussed.

Dr Foster measures the Hospital Standardised Mortality Ratio (HSMR). The HSMR is an indicator of healthcare quality that measures whether the death rate at a given hospital is higher or lower than would be expected. The OUH is not an outlier for mortality according to their HSMR. The Department of Health has recently introduced an additional mortality measure, the Summary Hospital-level Mortality Indicator (SHMI). This measure also indicates that the OUH has a mortality rate within expected limits.

Mortality data is just one indicator that is used to determine the clinical quality of a healthcare system and it should not be viewed on its own. Focusing on numbers of excess deaths is not, in itself, an accurate measure, as a number of factors can lead to a high HSMR or SHMI (i.e. data quality, if there is a hospice on site, etc.). HSMR is one of a range of indicators regularly reviewed by OCCG when assessing the quality of the clinical services. The OUH and OCCG's ambition is to have one of the lowest mortality ratios in the country.

Commissioners can also use Dr Foster software to monitor the referral patterns of primary care into secondary care. They do this by looking at Standardised Admission Ratios. Oxfordshire is amongst the best in the country according to Dr Foster software. HSMR and SHMI focus only on acute hospitals and are not currently applicable to Oxford Health.

2.2 Audits

Clinical audit is a quality improvement process. It is used to improve patient care and outcomes through the systematic review of care against explicit criteria and the subsequent implementation of change. In Oxfordshire, clinical audits are requested from providers via the contract to assure commissioners that National Institute for Clinical Excellence (NICE) guidance is followed. Performance in clinical audits is reviewed by the Quality Team of OCCG and the evidence from these reports is triangulated with other information collected.

3. Patient safety

3.1 Serious Incidents

There is an established system for reporting and reviewing patient safety incidents. All providers manage incidents internally. Serious incidents (i.e. ones that result in severe harm or death) must be reported to the commissioner. There is a nationally designated list of Never Events which must also be reported to commissioners. The provider must then conduct a root cause analysis for these incidents. The commissioner manages the investigation process and incidents are only 'closed' when commissioners are satisfied that an incident has been thoroughly reviewed, that lessons have been learnt and that steps have been taken to prevent recurrence. As recommended in the Berwick report, to the emphasis is on learning from these incidents in order to prevent recurrence rather than on punishing individuals for mistakes.

Where themes emerge in the investigation of serious incidents providers are required to understand these and to demonstrate that they are being addressed. Issues about the culture of organisations often emerge in the analysis of serious incidents, as well as in the response of trusts to the events. In these circumstances the commissioners may require action to be taken to address these issues, for example, through increased clinical leadership.

We can begin to understand the safety culture of a trust by looking at how they respond to incidents. The ideal culture is one in which staff feel able to voice their concerns, and where patients are always listened to and their concerns attended to promptly. Trusts should be able to receive information which shows that they may have issues with a willingness to understand and investigate further.

3.2 Safeguarding

Commissioners have a statutory safeguarding function. They are notified of safeguarding alerts relating to both adults and children and are instrumental in responding to alerts. This means that safeguarding information can be viewed alongside other quality information to alert OCCG to areas where poor care may be causing harm.

4. Patient Experience

Patient experience is perhaps the fastest growing area of quality information. In order to be assured of quality we need to put feedback from patients at the centre. Patient experience is a good early indicator of where thing may be going wrong.

Patient experience is also the most difficult area to measure. Patient satisfaction can be collected through simple scoring - as in the new 'Friends and Family test', but experience is not measurable. Hospitals in Oxfordshire perform well in satisfaction surveys. OUH has implemented the Friends and Family test which is being extended to include the services provided by Oxford health. Both trusts have a range of other surveys which they use to understand the patient experience.

Methods of looking at experience include scrutinising complaints, PALS and MPs' letters. The Keogh report noted the tendency for some hospitals to view complaints as something to be managed, with the focus on the production of a carefully worded letter, rather than addressing the issues within the complaint or apologising to the patient. The content of the complaint also needs to be understood in order to detect themes and possible trends. We also look at PALS queries for insight into areas where patients are finding difficulties, and to provide us with an indication of how well providers respond to patients' concerns. Crucially, we look at how trusts use the information they receive in complaints to inform the way in which they deliver services and to make improvements.

There is a close correlation between overall patient experience and the quality of nursing care. In both Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust the quality of nursing has been a focus for improvement. We continue to work with them on developing leadership in this area.

OCCG has set up a web page to collect patient experience or commissioned services. This survey can be found at www.oxfordshireccg.nhs.uk/patient-survey.

4.1 Patient and Staff Surveys

The views of patients are frequently sought through local and national surveys. The national acute inpatient survey is conducted every year and allows comparison between trusts and within trusts over time. There are also more specific surveys, for example the cancer patient survey and the maternity survey, which provide a view of patients' experiences of individual services. The OUH generally scores well in the national inpatient survey.

It is well known that the wellbeing of staff has a direct impact on the experience of patients. For this reason we look at the results of the staff survey in conjunction with those of the patient survey.

5. Contracts: Quality schedule

Commissioners receive monthly indicators on performance activity and quality. This range of indicators is set out in different schedules of the contract held between the commissioner and the provider. The contents of this schedule are agreed as a part of contract negotiation. The schedule sets out the quality markers expected from providers. It includes limits for healthcare acquired infections such as MRSA bacteraemia and clostridium *difficile*, and national targets, for example those relating to A&E, cancer waits and 18 weeks referral to treatment times. It also includes relevant local indicators such as radiology turnaround times.

For the main providers the quality schedule is scrutinised monthly at performance meetings. Quality is discussed at the same meeting as activity. In this way quality is given the same weight as performance and the impact of each on the other can be understood.

6. Quality Information system

OCCG uses a risk management software package called Datix. This enables a range of quality data to be stored. Datix includes data on complaints, PALS, MP letters, and incidents. Importantly, Datix permits users to search for data – for example to see whether there have been a number of complaints about a particular area.

In 2012 the Datix system was expanded to provide GPs with direct access. They use this to report directly to the commissioners concerns they have about the quality of services. This facility provides the commissioners with a rich source of timely information which can be addressed rapidly to ensure quality is improved. Since being established in June 2012 we have received well over a thousand reports through this system, all of which have been or are currently being followed up.

7. Whistleblowing

OCCG has, on occasion, received ‘whistle blowing’ allegations. When this has happened we always follow up allegations by conducting investigations or ensuring that Providers follow up on the issues raised.

8. Action to address quality concerns

When there are concerns about the quality of services a number of steps are taken. The first step is usually to raise the issue formally at a contract meeting. The provider is then expected to produce a detailed rectification plan. If the commissioner receives an inadequate action plan or the plan is ineffective then a contract query will be issued. If this approach fails or the concerns are significant then the commissioner will issue a performance notice. If OCCG believes a service to be dangerous it will suspend the service immediately. In parallel with

this process provider executive directors and the chief executive would be informed.

OCCG also has the option of commissioning an external review of quality from national experts such as the Royal Colleges. This facility was used by the PCT on a number of occasions to seek additional information and advice on issues of concern.

OCCG has a structure which puts quality at the heart of commissioning. It has established a formal subcommittee of the board to focus on quality and performance. The group is chaired by a lay member of the governing board and has a lay member in attendance.

The Francis report identifies a number of recommendations for commissioners. OCCG will review these and agree a programme of implementation. We have had initial meetings with Healthwatch, and will work closely with Healthwatch, to help strengthen the patient perspective.

9. Quality Surveillance Group

A Quality Surveillance Group has been established by the Thames Valley Area Team and it brings together commissioners, the local authority, Healthwatch, CQC and Monitor to review the quality of healthcare provision within Thames Valley.

10. Conclusion

This paper sets out the range of tools, methods and intelligence which are currently in use in Oxfordshire to provide commissioners with assurance of the quality of the services they commission. OCCG has intentionally placed quality at the centre of the organisation. The Quality Team work closely with providers and have developed a relationship where they are expected to challenge. When necessary decisive action is taken to address situations where quality falls below the standard we would expect.

Providing assurance of the quality of services is complex and no system is infallible. Systems are evolving all the time as information becomes more sophisticated. The uncovering of poor quality within NHS commissioned services frequently leads to increased scrutiny and changes in the way in which we seek to understand the quality of services.

It is the role of provider boards to ensure services are safe and of a high quality and it is the responsibility of the Governing Body of OCCG to seek assurance on quality. As far as possible the systems we use provide this assurance. However, it is always important to be alert to the possibility of poor quality. The acknowledgement that things can and do go wrong is essential and constant vigilance is required.

Where possible we use validated tools to measure the quality of commissioned services. These are not, on their own, sufficient to provide assurance of quality. We also use the ‘soft intelligence’ we receive. Where there have been extreme

cases of poor quality, culture is frequently cited. While it may not be the cause of the poor quality itself, it is a culture of acceptance and of secrecy which prevents the issues being tackled.

It is essential that providers are open in their reporting and consideration of quality issues. The quality team has built good working relationships with provider trusts. This means that we can work together to understand and address potential quality issues while crucially maintaining the critical distance which scrutiny and assurance requires. Importantly, data which suggests poor performance and data which indicates good performance should be afforded the same degree of scrutiny.

Seeing the organisation or service as a whole is also crucial. When viewed individually indicators may not be the cause for a high level of concern. When viewed in the context of a range of other information a high level of concern may be indicated. This whole picture view is achieved through close working within the quality team and across the organisation.

In light of the Keogh, Berwick and Francis Reviews, OCCG will be reviewing its quality framework in the autumn.

Sula Wiltshire, Director of Quality and Innovation, Oxfordshire Clinical Commissioning Group

August 2013

Appendix – Recommendations taken from the Keogh and Berwick reviews

Eight ambitions from the Keogh report

1. We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

2. The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

3. Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

4. Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

6. Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

7. Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

8. All NHS organisations will understand the positive impact that happy and engaged staff has on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

Ten recommendations from the Berwick report

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

This page is intentionally left blank

Oxford University Hospitals NHS
NHS Trust

Title	Actions being taken to accelerate further improvement in clinical quality at Oxford University Hospitals NHS Trust in the context of the second Francis Report, the Keogh Reviews and the Berwick Report – a briefing for a meeting of Oxfordshire Health Overview and Scrutiny Committee to be held on 5th September 2013
Author	Professor Edward Baker, Medical Director, OUH
Date	22nd August 2013

Executive Summary

1. This paper provides a briefing to Oxfordshire HOSC on work being undertaken within Oxford University Hospitals NHS Trust (OUH) following the publication of the second Francis Report in February 2013. It has also been developed in the context of the recent publication of the Keogh Reviews into fourteen NHS Trusts with higher than average mortality rates, and the Berwick Report on patient safety.

2. These publications have had a major impact on the NHS at large. The Trust's overarching response has three key elements - the further development of a culture within the organisation in which clinical quality is the primary concern of all staff members; enhancement of systems to determine and monitor appropriate staffing levels within clinical areas in real time; and, the adoption of a system of internal peer review for quality assurance and improvement purposes.

3. The paper describes a number of current and potential projects which, taken together, form a comprehensive programme of work aimed at further accelerating the desired cultural change. Many of these projects were underway in advance of Francis, and these will be strengthened going forward. Others are new proposals. Recognising the time and commitment that will be necessary to ensure that these projects are delivered successfully and sustained, relevant leaders and departments within the organisation will be encouraged to adopt projects relevant to their area in forthcoming work plans.

4. Enhanced systems are being put in place to facilitate the real time monitoring and reporting of staffing levels against the number, acuity and dependency of patients admitted to the Trust's hospitals.

5. The immediate establishment of a programme of work of internal peer review and inspection of clinical services is envisaged to strengthen the Trust's assurance of clinical quality.

6. The input of Oxfordshire HOSC and other stakeholders would be welcomed by the Trust as we respond to these major NHS reports.

National Background

1. The report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Chair – Robert Francis QC) was published on 6th February 2013 - *'Francis 2'*. The report made 290 varied and far-reaching recommendations.

2. The Keogh Reviews were published on 16th July 2013 and examined quality issues at fourteen Trusts that have had a consistently high mortality rates (HSMR or SHMI). They set eight ambitions for the NHS. Several of these ambitions mirror declared OUH priorities following publication of *Francis 2* (paragraph 15).

3. Central to the Keogh reviews is the introduction of a new process for assessing quality in NHS trusts. The process is data-driven, multidisciplinary, and transparent and has a great deal of patient involvement both in providing feedback, but also as members of the review teams. The key difference between these reviews and others is the transparency of the process and engagement of different groups in the agreeing the outcomes.

4. Ambition 4 of the Keogh review is for improvement in CQC inspections drawing on the experience of the Keogh review process. The report specifically suggests that trusts might use the methodology of the reviews to assess and improve their own clinical quality.

5. The Berwick Report, itself a governmental response to *Francis 2*, was published on 6th August 2013. It focuses on creating an effective safety culture within the NHS. The risk management culture Berwick advocates is one of transparency, learning and improvement. Like Keogh he emphasises the importance of defining safe staffing levels for all clinical areas based on the clinical burden and the real-time monitoring of actual staffing against this standard.

Relevant actions taken within the Trust before and following publication of Francis 2

6. Several highly relevant pieces of work have been underway within the Trust over the last three years pre-dating the publication of Francis 2. These include: articulation of organisational values; a programme of work around *Delivering Compassionate Excellence*; and, the development of the Quality Strategy.

7. The Trust's Clinical Governance Committee received a presentation and discussed the *Francis 2* report at its meeting on 20 February 2013.

8. A series of open staff briefings were arranged in February and early March. Approximately 750 members of staff attended the briefings. Staff members made thoughtful and well considered contributions in the discussions that followed.

9. There was consistency in the issues highlighted by staff in the briefings. Issues raised could be divided into the following eight broad categories:

- Feedback – gathering and using information at service level
- Training – profile and priority
- Financial constraints
- Leadership and empowerment
- Nursing – changes in shift patterns
- Staff – numbers and skill mix
- Staff – valuing contribution
- Staff – agents for change.

Governmental Response to Francis

10. The Government published its initial response to the report on 26th March 2013. A full response in anticipated in due course. The Government accepted *'the essence of the Inquiry's Recommendations'*. The initial response was divided into 5 areas:

- Preventing problems arising by putting the needs of patients first
- Detecting problems early
- Taking prompt action
- Ensuring robust accountability
- Leadership and motivation of NHS staff

11. The Government's response inevitably focused upon structural and system wide changes. The key challenge for the Trust is to make further progress in achieving and maintaining a culture in which the focus on quality and patient experience is primary and pervasive.

Key Priorities and opportunities at OUH in light of Francis 2

12. At its meetings in March and May 2013 the Board considered its response to *Francis 2*. It agreed that the priorities for action were:

    - Culture - The Trust should consider whether the work already underway is sufficient
    - Complaints - The Trust should review its complaints handling process
    - Risk management - There should be a review of the Trust's approach to clinical risk management
    - Mortality - The systematic review of patient deaths already underway should be made a priority
    - Response to quality concerns - The Trust should make sure quality concerns are addressed rapidly and effectively

13. In addition to these priorities the Board agreed that there should be a review of clinical staffing in all services to ensure it was at a level necessary to provide a safe high quality service.

14. A small working group met to further consider the Francis report, the Government's initial

response and staff feedback from the briefings in order to inform and develop the Trust's response. The group was mindful of the many work streams that are already underway within the Trust. The group has identified a set of projects and interventions, some in progress and others new, which together form a coherent and substantial programme of work to accelerate further improvement in clinical quality at OUH. Recognising the time and commitment that will be necessary to ensure that these projects are delivered successfully and sustained, relevant leaders and departments within the organisation will be encouraged to consider adopting new projects relevant to their area as part of their 2014/15 work plans.

15. The projects and interventions are divided into six broad domains of work that sit within the context of the Trust values (see figure 1 overleaf). Existing work streams have been mapped to these six domains. The further work proposed following *Francis 2* does not alter the direction that the organisation seeks to take but acts as a catalyst in moving forward (see figure 2 for existing work streams and proposed projects and interventions, mapped against the six domains).

Figure 1
Six key domains of work following Francis sit within the context of Trust Values

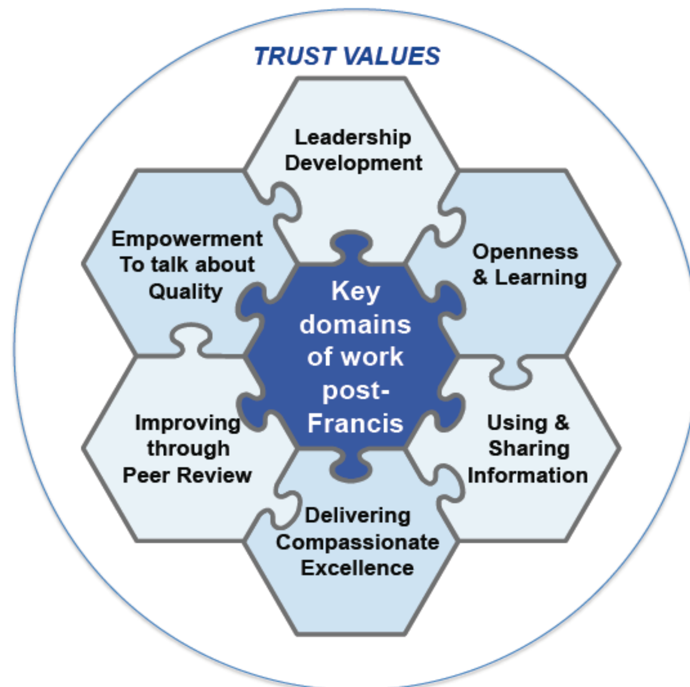
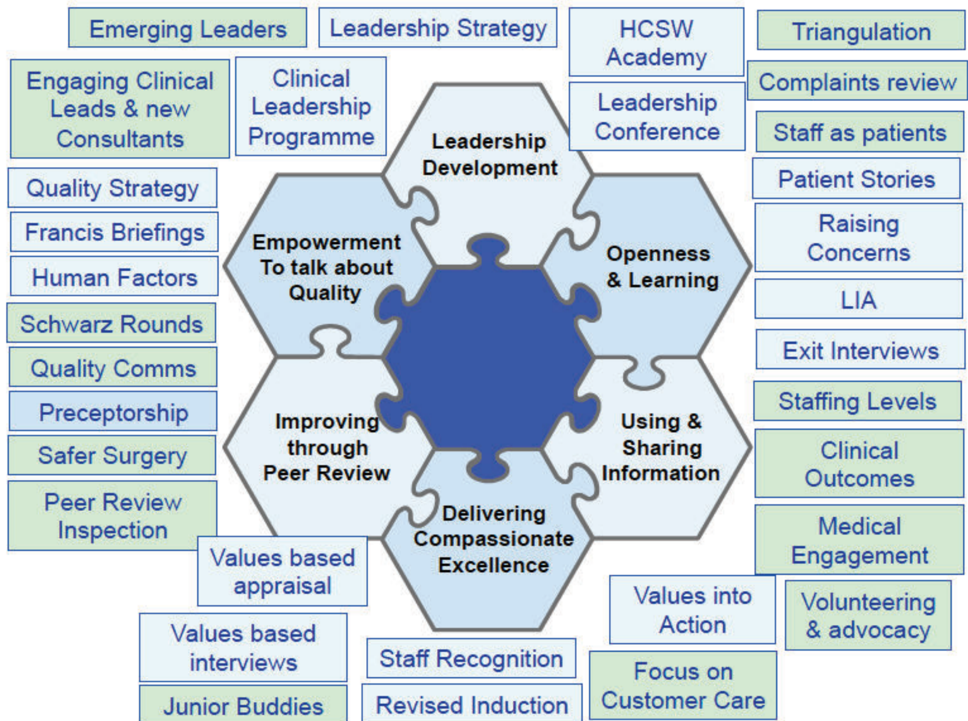


Figure 2
***Existing* work streams [blue boxes] pertinent to Francis and *proposed* projects and interventions [green boxes] (mapped to the six domains)**



16. The group has identified 21 projects and interventions that it considers should be considered with a view to adoption, or – where already in place – further developed and reinforced.

17. In the light of the Keogh Reviews, to strengthen the Trust's assurance systems it is proposed that work on establishing an internal peer review process should be expedited.

18. The projects and interventions are set out under these six domains in Appendix 1. A comment is provided as to whether these projects represent an extension to existing pieces of work, or constitute a proposal for new work going forward into 2014/15.

19. The Trust's Management Executive is scheduled to discuss the content of this paper at its meeting on 22nd August 2013. There will then be further opportunity for consultation with staff and review at Board level. OUH will be able to update HOSC on the conclusions drawn by Trust Management Executive at the meeting on 5th September.

Dr Ian Reckless
Assistant Medical Director (Clinical Governance)

Professor Edward Baker
Medical Director

22nd August 2013

Appendix 1: Projects proposed to accelerate further improvement in clinical quality at OUH

Domain: Delivering Compassionate Excellence		
Value Based Interview	*Incorporating Trust values into everyday processes starting with recruitment*	EXISTING
Focus on Customer Care	*Customer service training and heightened profile for 'Friends and Family' feedback*	EXISTING
Patient Stories	*Establishing a catalogue of patient stories - positive, negative and mixed - for use in training*	EXISTING
Physical frailty and cognitive impairment - volunteering and advocacy	*Focus on the contribution of volunteers and formal advocacy services*	NEW PROPOSAL
Junior Buddies	*Enhanced communication and understanding between junior staff from different professional backgrounds*	NEW PROPOSAL
Domain: Improving through Peer Review		
Peer review inspection	*A comprehensive programme of internal peer review, involving patients and carers, based on Keogh / CQC model*	NEW PROPOSAL
Domain: Leadership Development		
Clinical Leadership Programme – *Safe in our hands*	*Leadership development programme for ward managers (sisters and charge nurses) and equivalent*	EXISTING
Healthcare Support Workers' Academy	*Induction and training for healthcare support workers*	EXISTING
Engaging with Clinical Leads and new Consultants	*Programmes aimed at supporting and developing these two important groups of medical staff to support cultural change*	NEW PROPOSAL
Emerging Leaders	*Programme aimed at developing service improvement skills of emerging leaders in a multi-professional setting*	NEW PROPOSAL
Domain: Empowering Staff to talk about Quality		
Schwarz Rounds	*Adoption of a standardised approach to debriefing and learning following adverse clinical events*	NEW PROPOSAL
Quality Comms – the interface between clinicians and corporate teams / functions	*Improving the accessibility of corporate level expertise for clinical services*	NEW PROPOSAL
Preceptorship for newly qualified nurses	*Assist new staff in making transition from student to qualified professional*	EXISTING
Safer Care associated with Surgery – Quality Account	*A programme of work aimed at improving the safety of surgery*	EXISTING
Domain: Using and sharing information		
Raising the profile of Clinical Outcomes including avoidable mortality	*Development of clinical outcome review group and enhanced focus upon the review of deaths to identify opportunities for improvement*	EXISTING
Raising the profile of staffing establishment levels	*Development of a system in order that information on the number of clinical staff are held in an agreed and format and shared openly within the organisation*	NEW PROPOSAL
Measuring Medical Engagement	*Use of the Medical Engagement Scale for assessment and monitoring*	NEW PROPOSAL
Domain: Openness and learning when things go wrong		
Transforming Complaints	*Review the way in which complaints and complainants are handled and valued*	EXISTING
Clinical Risk Management and Local Triangulation	*More effective learning through collation of the findings of patient feedback and clinical risk investigations at service level*	EXISTING
Staff experiences as patients	*Facilitate staff in giving feedback to colleagues as to their own experiences of healthcare in a supportive environment*	NEW PROPOSAL
Exit Interviews	*Consolidate work being undertaken to perform and learn from exit interviews*	EXISTING

This page is intentionally left blank

Oxford Health FT Response to the Robert Francis Inquiry for Oxfordshire OSC.

Review of progress following the second report of the Francis Inquiry (February 2013)

1. Application of Francis Inquiry findings to Oxford Health Foundation NHS Trust

Oxford Health FT provides a range of integrated mental health and general community health and social care services to people of all ages in Oxfordshire, mental health and social care services for all age groups in Buckinghamshire, specialist mental health services for the Thames Valley and children and young people's mental health services across five counties.

The second Francis report into the wider system failings associated with the events at Mid Staffordshire Hospital made the two following recommendations:

All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;

Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;

2. Overall findings of the Inquiry

The events at Mid Staffordshire were related both to specific failings associated with the way in which the organisation was functioning at that time; and to flaws in monitoring, communicating and addressing concerns within the wider system.

Specific criticisms within the report included:

- A lack of Board awareness of the reality of the way in which care was delivered in the organisation and experienced by patients and those close to them.
- Tolerance of poor standards of care (with stories of "appalling" provision of care).
- A focus on targets, finance and the FT application to the detriment of quality and safety.
- Little attempt to collect or review quality data in a systematic way.
- A focus on positive information and a failure to respond to information which suggested a cause for concern.
- Failure to remedy long standing deficiencies in staffing and governance.
- A lack of transparency and openness about issues and concerns.
- Failure to deal effectively with complaints and serious incidents.
- No culture of listening to patients and those close to them.
- Failure of external agencies to communicate and to tie together a range of information which suggested serious issues with the safety and quality of care being delivered at the Trust.

3. Our approach in Oxford Health FT to delivering quality and minimising harm

In line with a number of other NHS organisations Oxford Health FT has looked in detail at the findings of both Francis reports. We have analysed the ways in which the organisation proactively minimises the extent and impact of safety and quality issues in the standard of care provided. Part of this process involved a Board level review of the key findings and recommendations, this took place in three seminars, one with the whole Board , the Senior Management Team and Governors Council supported by a series of meetings with staff across the organisation.

Our approach to fully embrace the Francis report and its recommendations is to focus forwards on the integrated care we are currently providing to patients in 2013 including imminent plans to remodel our services to improve the integration of health and social care and improve outcomes and experience for patients; rather than to look back at the unfortunate set of events in Staffordshire occurring between 2005-9. We are planning our future with these key lessons identified by Robert Francis in mind.

Our Trust's core purpose is to ensure patients have a positive experience of care whilst enhancing outcomes, recovery and quality of life through services which aim to be caring, safe and excellent. We are taking full advantage of the opportunities to integrate physical and mental health care to produce better outcomes for patients as an integrated community and mental health service provider in Oxfordshire and in partnership with other stakeholders in Buckinghamshire, Swindon, Bath and NE Somerset.

There are some important principles which underpin our Trust's approach to quality and safety, which take account of the recommendations from the Francis Report namely:

- Strong Board engagement with and oversight of the safety and quality of care being delivered by the organisation.
- Placing patients and quality at the heart of decision-making.
- Fostering a culture of openness and transparency.
- Proactively soliciting feedback from staff and patients.
- Responding quickly to concerns and issues.
- Timely investigation of serious incidents.
- Full compliance with CQC Outcomes and Inspections. To date we have had four formal inspections of the John Hampden Unit, Bullingdon prison, Wintle Ward at the Warneford and Littlemore Mental Health Centre. We have responded and met the Minor concerns which were raised in two inspection reports at the Warneford and Littlemore.

A clear oversight of the quality and safety of care is reviewed proactively in a number of ways:

We hold an expectation that clinical staff are responsible for the quality of care being delivered to patients by themselves or their team members, understanding about what to do if they have concerns which they cannot address. Being caring, compassionate, person centred and evidence based is a standard expected of all staff. Significant resources are committed to training staff and percentages of staff trained in personal and professional education is high. We aim to maximise engagement in the persons own care and recovery which are fundamental and we are focussing on achieving the right clinical outcome for the person first time ,together with zero tolerance of harms. Individual patient feedback in every team at regular intervals also occurs.

We have developed a range of standards and measures with patients and staff to audits to check engagement, safety, outcomes and experience to underpin this proactive approach, and we are developing this in detail within each team this forthcoming year.

In the event of anything untoward happening ensuring a culture of reporting and acting immediately on service quality issues is in place underpinned by a developing culture of learning .Staff discuss local issues, incidents and concerns in team meetings and in regular management and clinical supervision sessions. These feed in to service level team meetings which review these issues across a number of services/clinical areas, and these are discussed in turn within the divisional safety and governance meeting. Risks to quality and safety are captured in the local and divisional risk registers and are managed or escalated as appropriate.

Our Trust has a formal governance structure organised around key safety and quality agendas – this is being reviewed to ensure it continues to provide a dynamic risk management process, aligned with rapid and robust reporting and monitoring of the quality and safety of the care delivered by our staff.

We have quality systems that capture this information at team level through a number of key measures which are reported both monthly and quarterly, including:

- The safety thermometer- this is a national measure of four patient harms including pressure ulcers, urinary tract infections, falls and VTE.
- Productive ward measures- a range of clinical standards, staff utilisation metrics and patient and staff experience feedback.
- Essential standards of care audit- in our mental health inpatient wards monitoring quarterly basic standards of care.
- Key performance indicators set nationally and locally by our CCG and Local Authority colleagues.
- Safer care collaborative measures-include a range harm reduction measures and uses improvement science to reduce prevalence.

- Friends and family test- this is a national question that is asked in all acute hospitals and community hospitals including urgent care services.
- Regular clinical audits- an annual programme is agreed with commissioners and the Board.
- Incident reports- frontline staff report potential or actual harms so immediate issues can be addressed which are reported through to the national reporting and leaning system.
- Patient Experience feedback collected through a programme of surveys.
- Complaints and PALS reports in all clinical teams.
- The Quality Account- which has been reviewed by the OSC Committee on an annual basis.

Oxford Health FT's annual Quality Account was developed in collaboration with our staff, the Governors and service user representatives and was submitted to the OSC. This document draws together a range of safety and quality indicators and measures, as well as qualitative examples of the standards of care delivered to patients and those close to them. This is reported to all stakeholders with a half year update and is in the public domain through our website .

Looking forward, improved dedicated safety and quality dashboards are being developed to pull together key measures which will be available at a ward/service level as well as across the whole Trust. Our aim is for all staff to have access to this information on a daily basis.

We emphasise the importance of patient involvement and feedback as a key component of quality care. Patient views are solicited in a variety of ways in our diverse patient population through "have your say" community meetings for inpatients; patients councils; patient satisfaction surveys; essential standards of care audits; friends and family test; and through PALS surgeries and formal complaints. We publish through our Board reports what patienst have told us about their experiences of care- good and poor in our Quarterly report to the Board and Governors Council .

We have had a longstanding incident reporting and serious incident investigation process. Compared with national data we are in the median range for similar Trusts for reporting incidents. Staff are actively encouraged to report all and any patient and staff safety incidents and these are all reviewed on a daily basis by the health and safety team. Serious incidents are subject to a detailed root cause analysis investigation which is overseen by senior clinical staff. Serious incidents are only closed following a review by the Clinical Commissioning Group. The implementation of recommendations is reviewed on a weekly basis and learning events are co-ordinated across our Trust to share learning and best practice.

4. Improving the culture of care – developing staff and a patient safety culture

Oxford Health FT aspires to ensure outstanding care is delivered by outstanding people. This ambition is supported by objectives we have framed in our Quality Account 2013/14 having taken account the Francis Recommendations. These have already been shared with OSC which include:

- Values based recruitment for undergraduates and developing this approach for all employees.
- Development of clear standards to define and measure care.
- No tolerance for poor standards of care and a rapid response where substandard care is considered to be identified.
- Developing a new Strategy for Caring, and establishing a process to test this.
- Effective multidisciplinary teams – Aston Teamwork embedded.
- A development programme for Effective clinical leadership in all teams.
- Commitment to the NHS Constitution - Staff Charter.
- Strong professions who uphold standards of professional practice in every clinical contact and staff actively pursue their on-going professional development.
- A strategy for the professions particularly nursing, including effective nurse leadership in ward areas and review of staffing levels in inpatient wards.
- Remodelling of services to provide more integrated models of care for all patients. This is already in place for children and young people and is going through a process of discussion and agreement with key stakeholders for adults and older people with distinct pathways being agreed to standardise and reduce variation and improve quality
- Within the remodelling of services particular attention to strengthening clinical leadership at the point of care and work on staffing levels is part of this work. We have undertaken a detailed review of staffing within the last two years in Community Hospitals. Within the mental health inpatient re-modelling we are looking at the number of patients and type of conditions requiring inpatient care and the levels of staffing required to effectively care for patients including further strengthening the range of health and social care services we provide out of hospital to prevent avoidable admissions to hospital in community and mental health settings.
- Working collaboratively with staff to embed a patient safety culture in all areas of the organisation.
- Public Board meetings and publication of all non- confidential Board papers to ensure the Trust is transparent and open to scrutiny. Over the next year reporting the quality of each service line detailing the safety, clinical outcomes and experience

5. Quality and safety improvements

Oxford Health is undertaking a substantial remodelling programme to provide integrated health and care services involving a complete review of current service provision. This change programme will deliver:

- Patient centred care and improved patient safety.
- Services designed along pathways of care (for example, services for adults , and older people with distinct care packages that follow the patient journey based on the National Institute for Clinical and Care Effectiveness public health and treatment guidance and standards.
- Integration of care (for example, services for children) and improved links with primary care.
- Care closer to home.
- A greater emphasis on outcomes based commissioning and patient reported outcome measures (PROMs).
- Enhanced and strengthened clinical leadership.
- Enhancing our care environments. A substantial capital programme will be completed in the winter of this year to deliver a purpose built centre in Aylesbury, the Whiteleaf Campus which will include acute inpatient units and will house local community mental health teams for north Buckinghamshire . We are also investing in enhancing our older estate at the Warneford and Littlemore Hospitals in Oxfordshire, and Marlborough House in Milton Keynes. Our purpose built regional centre for children and young people at Highfield on the Warneford Hospital site is a service for young people needing inpatient care opened in January 2013. We have just taken possession of the Community Hospital estate from the dissolving Oxfordshire PCT these will be developed into integrated care hubs in the future, starting with the recent development of the Emergency Multidisciplinary Unit in Abingdon Community Hospital with an extended range of community services such as hospital at home which are starting to provide alternatives to attendance at A and E for older and frail patients who may otherwise need to go to OUH.

In addition the Trust is supporting a number of local quality and safety projects and programmes, including the Productive Ward programme and the Safer Care (collaborative) programme.

The productive ward programme works with local ward teams to release more time to care through a review of working practices, provision of timely and up to date information on the safety and quality of care, and a rapid response to issues or incidents.

The South of England Safety Collaborative aims to reduce harm to patients using community and mental health services by focusing on improvement on:

- Senior leadership for safety.
- Safe and reliable delivery of mental health services.
- Getting medicines right.
- Improving physical care of patients.

We have also worked with 70 Teams using the Aston University team based working approach to improve the effectiveness of these teams. We are planning to roll tis out to all teams.

6. Summary

This paper is intended to be background briefing for the presentation and discussion we will be having in the forthcoming Committee. We have given careful consideration to the Francis Recommendations and we have a forward facing response to ensure and assure patients, carers, the public and our staff that the care we aspire to deliver is caring safe and excellent for all who use our services and work within them.

This page is intentionally left blank

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT VI

Reporting on 2011-2013
Recommendations for 2013-2014
Produced: May 2013

Foreword:

This is the 6th Director of Public Health Annual Report for Oxfordshire. It is also the first Annual Report produced since Public Health returned home to Local Government.

What is the purpose of a Director of Public Health's Annual Report?

The purpose of a Director of Public Health is to improve the health and wellbeing of the people of Oxfordshire. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population in Oxfordshire and by making recommendations for improvement to a wide range of organisations.

Producing a report is now a statutory duty of Directors of Public Health and it is the duty of the County Council to publish it.

The Director of Public Health's Annual Report is the main way in which Directors of Public Health make their conclusions known to the public. This helps the Director of Public Health to be an independent advocate for the health of the people of Oxfordshire.

The Annual Report:

- Is Scientific
- Is Factual
- Is Objective
- Focuses on long term gaps
- Makes clear recommendations

Public Health – everyone's business

Good health and wellbeing are not created in a vacuum. Good health is closely related to a wide range of factors such as employment, quality of neighbourhoods, quality of schools and having a part to play in society. These factors are, in turn, linked to issues of housing, skills and employment and all contribute to the general economic prosperity of the County. **In addition, to make a difference, it is necessary to focus on the same topics for a number of years to make sustained change.**

For these reasons, the recommendations made in this report are long-term and wide-ranging and are not confined to traditional areas such as health services and social care.

What Priorities are Highlighted In this Report?

The six main long-term challenges to long-term health in Oxfordshire are:

- An ageing population – the "demographic challenge"
- Breaking the cycle of disadvantage
- Mental health and wellbeing: avoiding a Cinderella service
- The rising tide of obesity
- Excessive alcohol consumption
- Fighting killer infections

These topics are dealt with one by one. The current issues and recent action are laid out and progress will be monitored in future reports.

Within these topics there is a particular emphasis in this report on 3 issues:

- Health in rural areas
- Loneliness as a health issue, and
- The increase in residents from minority ethnic groups

Your comments are welcome as long-term success will depend on achieving wide consensus across many organisations. Please direct comments to: andrea.taylor@oxfordshire.gov.uk .

Many people have helped to produce this report. It would have been impossible without them. They are acknowledged at the end of the document.

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam

Director of Public Health for Oxfordshire

May 2013

Contents

Foreword: 2

Contents...4

Chapter 1 – The Demographic Challenge 5

Chapter 2 – Breaking the Cycle of Disadvantage - New Opportunities: New Challenges 14

Chapter 3 – Mental Health: Avoiding a Cinderella Service 31

Chapter 4 – The Rising Tide of Obesity 34

Chapter 5 – Alcohol - what's your poison? 37

Chapter 6 - Fighting Killer Diseases 40

Acknowledgements 48

Chapter 1 – The Demographic Challenge

The increasing number of older people living in Oxfordshire remains both a blessing and the number one challenge for our health and social services. The 2011 census gives us a clear picture of the continuing increase in the number of older people in the County.

Many older people live healthy lives and need little help from local services, however, when people do need help; we need to ensure that it is available, at the right time and in the right place. Our services are becoming more responsive to the needs of older people, but there is still a way to go. Because there will be an increasing number of people needing care in the future, that care has to be both effective and affordable.

What should we do about this? We should do 3 things as a priority:

1) **We should join up health and social care** to align our priorities and give people a smooth passage through our services. This includes investing in prevention, joining up NHS services and social services, keeping people out of hospital and getting people home as quickly as possible.
2) **We should re-shape services to put people in the driving seat of their own care**. This includes making direct payments to people for care and giving 'expert patients' programmes a boost.
3) **We should help people and communities find their own solutions**. This includes finding new ways to help people help themselves and find new ways to support those who help them, notably family, friends, communities, faith groups and the voluntary sector.

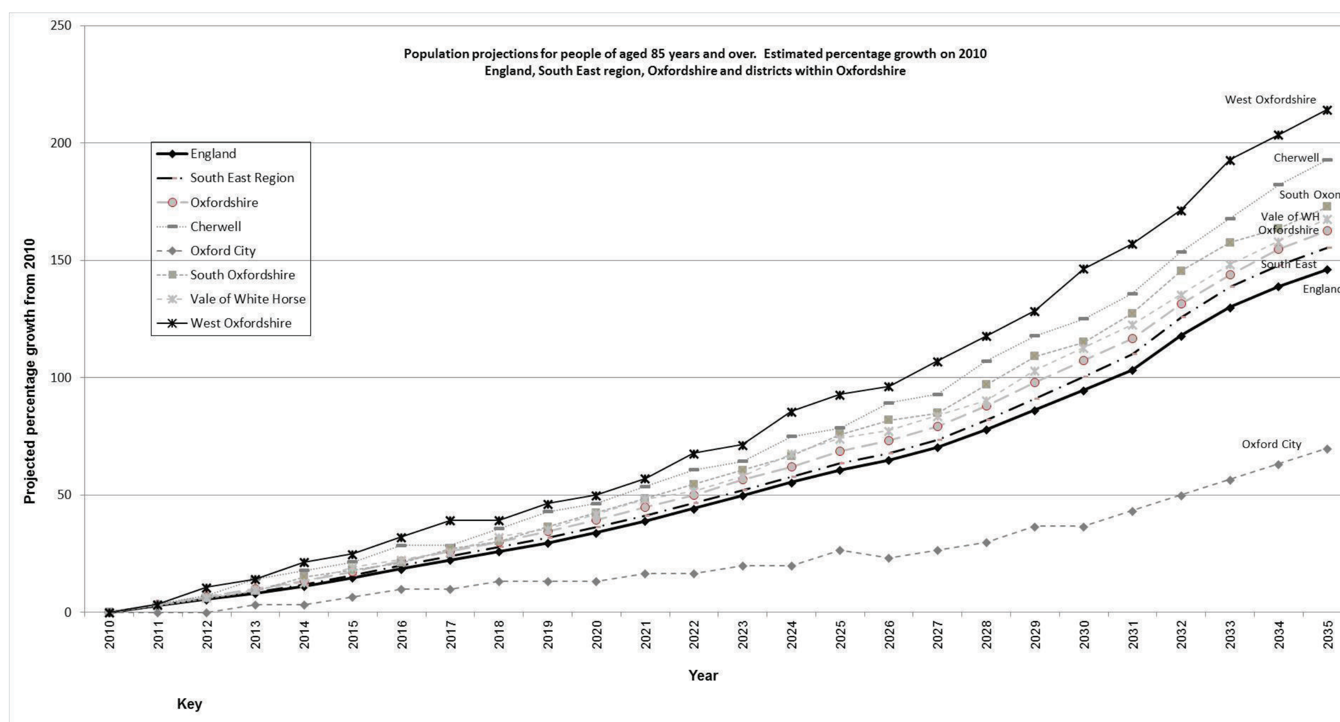
Much work is already underway on the first two of these topics and so this chapter will focus on the third, namely, **helping people find their own solutions**.

But first, let's take a look at the new census data in more detail because it gives us an up to date picture of the situation we face.

What does the new census data show?

The new data tells us important things about three topics: **population growth; rurality and loneliness**. These are all important if we want to help people and communities find their own solutions. The facts are summarized below, beginning with population growth.

The chart overleaf shows the new predictions of the increase of people aged 85+ in the County overall and its five Districts.



Office for National Statistics (ONS) Subnational Population Projections

This shows that:

- Overall, Oxfordshire's population is ageing faster than the national average.
- Ageing across the County is far from uniform. West Oxon and Cherwell will 'age' faster than the rest of the County.
- The City shows a fundamentally different picture with a much lower increase in numbers of older people.

The stark differences are highlighted in the table below which shows the percentage change in people aged 85+ comparing data for 2001, 2011 and predictions for 2035 for the County and each District.

Area	**Number of People over 85 in 2001**	**Number of People over 85 in 2011**	**Number of people over 85 in 2035**	**Increase in people aged over 85 from 2001 – 2011 (%)**	**Increase in people 85+ from 2011 to 2035 (%)**	**Increase in people 85+ from 2001 to 2035 (%)**
Oxfordshire	**11,277**	**14,683**	**39,400**	30%	168%	249%
Cherwell	**2,140**	**2,819**	**8,200**	32%	191%	283%
Oxford	**2,454**	**2,697**	**5,100**	10%	89%	108%
South Oxfordshire	**2,556**	**3,375**	**9,000**	32%	167%	252%
Vale of White Horse	**2,121**	**3,052**	**8,300**	44%	172%	291%
West Oxfordshire	**2,006**	**2,740**	**8,800**	37%	121%	339%

Office for National Statistics (ONS) Subnational Population Projections

This shows that, comparing 2001 and 2035:

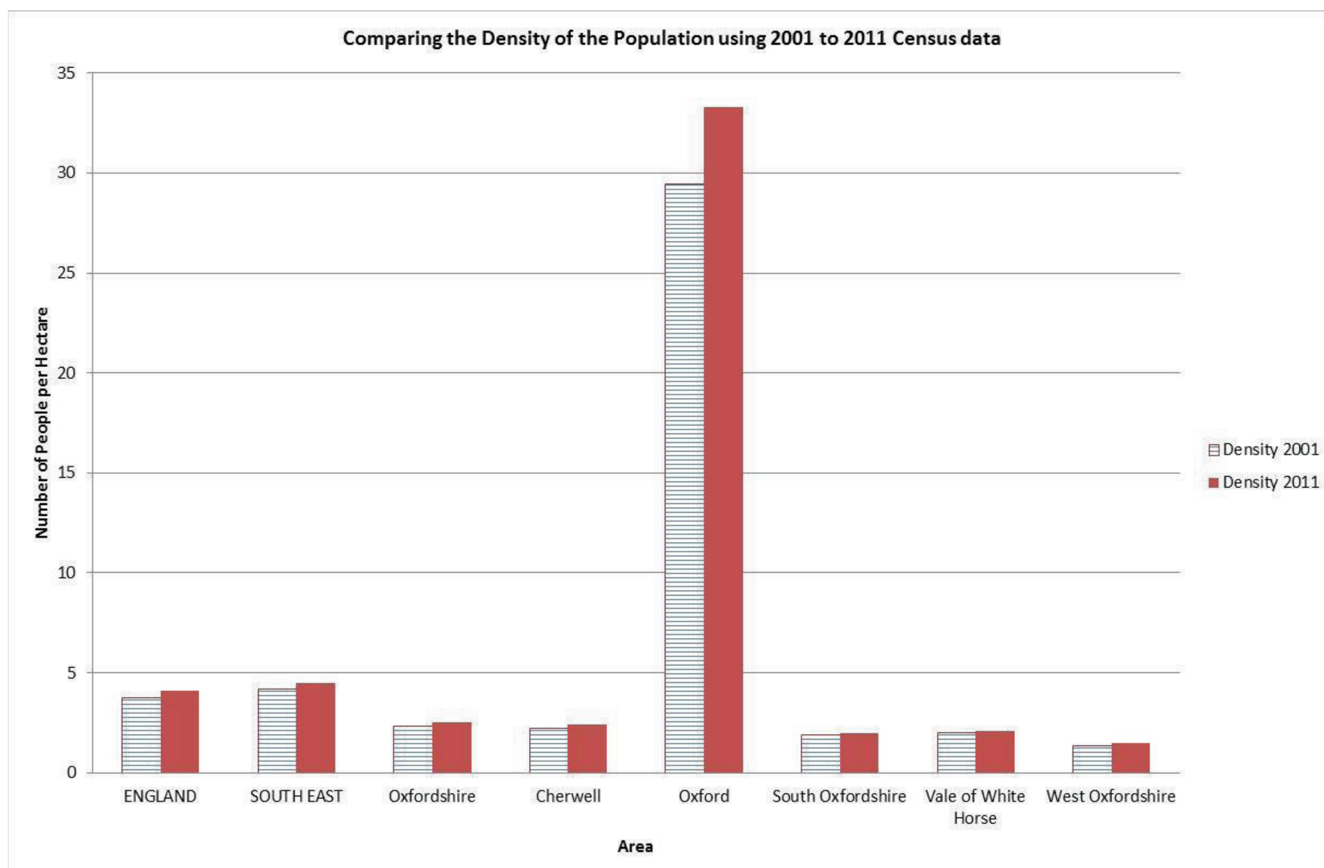
1) There will be more than three times as many people aged over 85 in the County.
2) There will be more than four times more in West Oxfordshire
3) There will be around double the number in the City.

Rurality and the over 85's

The more rural Districts of the County will experience the greatest increase in the over 85s over the coming decades. This is important because:

- Access to services is generally poorer in more rural areas
- Older people in rural areas are spread out and will be at more risk of isolation
- Each rural community is different across the County – if we want to support communities to help themselves, this means we need to find ways that are flexible enough to support 100s of different solutions.

Statistics for population density (i.e. people living per square hectare[1]- which is about 2 ½ acres) give a useful measure of rurality. Overall figures for Oxfordshire are given in the table below and show stark contrasts.



Office for National Statistics (ONS) Census 2011

[1] The **hectare** is a metric unit of area defined as 10,000 square metres (100 m by 100 m), and primarily used in the measurement of land. A hectare of land is 2.47 acres.

The chart shows that:

- Oxfordshire is much more rural than England and the South East Region with about half the Region's population density.
- Within Oxfordshire there is a massive difference between the City and the other Districts. People in the City are more than 10 times more 'densely packed' (around 33 people per hectare) than in other parts of the County (County average is 2.5 people per hectare).
- Population density for Oxford City (excluding the more rural parts of Wolvercote and Marston) is 39 people per hectare.
- West Oxfordshire is the most rural District with a population density of 1.5 people per hectare. However it is no longer the most rural area in the South East, this honour has been claimed by Chichester.
- Even the presence of Banbury and Bicester in Cherwell District do not raise the population density above 2.4 people per hectare.
- However looking at the wards that make up Banbury and Bicester shows that Banbury has a density of 37.6 and Bicester 40.2 people per hectare which are about the same as Oxford City.

This means that:

- We need to be flexible enough to design services in different ways in different places
- Better still, we need to be flexible enough to allow local people to design their own services in their own way in different places
- Services in the City will need to be very different from the more rural parts of the County because the age structure, population density and needs are markedly different.
- Partnership work between the County Council and Districts and Clinical Commissioning Group localities will need to be flexible. – **There is no 'one size fits all' solution for Oxfordshire.**

Loneliness and older people

Loneliness is becoming a topic of increasing concern. Loneliness can happen anywhere, in both rural and urban communities, but older people living in greater isolation in more rural parts are more at risk. Recent research and a recent conference held in Oxfordshire under the auspices of Age UK pointed out that loneliness is a "hidden killer", increasing the risks of death in elderly people by 10 per cent. Those who are lonely have a higher risk of heart disease and blood clots as they tend to adopt a more sedentary lifestyle, exercise less and drink more alcohol.

Loneliness has a wide range of negative effects on both physical and mental health. Some of the health risks associated with loneliness include:

- Depression and suicide
- Heart disease and stroke
- Increased stress levels
- Decreased memory and learning ability
- Poor decision-making
- Alcoholism and drug abuse
- Faster progression of Alzheimer's disease (dementia)

The impact of loneliness on mental health is well known but the impact on physical health is only just being understood.

We can get a handle on loneliness in older people by looking at the census data on people living alone who are aged over 65. The table below gives the figures:

Area	One person households aged 65 and over in 2001	One person households aged 65 and over in 2011	One person households aged 65 and over in 2001 – As a percentage of all households	One person households: Aged 65 and over in 2011As a percentage of all households
Oxfordshire	31,140	29,852	13%	12%
Cherwell	6,118	5,967	12%	11%
Oxford	7,415	6,049	14%	11%
South Oxfordshire	6,728	6,570	13%	12%
Vale of White Horse	5,738	5,947	12%	12%
West Oxfordshire	5,141	5,319	14%	12%

Office for National Statistics (ONS) Census 2011

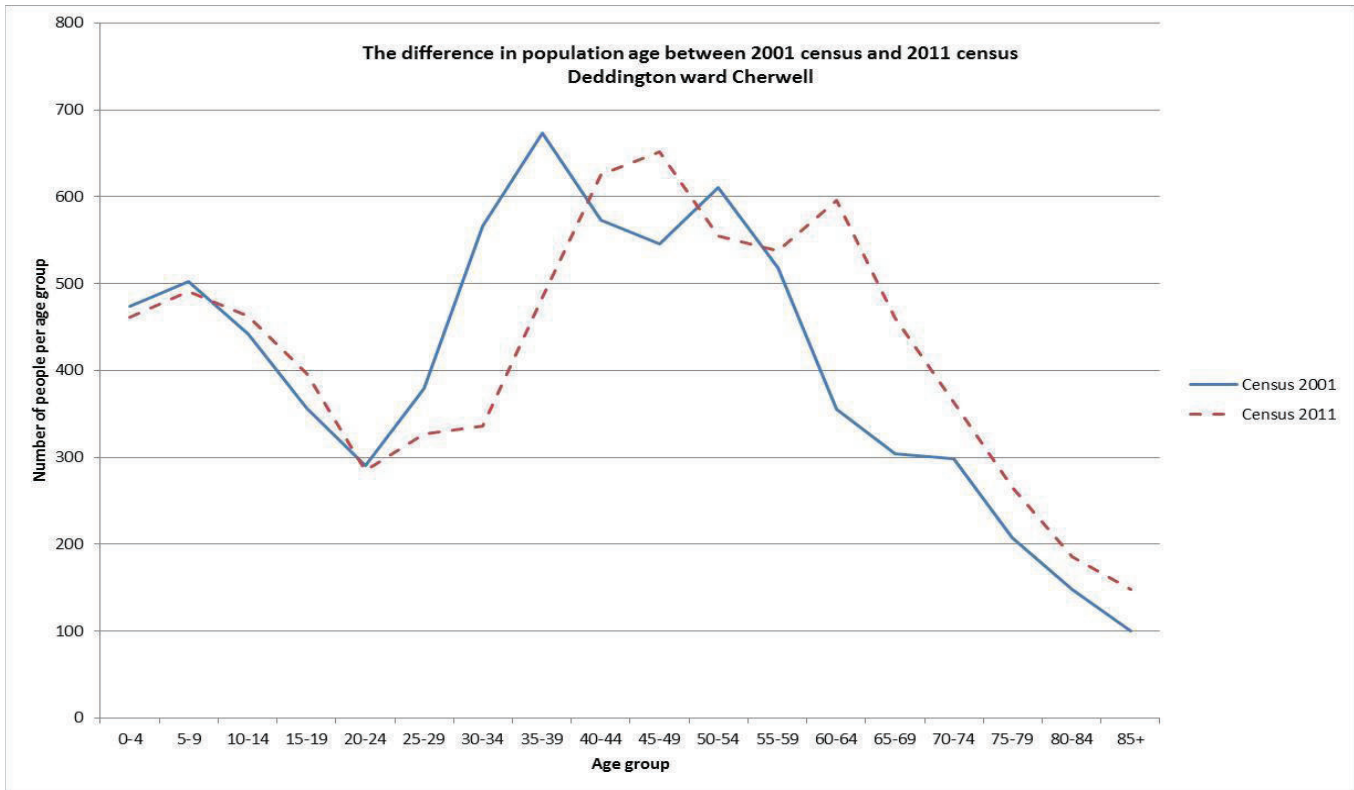
The data tells us that:

- Living alone in older age is a common finding. There are nearly 30,000 people over the age of 65 living alone **– that's about one in every 8 households across the County.**
- The percentage of older people living alone is about the same in rural and urban areas.
- The percentage has been fairly stable on average over the last 10 years at around 12% to 13%

Unfortunately we can't tell from census data what the figures for over 85s living alone are.
The implications of this are:

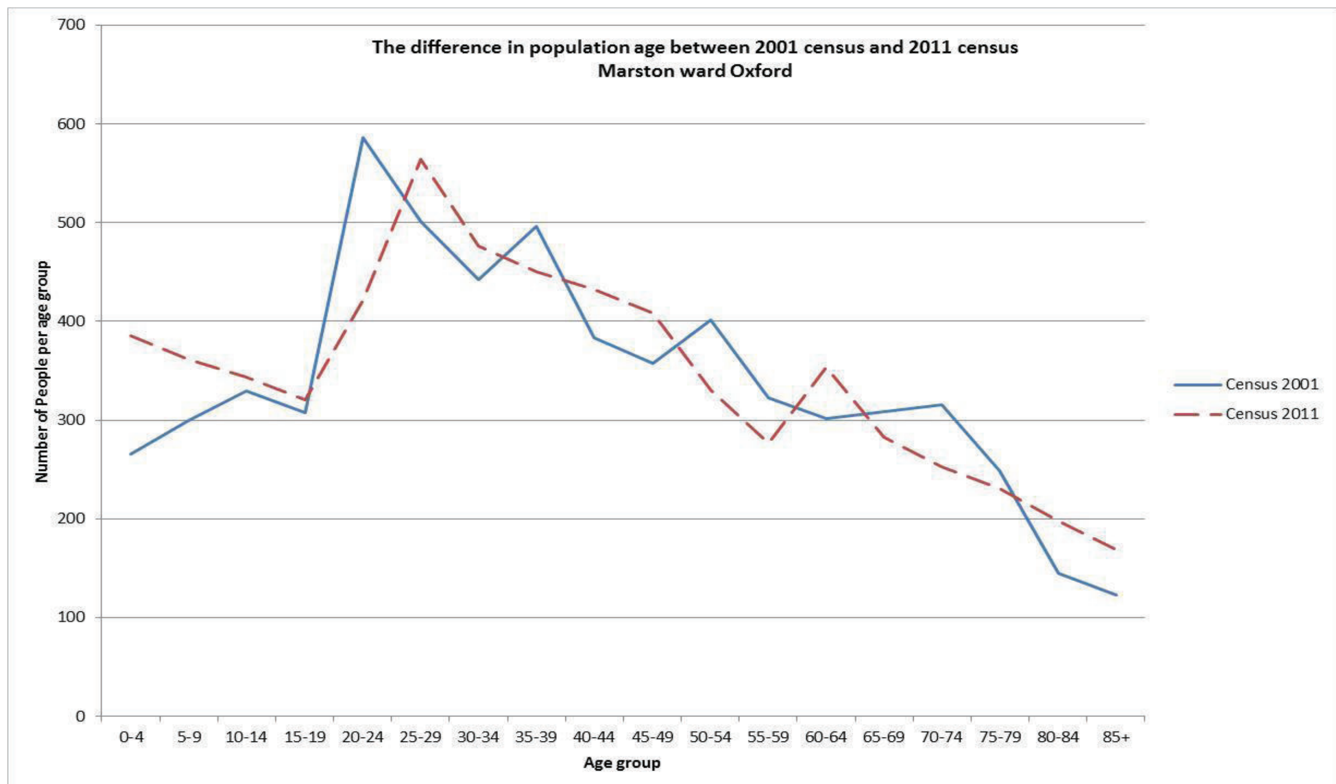
- We CAN use this data to give us a feel for helping to target those most at risk of loneliness.
- Services need to become more geared to recognizing loneliness as a risk factor for disease.
- Individuals and communities need to find ways to use their resources to combat loneliness and statutory services need to help them

As society changes, many of our most rural villages may become populated predominantly by older people with fewer children and young adults. This is the overall trend of the last 10 years. Take a look at the charts below. These show the 'ageing shift' that has taken place in many rural areas over the last 10 years. The blue solid line shows the population in 2001 and the red dashed line shows the population 10 years later in 2011. The more the line 'moves to the right', the more the population is ageing.



Office for National Statistics (ONS) Census 2001 and 2011

Contrast this with the picture in more urban areas. The two lines for Marston in Oxford City show very little difference – the population here is not ageing in the same way at all. Here the biggest feature is an increase in the number of children aged 0-4.



Office for National Statistics (ONS) Census 2001 and 2011

This means that, we need to plan differently in different parts of the County and find both 'rural solutions' and 'urban solutions'.

Once again it should be stressed that each rural community will be individual in its needs and individualistic in the way it finds solutions. The solutions will characteristically depend on the nature of the community and the willingness of its leading members to make a difference. The question is, "How can we best help them to do it?"

Implications
Putting the facts together about population growth, rurality and loneliness alongside a recession, a squeeze on public spending and the government's encouragement for local communities to help themselves to find their own solutions creates a powerful cocktail of factors which affect Oxfordshire deeply.
What does all this mean for policymakers, and what should public sector organisations do? Common sense suggests that we need to find new ways to **empower** the people of Oxfordshire to help themselves.

Empowering Oxfordshire
Local government is well placed to continue its traditional leadership role to empower people and communities to help themselves. The Clinical Commissioning Group, Faith Groups and Voluntary organisations have major roles to play too. What might this look like?
It means finding ways to encourage local people and local organisations to find their own local solutions, particularly in rural communities. This may mean promoting and spreading solutions such as community planning and time-banking, and making it easy for villages to own and run their own village shops. Identifying 'village agents' as a focus for some of this work is also a promising idea. Finding ways to harness the collective power of individuals, local societies, voluntary agencies, faith groups and philanthropists will be crucial if this is to work.

Recommending that we turn our attention towards 'Empowering Oxfordshire' is the main thrust of this chapter. What are the elements of this?

Empowering People
We need to exploit the full possibilities of new rules around making direct payments to people so that people can buy the services they need. We have already noted that this is well underway in Oxfordshire, but we may be able to extend this further and cut more red tape.
Linked ideas in the NHS about helping patients to become the experts driving their own care and owning their own records and care plans may also help. Getting people involved in service planning through our Public Involvement Networks and through the new 'Local Healthwatch' will be important too.

Empowering Prevention
It goes without saying that *'an ounce of prevention is worth a pound of cure'*. We need to make sure that older adults benefit fully from programmes such as bowel screening, which find disease early enough to treat, and flu jabs which directly prevent disease and disability.
We also need to 'mainstream' the prevention of loneliness as a direct means of improving health. This may mean that in the future, every visit to the local lunch club run in the local community becomes as important as a visit to the GP's surgery.

Empowering carers and volunteers.
Without the army of carers and volunteers at work in Oxfordshire, services as we know them would be unable to continue. Recent years have shown a welcome recognition of the work of carers and volunteers. We need to keep our foot pressed fully on the accelerator in terms of identifying and supporting carers and finding easy ways to recruit and encourage volunteering.

What we said last time
The last annual report was produced at a time of unprecedented upheaval in the public sector and was most concerned to keep the demographic challenge high on the agenda of the new Clinical Commissioning Group, the Health and Well-being Board and Public Involvement Network. The Health Overview and Scrutiny Committee were also encouraged to keep a close eye on proceedings.

These things have been achieved and the NHS and social services now work more closely together than ever before - **this is a major achievement.**
It is now time to add a new emphasis which picks up the theme as of an increasingly ageing population, loneliness and isolation particularly in our communities.

Empowering people and empowering communities and the voluntary and faith groups which support them to help themselves has now become the major gap we need to fill.

A final word on dementia.
Previous annual reports have highlighted the need to improve the recognition of dementia and to strengthen treatment services and the care of carers. This remains a priority. There is also a need to ensure that dementia is seen as part and parcel of mainstream health services as it co-exists with other physical illnesses. It should not be seen as solely a ‘mental health problem’.

Recommendations

One strategy: One pooled budget: One Plan
By October 2013:

- The County Council and the Clinical Commissioning Group should have implemented the agreement to create a genuinely pooled budget bringing together adult social care resources and community health resources
- The Health and Wellbeing Board should be re-designed to oversee the management of this resource.
- The use of this resource should be guided by a single plan formally agreed between Oxfordshire Clinical Commissioning Group and Oxfordshire County Council (as part of the Oxfordshire Older Peoples' Joint Commissioning Strategy).
- This plan should be driven by re-vamped outcome measures and targets agreed as part of the refreshed Joint Health and Wellbeing Strategy.
- The Health and Wellbeing Board should receive regular reports on how this money is used.
- The Health Overview and Scrutiny Committee should provide strict external scrutiny of these arrangements.

A coordinated approach to tackling Loneliness
By March 2014:

- Oxfordshire Clinical Commissioning Group, Oxfordshire's 6 Local Authorities, Age UK, Carers Representatives and other Voluntary and Faith sector partners should bring together practical proposals for tackling the issue of loneliness.
- This should build on the start made in The Oxfordshire Older People's Joint Commissioning Strategy.
- This work should be overseen by the Health and Social Care Board.
- Tackling loneliness should be a goal of the refreshed Joint Health and Wellbeing Strategy.

Chapter 2 – Breaking the Cycle of Disadvantage - New Opportunities: New Challenges

This County is committed to breaking the 'Cycle of Disadvantage', but what does this mean?
It means that we are determined to improve the life chances for our residents living in the areas of the County where disadvantage is passed down from one generation to the next.
The last year has been a year of new opportunities and new challenges.
The 3 main opportunities are:

1. The new 'Thriving Families' initiative
2. The work of the GP Commissioners' locality groups
3. The work of the Health and Wellbeing Board

The 3 major challenges are:

1. The changing ethnic minority structure of the County
2. The possible impact of benefit changes for those on the brink of homelessness
3. The need to guard against complacency and continue to monitor our bread-and -butter indicators of disadvantage

Let's take a look at these one by one:
The 3 Main Opportunities

Opportunity 1) The way in which we have picked up the 'Thriving Families' initiative and run with it.
The Government launched its 'Troubled Families' initiative in December 2011. The County Council adopted this as the more positive 'Thriving Families' programme and invested £1.6 Million into it to make it really fly. Working with partners, the aim is to identify the County's most needy families and give them a hand-up rather than a hand-out.

There are already important lessons to learn from the first 9 months of operation:
Lesson 1: It is only by persistently joining up the long term information held by all organisations like social services, police, NHS and probation that we find the families who need the help most. Individual agencies all have data, but it is knitting it together over the long term that counts. *This has never been done systematically before, and it is bearing fruit.*
Lesson 2: Local sources know best: Talking to the local schools and the local 'bobby on the beat' is a good place to start to piece together a local story
Lesson 3: The families we need to help are spread right across the County. **This approach is helping to identify families in both urban and rural settings. This is a real achievement. We have been searching for a way to find those most in need in rural areas for many years.** These families are too often 'hidden' when we look at data on a bigger scale. It means that we can help people based on their needs not on where they live.

The table below gives an early indication of where the families who need help the most might live.
Take a look at the column on the far right which shows how evenly spread these families are as a percentage of all 'families' in each District.

Area	Number of families tentatively identified so far	Number of families identified as a percentage of all households in the area
County	761	1%
Cherwell	208	1.2%
Oxford	229	2%
South Oxfordshire	122	1%
Vale of White Horse	108	1%
West Oxfordshire	94	1%

Oxfordshire County Council, Thriving Families Team

During the next year work will start to help families in earnest, aiming to make a measurable difference to their lot – watch this space.

Opportunity 2) The way the Clinical Commissioning Group is handling locality planning
The GP Commissioners divide the County into 6 localities. These map roughly onto the District Councils, with separate localities for Banbury and Bicester. Each locality has now started to make plans based on local needs. Some green shoots are beginning to show from this work, for example:

- In Banbury "equalities and access managers" are working with local practices to increase the uptake of cervical screening amongst ethnic minorities.
- Targeting advice on healthy lifestyles and screening programmes to areas of the City with worst health outcomes. This includes a weight loss programme for men called 'Footy Fitness at Oxford United'. Men can be referred by their GP during their NHS Health Check or can just turn up for the weekly weigh-in, advice and football fitness session.
- Encouraging smokers to pledge not to smoke at home or in the car so they can keep the air smoke-free for their children. This work is being targeted in both Banbury and parts of Oxford.
- Providing information and support to people from Asian backgrounds to identify diabetes and make sure they get the right help to manage their condition successfully.
- The 'Benefits in Practice' initiative which places benefit advisors in GP practices - new work in Hardwick and Horsefair surgeries has directed almost 100K to the families who need it most.
- Cooking skills courses in Banbury and in Barton. 17 courses took place in Banbury in 2012 and 247 people have participated from the start of the courses with good results such as reduced consumption of ready meals and takeaway meals and an increase in cooking from scratch and consumption of fruit and veg.
- Working with End of Life Care services to outreach into Black and Minority Ethnic communities and break down barriers to access these services and ensure that services provided are culturally appropriate.
- Working with new migrant communities such as Portuguese speaking communities and East Timorese community, to improve access to health services.

Opportunity 3) The potential for the Health and Wellbeing Board to bring things together.
The Health and Wellbeing Board has identified inequalities as a major theme, and reducing inequalities in life expectancy is one of its targets. It is also working to promote breastfeeding, reduce teenage pregnancy and raise educational attainment, all of which will help to reduce inequalities.

So much for the opportunities, the 3 biggest **new challenges** we face to break the cycle of disadvantage are:

Challenge 1 The changing ethnic minority structure of the County
Early data from the2011 census shows that the County has a substantially increased ethnic mix compared with 10 years ago. Of course, ethnicity doesn't necessarily equate with disadvantage, and the needs of different communities will differ widely – the needs of Polish, Lithuanian or Czech economic migrants are unlikely to be the same as a first generation Asian immigrant for example.
A real wake-up call was the fact reported in the press that:
"In Oxford nearly half of births (47%) in 2010 were to non UK-born mothers, compared to a national and County average of 26%."
Early indications show that the % of people in ethnic minority groups has risen in between censuses as follows:

Area	% of all ethnic minority groups in the 2001 census	% of all ethnic minority groups in the 2011 census	Number of additional people from ethnic minority groups between 2001 and 2011	% increase over the last 10 years in the proportion of ethnic minority groups in the overall population	% increase over the last 10 years in the ethnic minority population
Oxfordshire	**10%**	**16%**	**46,081**	**7%**	**57%**
Cherwell	7%	14%	9,527	7%	51%
Oxford City	23%	36%	24,006	16%	57%
South Oxfordshire	6%	9%	4,278	3%	65%
Vale of White Horse	7%	10%	4,624	4%	63%
West Oxfordshire	4%	7%	3,586	4%	54%

Office for National Statistics (ONS) Census 2001 and 2011

The headlines are:
- **An across the board increase in residents from ethnic minority groups of 57% on 2001 figures INVOLVINGEVERY DISTRICT IN THE COUNTY**
- **An increase of 46,000 residents** from all ethnic minority groups over the last 10 years
- **Over 1/3 of all City residents are from ethnic minority groups** and over 10% of all Cherwell residents.

The table below looks further ahead at predictions for the growth of Oxfordshire's BME communities up to 2051:

Area	People from All Ethnic Minority Groups in 2001	People from all Ethnic Minority Groups Predicted for 2051	% increase from 2001 to 2051
Cherwell	5431	17164	216%
Oxford	17528	44065	151%
South Oxfordshire	2762	11663	322%
Vale of White Horse	2837	8561	202%
West Oxfordshire	1593	7289	358%
OXFORDSHIRE	30150	88242	193%

Office for National Statistics (ONS) Census 2001 and 2011

Long term trends should always be treated with caution, but the headlines are:

- There is a predicted long term increase in people from BME communities across the County from 30,000 residents to almost 90,000. **This is a tripling of numbers predicted for the first half of this century.**
- Around half of these will live in Oxford (44,000)
- The whole County is involved.

There **WILL** be implications for the policies of all organisations in these figures, some minor and some major but it is too early to indicate yet what they might be. All schools, all public services and all employers will need to continue to adapt. We will need to unpack the more detailed census data as it arrives over the coming months, so this is very much an early indication to 'watch this space'

Challenge 2 To keep a weather eye on the impact of benefit changes for those on the brink of homelessness.

As a result of changes in the way welfare benefits are calculated and paid there may be a temporary or longer term impact on some of the more vulnerable people in our population. These changes have attracted much publicity nationally and the situation needs to be monitored with care. People with mental health problems are thought to be particularly vulnerable. Work is on-going in all Local Authorities to monitor these changes and we need to make sure we are able to respond if need be.

Challenge 3) The Eternal Need to Guard against Complacency

It is vital that we keep a close eye on our routine, well-established indicators of disadvantage. Following increased vigilance over the last 5 years, many of these indicators do show improvement….
However it is all too easy to let the situation slide, and we must not let this happen – the key lies in openly and honestly reviewing the data we have and reviewing it regularly – and *this* is what the remainder of this chapter will do.

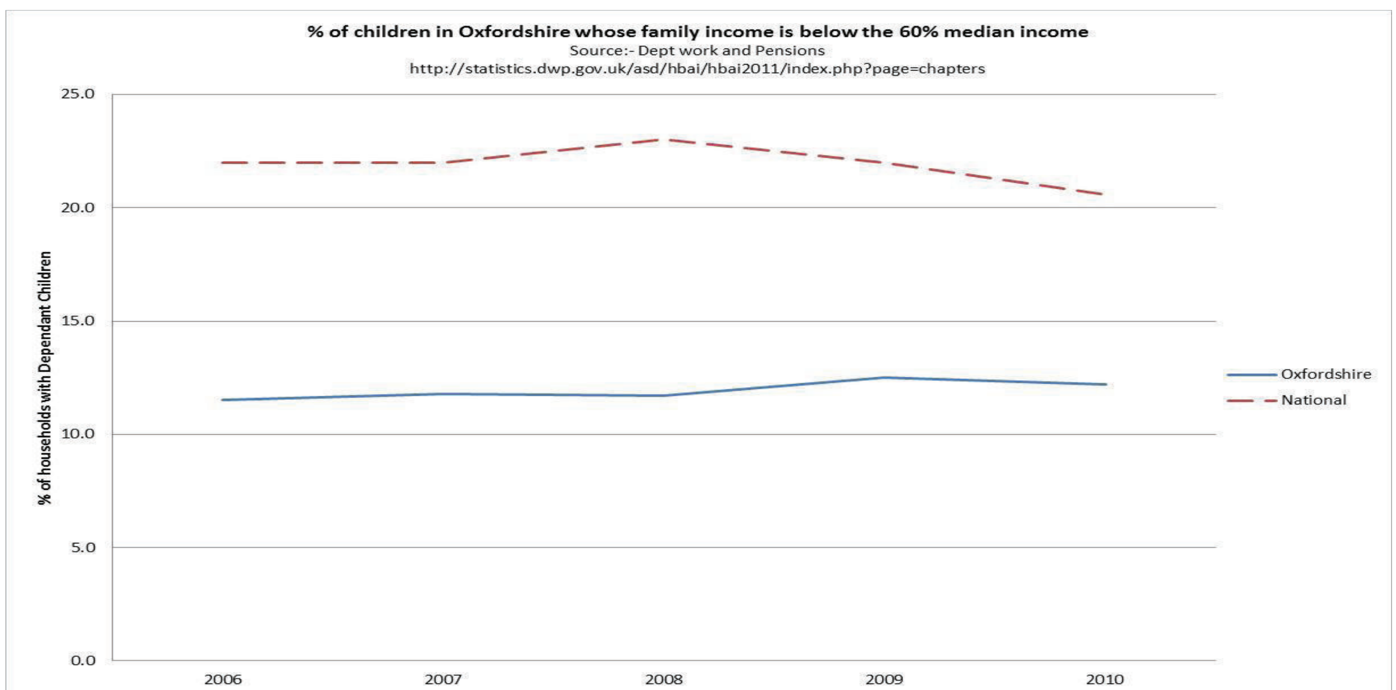
We will look at 8 key indicators in the remainder of this chapter.

Indicator 1 - Child Poverty

The County's Child Poverty Strategy shows that the number of children who live in Poverty in Oxfordshire fell slightly from the 2009 figure. In 2008 there were 15,660 children living in poverty. This jumped to 16,940 in 2009 and fell to 16,645 in 2010. These are children living in families who meet the government's definition of child poverty i.e. *'a child living in homes taking in less than 60% of the median UK income'*.

In November 2012, the average annual income was £26,500. The median national income is £565 per week and 60% of it is therefore £339 a week or £17,628 per annum.

There is a lot of debate about whether this is a good measure of poverty, but whatever the rights and wrongs, it does allow us to monitor progress and to compare Oxfordshire's performance with elsewhere. The detail is set out in the chart and table below:



Source: Dept of Works and Pensions, http://statistics.dwp.gov.uk/asd/hbai/hbai2011/index.php?page=chapters

The figures show that:

- Child poverty in Oxfordshire is way below national levels – almost 50% below.
  This is very good news but the County average does mask small areas where levels of poverty are high.
- The Oxfordshire figure is fairly static over time whilst nationally the data shows a reduction; we await more up to date data.

Because the spread is not even across the County we need to look at more detailed data at District level. Data on children living in households claiming out of work benefit gives the following picture from 2011:

Children living in Families who are claiming any Out of Work Benefit

Local Authority	Age 0-15	Age 16-18	Number of Households	% of all households in each District claiming out of work benefit	% of households with Children in each District claiming out of work benefit	Where families claiming out of work benefit live.
Oxfordshire	14,180	1,450	8,100	3.10%	10.7%	
Cherwell	3,350	330	1,950	3.40%	10.9%	24%
Oxford	5,000	520	2,730	4.90%	18.4%	34%
South Oxfordshire	2,150	210	1,260	2.30%	7.8%	16%
Vale of White Horse	2,090	230	1,210	2.40%	8.3%	15%
West Oxfordshire	1,590	160	950	2.20%	7.6%	12%

Snapshot data as at 31 May 2011, DWP using census 2011 household data
http://research.dwp.gov.uk/asd/asd1/ben_hholds/index.php?page=child_ben_hholds

This shows that:

- Around a third of all households in the County which claim out of work benefit live in Oxford (2,730 households out of 8,100) and around 1/4 live in Cherwell (1,950 families).
- Around 5% of all households in Oxford claim out of work benefit compared with between 2% and 3% in the other Districts
- There are 5 wards with over 200 families claiming out of work benefit, these are: Northfield Brook, Blackbird Leys and Barton and Sandhills in Oxford, and Ruscote and Grimsbury and Castle wards in Banbury.

The overall picture means that:

- Oxfordshire is very prosperous overall compared with the national average, and
- We *can* use data about children living in our worst-off households to target resources within the County

Indicator 2 - Unemployment Benefit Claimants.

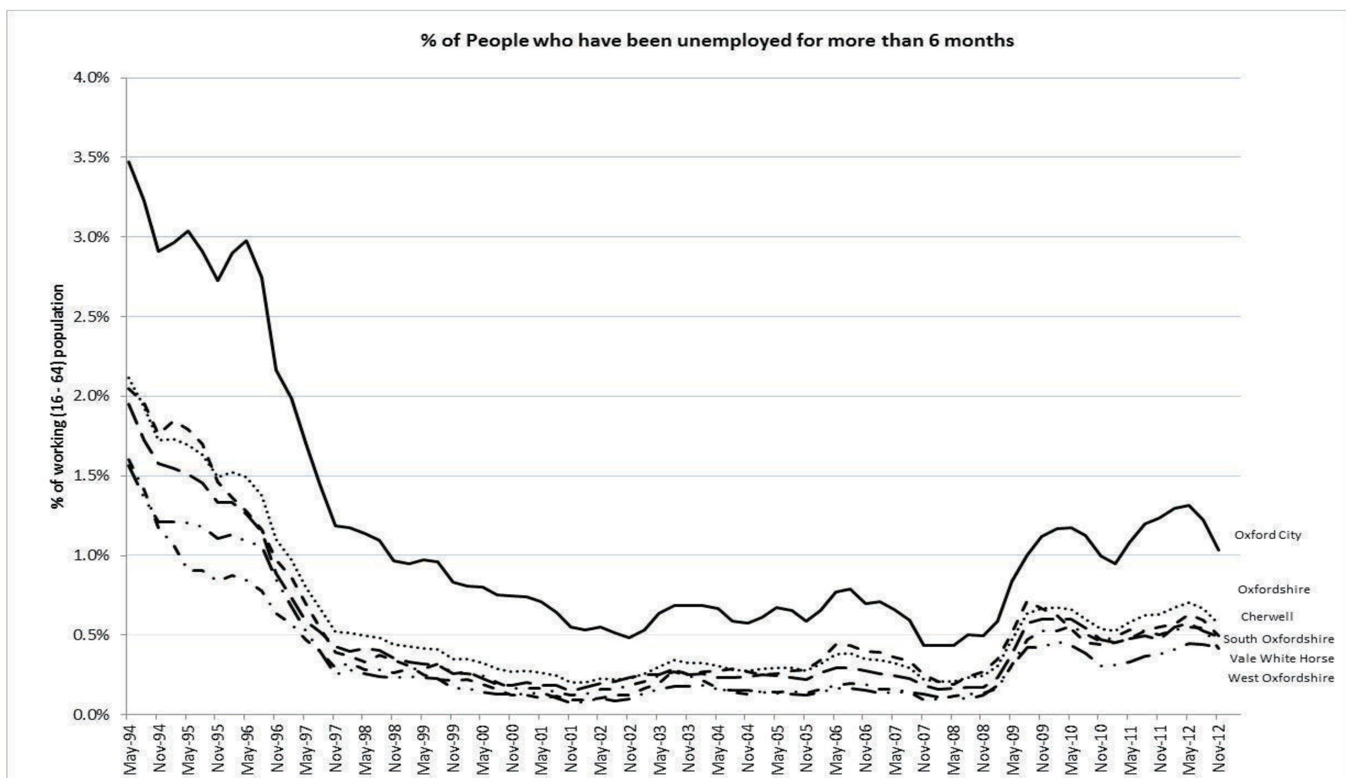
Research shows that being unemployed is bad for both the physical and mental health of those affected. Mental health impacts include:

- Increased levels of depression
- Higher anxiety levels
- Feelings of alienation from the local community and therefore lower levels of life satisfaction
- Low self-esteem

Physical health impacts include:

- Increased number of visits to Doctors
- Increased use of hospital beds
- Higher number of medications taken compared to working counterparts and poorer self-assessed health with an increased number of diagnoses
- Poor lifestyle choices which may include poorer diet, lack of physical activity increased use of alcohol and smoking

If we look at the percentage of people in the County who have been unemployed for more than 6 months we can see the following picture:-



Source: Office National Statistics, Regional Labour Market, March 2012.

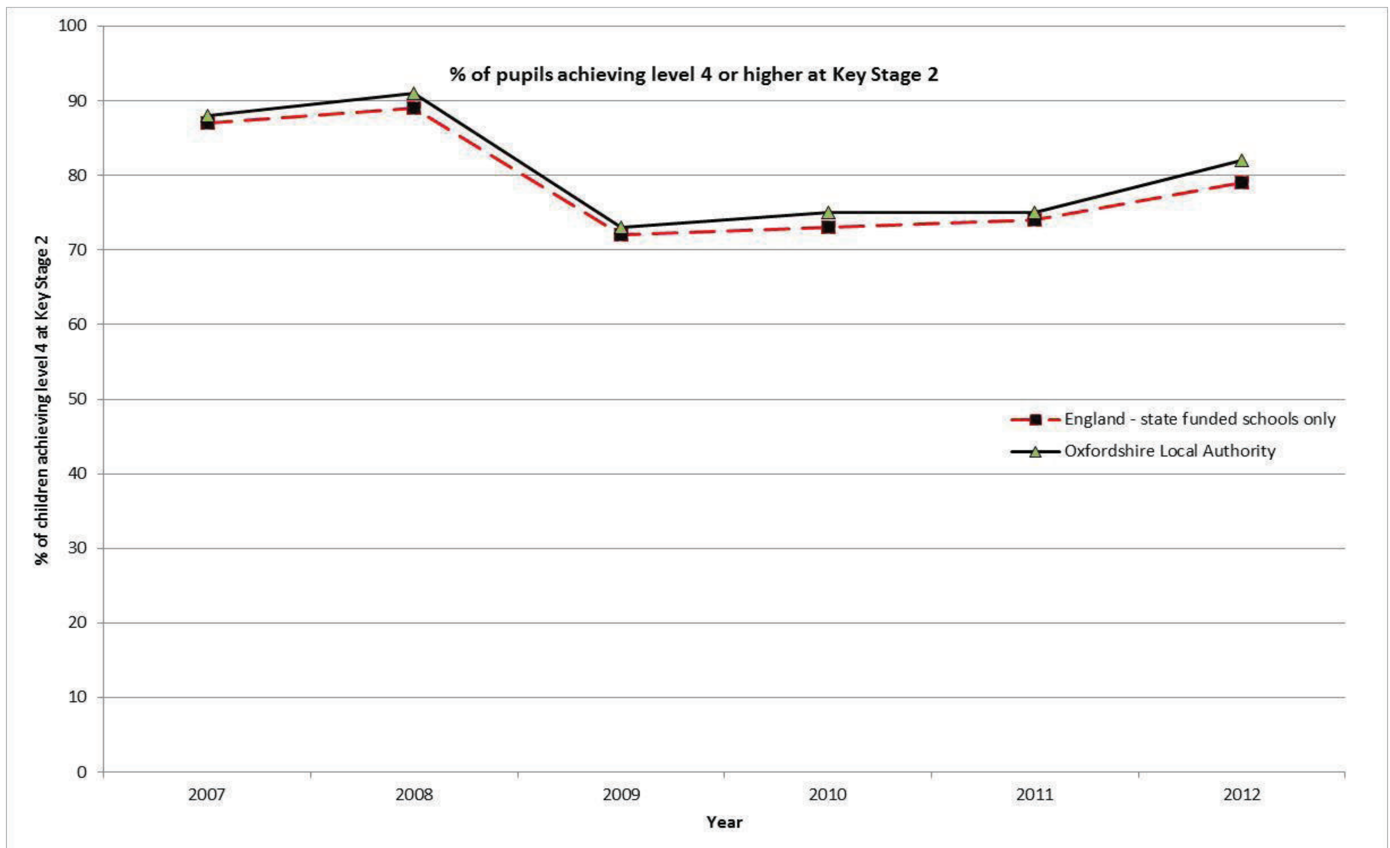
This shows that:

- The percentage of people unemployed fell sharply from a high point in the early '90s
- The county figures are well below the national percentage of 1%. Oxfordshire's unemployment rate is only half the national rate – which is good news. Oxford City's rate however is equal to the national average and double the County average.
- The numbers increased as a result of recession in 2009.
- The most recent figures show another welcome downturn.
- There is a marked difference across the County with a higher rate of long term unemployed people living in the City (around 1% compared with ½% in the other Districts).

Indicator 3 – Educational Attainment

Educational attainment in Oxfordshire has been a concern over the past few years, however, there is evidence that the hard work which has gone into this area is beginning to pay off. There is good news and not so good news and we must continue to focus on this topic.

The good news is that we are seeing improved figures in younger years, particularly key stage 2 (Children aged 7 – 11years old).



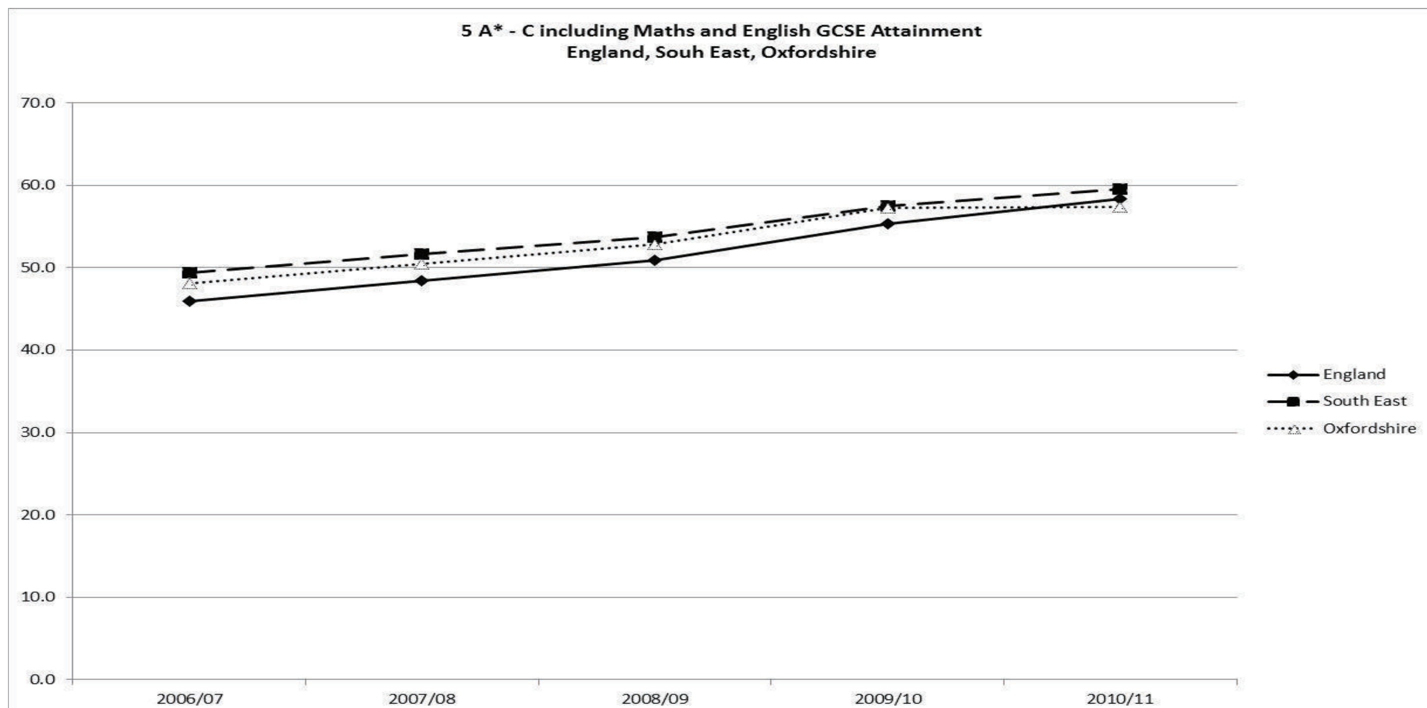
Source: - Department for Education, Statistics: GCSEs (key stage 2).

The chart above shows that Oxfordshire are outperforming England at Key Stage 2 (i.e. children aged 7) and a clear gap is opening up. **This is good news.**

Whilst we are beginning to see the fruits of our labours in these early years, there is continued concern however about GCSEs which has already been widely reported.

A principal concern relates to pupil progress from key stage 2 to key stage 4. Data shows that certain groups of children and young people perform particularly badly, for example those in receipt of free school meals and other vulnerable groups such as children in care. Steps are being taken to address these areas of concern

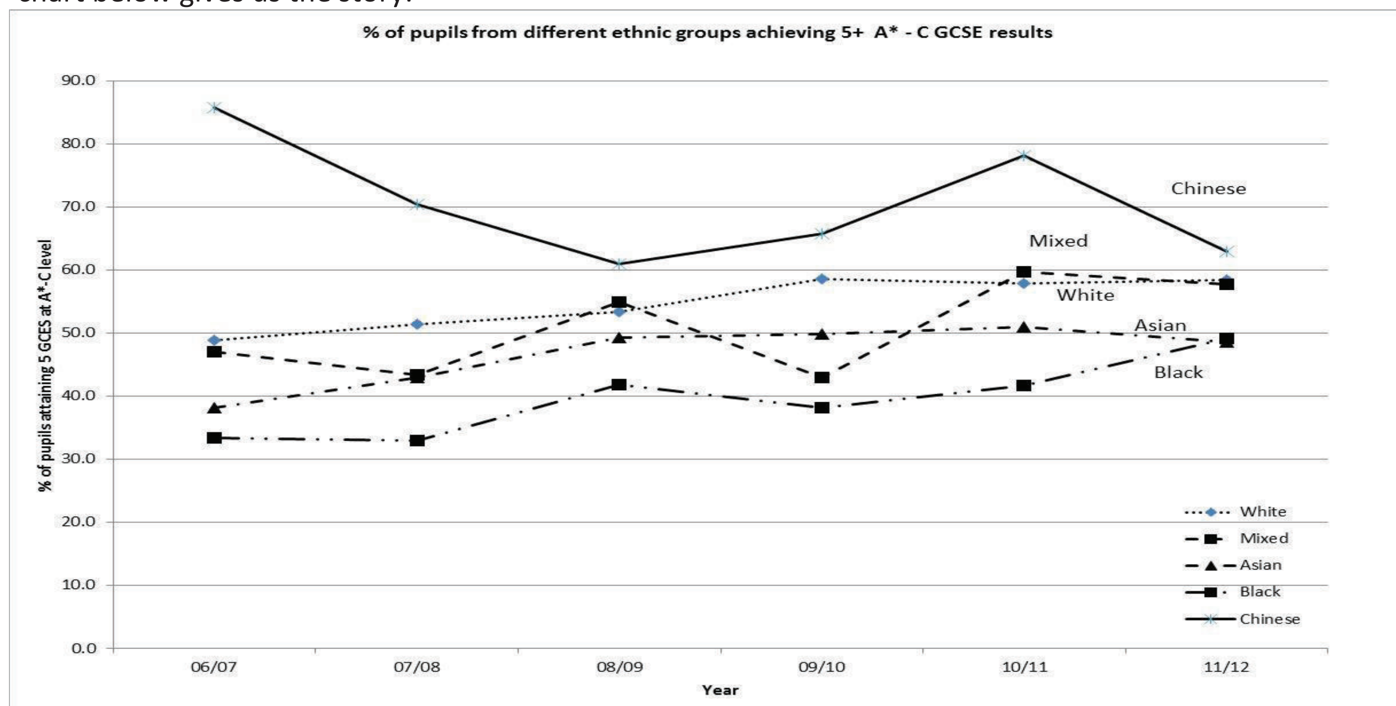
Looking at pupils achieving 5 A* to C results at age 16 gives the following picture:



Source: - Department for Education, Statistics: GCSEs (key stage 4).

This chart shows that our GCSE results continue to be lower than the national average. This remains a high priority for the County Council and the Health and Wellbeing Board.

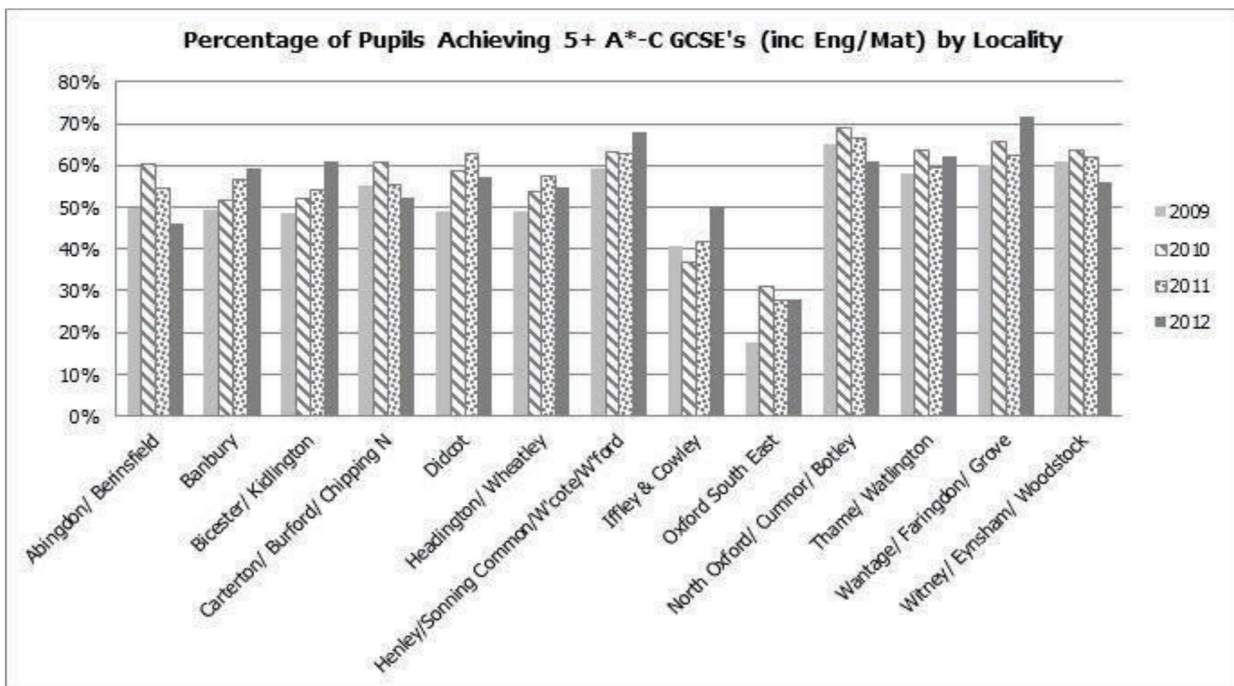
There is also continued concern that performance varies widely across our ethnic minority populations. With the increase in numbers of these populations in the County this is a particularly important issue. The chart below gives us the story:



Source: - Department for Education, Statistics: GCSEs (key stage 4).

This shows that children from Asian and Black ethnic minorities perform markedly less well at GCSE than their 'white' counterparts. On the other hand, children from the Chinese community perform well, but we are talking about small numbers of children in this case.

The final facet of inequality in these results we will look at is geographical inequality. The chart below tells the story.



Source: Oxfordshire County Council, Data Observatory

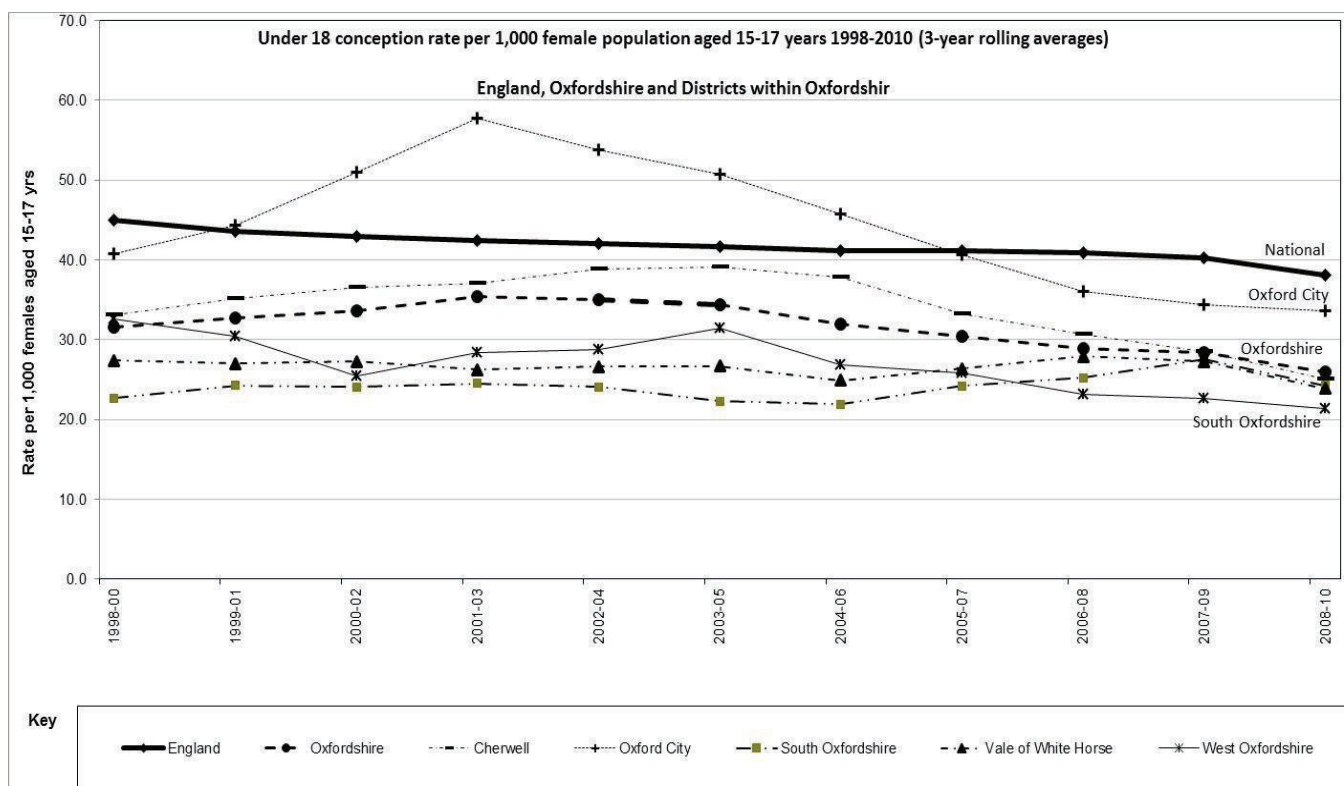
Once again this shows marked variation across the County with children from 'Iffley and Cowley' and 'Oxford South East' performing less well. These are the areas which tend to show poor results across all statistics. This is evidence of the cycle of disadvantage being maintained.

On the other hand, the results for Banbury and Bicester are improving with consistent improvements for the last 4 years. The recent upturn in results in Iffley and Cowley is good news.

Indicator 4 - Teenage Pregnancy

In terms of the cycle of disadvantage, 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 decade.** <u>This is a major success.</u>

The overall picture is shown in the chart below:



Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications. Conception statistics include pregnancies that result in: one or more live or still births (miscarriages are not included), or a legal abortion under the Abortion Act 1967.

This shows:

- Oxfordshire's average as well below the national average and the Regional average – this is good news
- Rates have fallen sharply in the City over the last 10 years. This is good news.

Overall the Oxfordshire under 18 conception rate is decreasing, broadly in line with rates in England. Oxfordshire has the 12th '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 disadvantage.

The key to success is to identify the 'hotspot' areas and focus services there. If we do this, the hotspots will change over time and reduce in number overall. The most recent analysis shows that **Oxfordshire has 10 hotspot wards with particularly high rates**. Hotspots are defined as those wards that are in the worst 20% of wards in the Country (i.e. currently those with more than 53.1 conceptions per year per 1,000 females aged 15-17 years).

There is no room for complacency, but **this is a considerable improvement to the picture 5 years ago when we had 18 hotspots.** This means we are moving 'up' the national league table and improving faster than elsewhere. The table below is a bit 'busy' but the detail is worth looking at.

It shows the hotspot wards in the County over the last decade.

There are 4 main themes:

- The number of hotspots has reduced.
- The pregnancy rates have all reduced over time – the worst rate in 2002-4 was 112 pregnancies per 1000 girls and in 2008-10 the worst rate was down to 77 pregnancies per 1000 girls.
- There is a group of 8 wards which appear in all 3 'league tables'. These are, from Oxford: Blackbird Leys, Northfield Brook, St Mary's, Rose Hill and Iffley, Barton and Sandhills and Iffley Fields, and from Banbury, Grimsbury & Castle and Ruscote wards.
- The latest figures show worryingly high rates emerging in Didcot in two wards: Northbourne and All Saints.

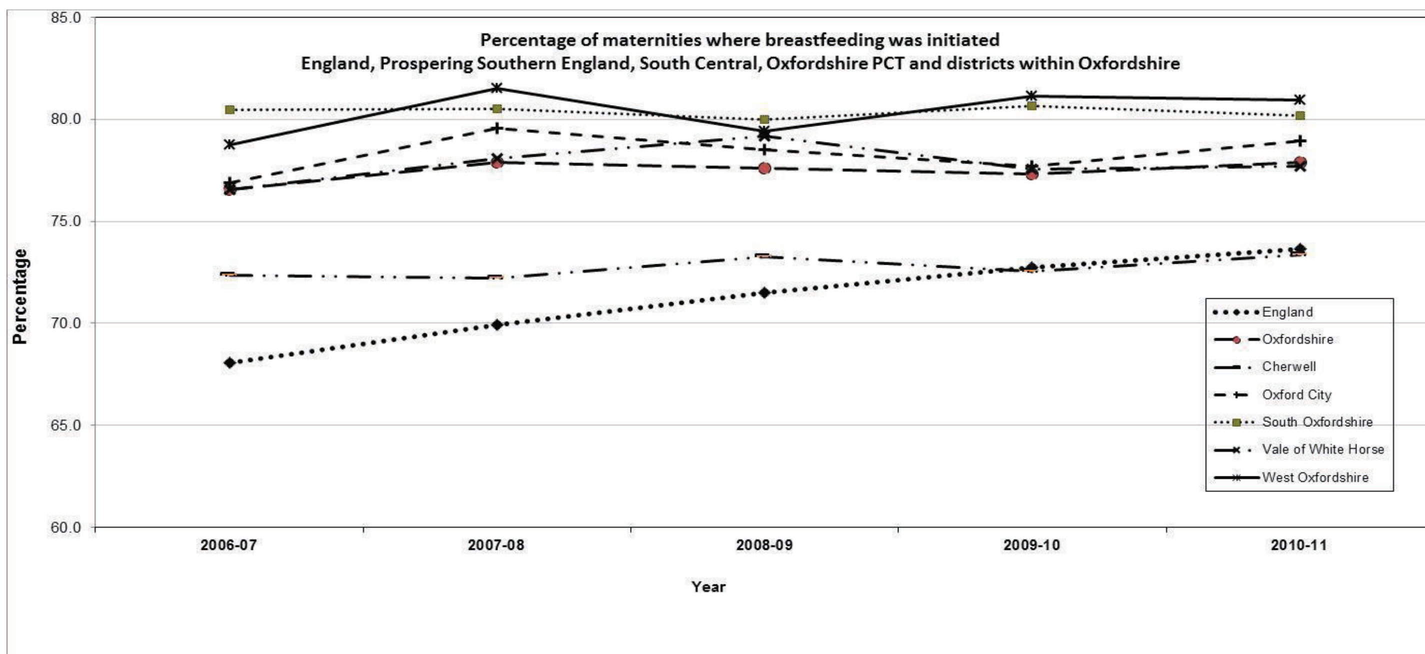
The key to this topic is to keep up our strict surveillance of the issues and then to target our services where they are needed the most.

Wards with high conception rates (in top 20% nationally) 2002 to 2004			Wards with high conception rates (in top 20% nationally) 2004 to 2006			Wards with high conception rates (in top 20% nationally) 2008 to 2010	
Ward Name	Rate 2002/04		Ward Name	Rate 2004/06		Ward Name	Rate 2008/10
Cowley Marsh	112.75		Banbury Grimsbury and Castle	103.91		Blackbird Leys	77.00
Banbury Grimsbury and Castle	103.45		Banbury Neithrop	89.72		Northfield Brook	71.00
Northfield Brook	98.21		Northfield Brook	81.30		St Mary's	65.00
Littlemore	94.34		Littlemore	78.81		Didcot Northbourne	63.00
St Mary's	90.20		Banbury Ruscote	77.52		Rose Hill and Iffley	61.00
Cowley	87.72		Witney Central	70.82		Banbury Grimsbury and Castle	57.00
Blackbird Leys	83.33		Banbury Hardwick	69.44		Banbury Ruscote	57.00
Banbury Ruscote	79.04		Cowley	66.31		Iffley Fields	57.00
Banbury Hardwick	77.88		Blackbird Leys	65.69		Barton and Sandhills	55.00
Iffley Fields	76.70		Lye Valley	63.84		Didcot All Saints	54.00
Barton and Sandhills	73.45		Ducklington	62.60			
Abingdon Caldecott	69.84		Iffley Fields	62.50			
Lye Valley	62.71		Carterton South	59.83			
Rose Hill and Iffley	63.49		Rose Hill and Iffley	58.88			
Jericho and Osney	61.40		Berinsfield	57.35			
Marcham and Shippon	56.91		Abingdon Caldecott	56.74			
Abingdon Abbey and Barton	65.93		Carterton North West	56.13			
Witney Central	64.81		Brize Norton and Shilton	55.87			

In the last 12 years, teenagers in Oxfordshire have had 120 fewer pregnancies than if rates had remained at the 2001/03 levels. The most conservative estimate of the financial impact of a teenage pregnancy is

£19,000- £25,000 over three years, according to the Department of Education and Skills in 2006. This equates to a saving of around £3 Million over 3 years and longer term.

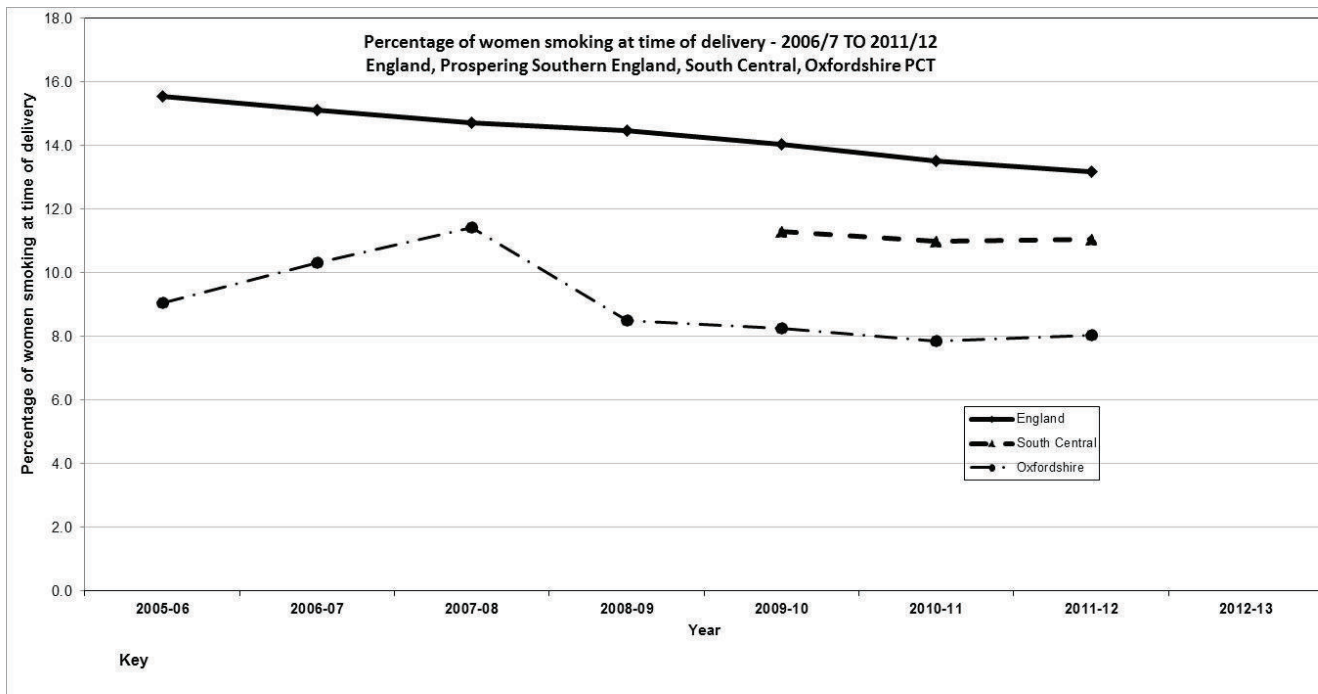
Indicator 5 - Breastfeeding



Source: Department of Health, Vital Signs Monitoring Return

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.
The data shows high levels of uptake across Oxfordshire but lower levels in Cherwell.
Breastfeeding remains a high priority for the Health and Wellbeing Board and this should be maintained.

Indicator 6 – Smoking in Pregnancy

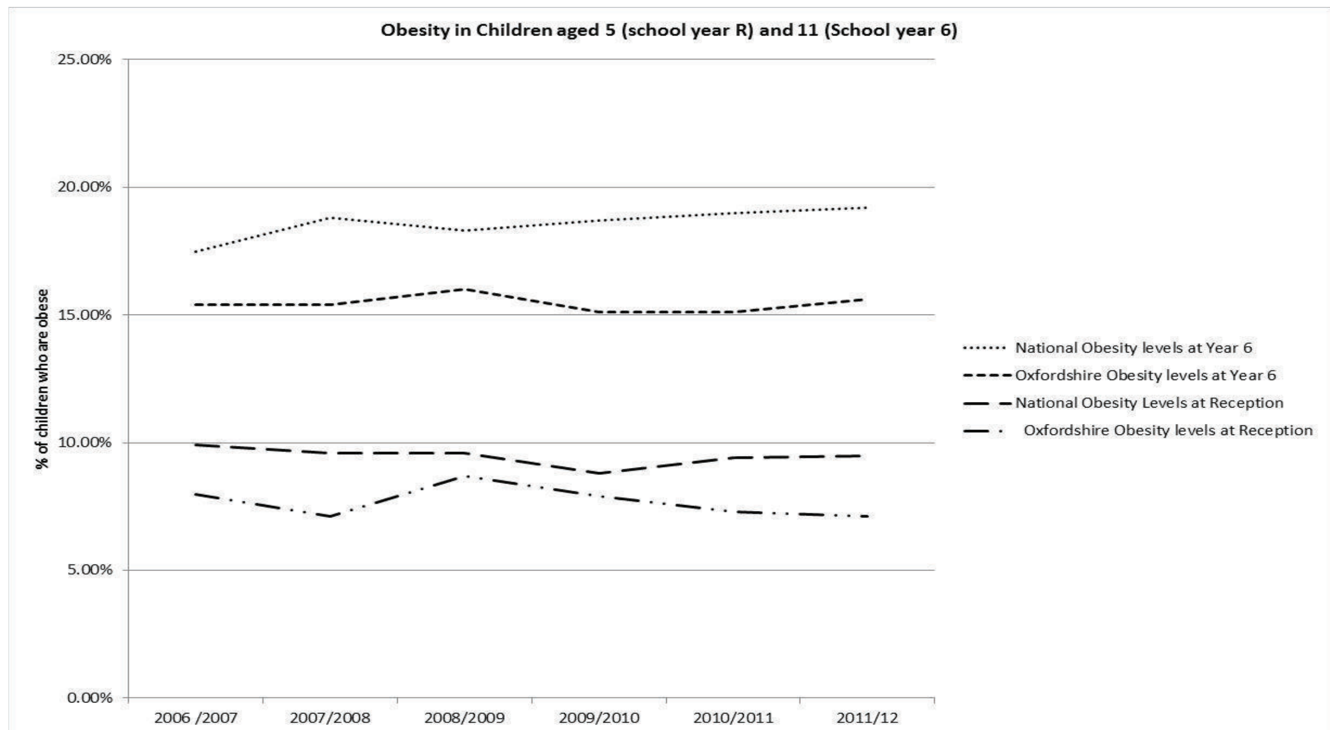


Source: - Prior to 2011/12: Department of Health (national and PCT data); NHS Information Centre Omnibus Survey (local data), 2011/12 onwards: NHS Information Centre (national and PCT data); local hospital trusts (local data)

Smoking in pregnancy is bad for the health of both mother and baby. Oxfordshire's figure stands at 8.1% of pregnant women smoking at the end of their pregnancy which is well below the national level of 13.2% and the regional level of 11.1%. This is a good result but we need to press on and make it even better as this is a really important indicator. Pregnancy is a good time to persuade mothers to give up smoking and if we grasp the opportunity we will produce real long term benefits for both mothers and their families.

This means out of 8,000 or so pregnancies each year, 650 mothers are smokers and only 160 quit using our local services. We perform well compared with elsewhere, but surely Oxfordshire could be doing better. When we look at the number of smoking quitters during pregnancy, we see that rates have not really changed much over the last three years and hover around 40 quitters per quarter.

Indicator 7 - Obesity in Children



Source: National Child Measurement Programme (NCMP) report, NHS Information Centre, Child Obesity e-atlas, National Obesity Observatory

This section focuses on inequalities in obesity. See chapter 4 for a thorough look at all aspects of obesity.

The data tells us that

- Oxfordshire has significantly lower levels of childhood obesity than the national average and we are bucking the National trend. **This is very good news.**
- Levels of obesity more than double (from 7% to 15%) between the ages of 5 (reception year) and 11 (year 6). The rise in obesity levels continues into adulthood. **This is not good news.**
- National data shows that there is a strong relationship between social disadvantage and childhood obesity. This is borne out when we look at Oxford's data where obesity levels are higher than the County average
- Analysis for England indicates that there is a higher prevalence of obesity amongst 'Black British' reception year children (15.5% compared with an average of 9%)
- When we look at exercise data, there are no significant differences between Districts in the County.

Indicator 8 – Deaths in Oxfordshire

Many of the indicators we have looked at have shown that disadvantage has a bad effect on people's health. Disadvantage is also associated with an earlier death.

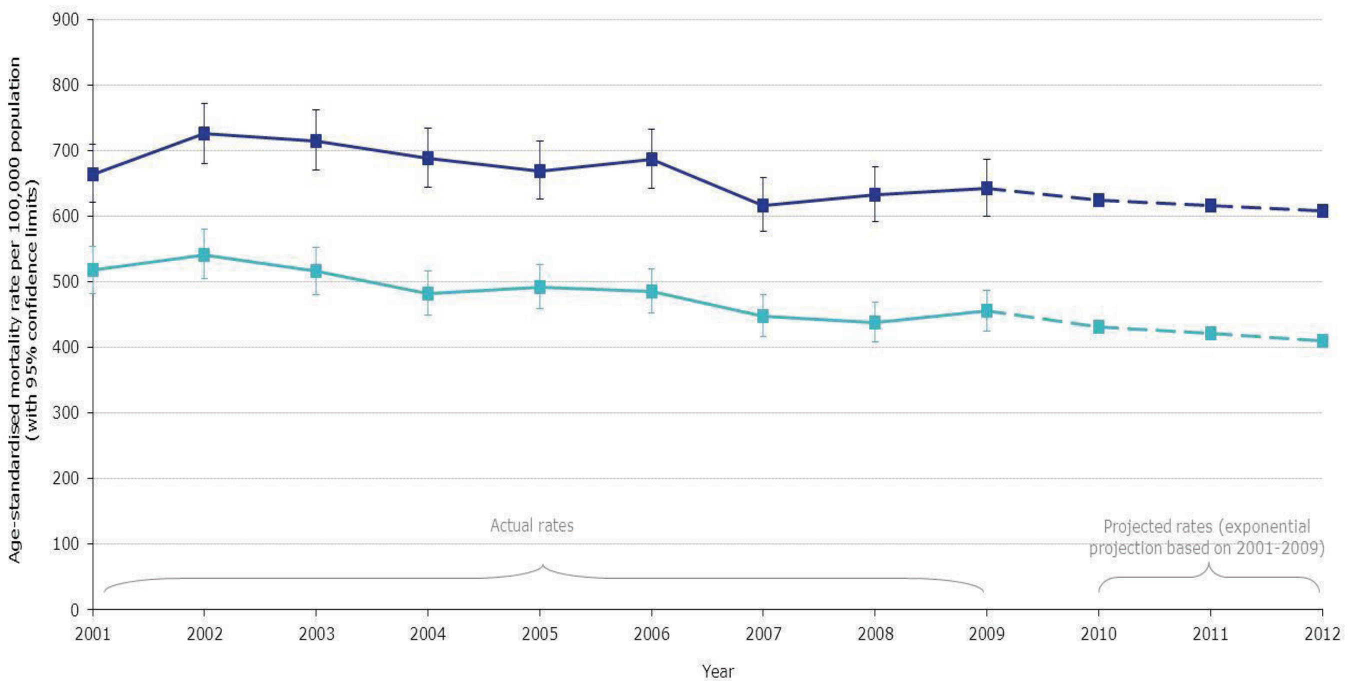
If we compare the latest death rates for those living in the 20% best off and 20% worst off small areas of the County we find that there is a 6 year difference in life expectancy, *i.e. :*

'On average the sum total of disadvantage could be said to knock 6 years off your life'.

To put it another way, the odds of you dying in any one year if you come from a well-off area are around 1 in 250. In the most disadvantaged areas the chances of dying each year are 1 in 170.

The chart below shows 2 lines. The top solid line shows the high death rates in the 1/5th most disadvantaged wards in the County. The lower solid line shows the lower death rate in the most well off 1/5th of wards.

Death Rates in Oxfordshire showing the top 1/5th and bottom 1/5th of wards



Source: SEPHO Health Inequalities Gap measurement Toolkit. http://www.sepho.org.uk/gap_intro.aspx

The Data shows that:

- The gap in death rates between the best and worst wards (the distance between the two lines) is fairly static over time.
- The overall trend in death rates is falling, indicating better health for everyone in general.

Also, we know that Oxfordshire's death rates are considerably lower than the national average - another reflection of our relatively good health overall. This highlights the two biggest common factors for most health data in Oxfordshire:

- We enjoy better health than the England average
- There are marked differences in health between the best off and worst off, and these trends are persisting.

The wards in the County with the lowest life expectancy are:

- Sandford - Oxford (73.1years)
- Carfax – Oxford (73.6 years)
- Caversfield- Bicester (74.7 years)
- Blackbird Leys – Oxford (74.8 years)
- Banbury Grimsbury and Castle – Banbury (75.5 years)
- Northfield Brook – Oxford (77.8 years)

The wards in the County with the highest life expectancy are:

- Didcot Ladygrove – (90.3 years)
- Bicester South (86.4 years)
- North Leigh (85.2 years)
- Abingdon Dunmore – (84.9 years)
- Burford (84.9 years)

Source: Office of National Statistics, Life expectancy at birth for wards in England and Wales, 1999-2003 (experimental), Results for all persons.

Recommendations

Keeping up the pressure to break the cycle of disadvantage.
By October 2013 The Health and Wellbeing Board should ensure that the updated Joint Health and Wellbeing Strategy continues to have reduction of inequalities as a major theme.
This should include improvements in educational attainment, improvements in obesity and in breastfeeding.

By March 2014 Oxfordshire's Thriving Families programme should demonstrate a measurable impact on wellbeing of our most needy families.
The database of families most in need of help should also be maintained.

By March 2014, Oxfordshire Clinical Commissioning Group should be able to demonstrate practical results to reduce disadvantage in each of its localities.

By March 2014 the Health Improvement Board should have monitored any impact on housing and homelessness arising from recent changes to benefit entitlements homelessness. If these changes have an impact on health and wellbeing, the Health Improvement Board should coordinate action to ameliorate this.

Chapter 3 – Mental Health: Avoiding a Cinderella Service

Why does mental health matter?
There are three main reasons.
The first is that mental health problems are common in England, and Oxfordshire is no exception. For example

- 64,500 people in Oxfordshire suffer from common conditions in this County such as anxiety and depression.
- 5,000 people in Oxfordshire suffer from severe mental health problems such as schizophrenia
- 3,200 people in Oxfordshire suffer from dementia and this figure will rise as the population ages.

The second reason mental health matters is that it cannot be separated from physical health. The one can cause the other. For example if you are suffering from chronic lung disease and you are also depressed, your health outcomes will be worse.

The third reason is that mental health problems occur hand in hand with some of the most serious social issues we face as a society, such as homelessness, alcoholism and drug addiction.

These are the 3 reasons why mental health will remain a main priority for this annual report.

The next section reviews progress made over the last year and looks ahead to the challenges we face.

A good, year but storm clouds are gathering
Useful progress has been made during the last year in the following areas:
Strategic alignment of plans - the new GP led Clinical Commissioning Group has adopted the 'Better Mental Health in Oxfordshire Strategy' and the Health and Wellbeing Board has adopted a raft of mental health priorities as part of its Joint Health and Wellbeing Strategy.
Direct payments - good progress has been made in making direct payments to people with mental health problems so that they can have a bigger say about the type of care they receive.
Successful recovery and wellbeing services - the new 'Keeping People Well' service, which aims to ensure those recovering from Mental Health problems are supported, has had a good year with more than 2,000 patient contacts.
Public involvement. The new Public Involvement Network has had success in engaging people who have mental health problems
Integrating services for mental and physical health - new services are planned to support people with physical illness in our local hospitals with mental health services.
The service which supplies 'talking therapies' for people with common mental health problems has been extended - to cover young people and to improve the service for people from black and minority ethnic groups.
The dementia challenge - a huge amount of new work has begun to improve services for people with dementia. This is spearheaded by Oxford University Hospitals Trust and Oxford Health Foundation Trust and brings together all services from the NHS, Local Government and academia.

The storm clouds
We have come a long way in improving mental health and mental health services in this County over the last five years. We now need to prepare to meet a new set of challenges which are growing.
In order to protect the people of Oxfordshire we need to respond to these challenges now. The challenges are:

The danger of integration - Integrating mental health and physical health services is a good idea. However there is a real danger that the focus on mental health issues will be lost within the much bigger topic of physical health services.
Our success in improving mental health services in Oxfordshire arose from focussing specifically on mental health services. We need to make sure this focus is not lost

The need to ensure that severe and enduring mental health problems do not lose out to less severe mental illness.
The focus of recent years has rightly been on improving services for common conditions and dementia and on improving our commissioning. We are now moving on to new services which join up mental health and physical health services.
All of these things are good, but the overall pay packet we are dipping into is not getting any bigger. We are in effect trying to stretch the same old balloon of resources and hoping it does not burst.
Above all we need to take action to ensure that services designed to treat severe and enduring illnesses such as schizophrenia and manic depression do not lose out.

Homelessness: a new threat?
The chapter on breaking the cycle of disadvantage has highlighted the potential issue of an increase in the number of homeless people in society. People with severe mental illness who are on the brink of homelessness face a triple whammy (particularly in Oxford City) of high housing costs, the possible impact of changes in the benefits system and practical difficulties in getting a job. Action is needed to guard against this.

Summary
We have kept up the positive progress on mental health issues in this County over the last year and there are more promising developments on the horizon.
However we also now need to take steps to ensure that the storm clouds gathering on the horizon do not combine to produce a tempest which sweeps our best efforts away.

In this context, the following recommendations are appropriate:

Recommendations

Keeping up the good work

- Close monitoring is required to make sure that recent gains are not lost. The Health and Wellbeing Board should continue to treat mental health issues as a priority and this should be included in the refreshed Joint Health and Wellbeing Strategy by October 2013.

Keeping a close eye on serious mental illness.

- By March 2014.Oxfordshire's Clinical Commissioning Group should monitor the health of people with severe and enduring mental illnesses to ensure that standards of care do not fall.

Keeping a close eye on homelessness.

- By March 2014 the Health Improvement Board should have monitored any impact on housing and homelessness arising from recent changes to benefit entitlements. If these changes have an impact on health and wellbeing, the Health Improvement Board should coordinate action to ameliorate this.

Chapter 4 – The Rising Tide of Obesity[2]

'If you were the standing on the bridge of HMS Oxfordshire you'd be pressing the panic button as the iceberg of obesity loomed dead ahead……'

The Facts

The problem is that every little lifestyle choice you make, or make for your children, decides whether you will put on weight or not. After a decade or so you wake up one day and find that you're in the red zone on the bathroom scales. To a large extent it's your choice, but it's a choice we should all make with our eyes wide open. Why should we care?

Because:

- Being obese knocks around 9 years off your lifespan
- Once obesity is established in childhood it is very hard to shake off in later life.
- Obesity can lead to high blood pressure and long term conditions such as diabetes, heart disease, 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.
- 1 in 10 of all cancer deaths among non-smokers is linked to obesity.
- Obesity decreases mobility making independent living harder which boosts the bill for social care.
- The risks of obesity causing diabetes are higher in some groups than others. If you are of South Asian origin your risk of developing type 2 Diabetes is 4 times greater, whilst those from Black African origins have a risk 3 times greater than the white population. Given the changes in Oxfordshire's ethnic minority profile this will become an increasingly important issue.

But it's not all doom and gloom. Next to giving up smoking, losing just a bit of weight is the best favour you can do yourself in terms of your health. The good news is that taking action really does work - a reduction in 10% of body weight gives the following benefits, even if you don't return to a normal weight category. So, if you weigh 12 stone, getting down to just under 11 stone means:

- a 20% fall in your chances of dying in any one year
- a 30% reduction in your chance of dying from a cause linked to diabetes.
- a 40% reduction in your chance of dying from an obesity-related cancer (e.g. bowel cancer).
- a 90% decrease in the symptoms of angina.
- a significant reduction in blood pressure and cholesterol levels.

Now that's a really good deal!

---

[2] [2] 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
- a BMI greater than or equal to 30 is obesity.

How does Oxfordshire compare with elsewhere?
We have very good data about childhood overweight and obesity thanks to our child measurement programme in schools (this is highlighted in Chapter 2 as indicator 7). This shows that we are still doing better than the national average…… but doing better during what amounts to a national epidemic of obesity is cold comfort.

Data on obesity in adults is less reliable, but again shows that our Region is generally healthier than the national average.

However, the fact remains that around 1 in 4 adults in this County (and rising) are obese

Also, on the exercise front, we are still measured as the sportiest County in the Country for the second year in a row. This is a great achievement and our Sports Partnership is to be congratulated. So, the conclusion is that Oxfordshire is still bucking the national trend – but not by much and not by enough.

Why are we as a society sliding into obesity?
It's really quite simple. There seems to be a delicate balance between eating and exercising as to whether or not we put on weight, and as a nation we tipped over the balance point about 30 years ago. To put it simply, we now eat more and exercise less. We ride in cars when we could walk, we take the lift not the stairs and we eat sweets and biscuits and burgers and drink more beer and wine. We pass on these messages to our children and hey presto! We have obesity.

What can we do about it at local level?
A lot of the causes are complex and are linked to national policies and how we behave as a nation. So what can we do locally?
The key is to take a long term view, stay focused and be persistent. This isn't a quick fix - it's a case of turning The Titanic around. It has taken us a few decades to get into the current situation and it will take decades to get out of it again.
Much work is going on in Oxfordshire and this is a priority for our Health and Wellbeing Board.
We are increasing physical activity initiatives, getting a healthy eating message 'out there' and helping people who are overweight to access treatments. We are joining up agencies to address obesity in a concerted way using the best available evidence. For example:

Initiatives with children

- Oxfordshire has over 50 practitioners who are trained to deliver parenting courses covering Heath, Exercise and Nutrition for the Really Young (HENRY). In 2012, 20 courses were delivered in Children's Centres across Oxfordshire reaching over 160 families
- To celebrate Playday in Oxfordshire a record number of large, community events took place across the County in 2012. Approximately 16,000 people attended the 12 events run in local communities and on Armed Forces bases across Oxfordshire.

Initiatives with adults

- In 2012, the Oxfordshire Sports Partnership launched the popular **Active Women project** which is helping to get more women taking part in Athletics, Badminton, Tennis, Netball, Football and Gymnastics by removing barriers such as lack of childcare, inconvenience, no 'buddy' to play with and expense.

- The ***Get Oxfordshire Active*** **(GO Active)** partnership continues to go from strength to strength and from April 2011- March 2012, 7,296 new participants attended activity sessions such as Just Jog, Zumba and Health Walks throughout the year.
- Oxfordshire Weight Loss and Lifestyle Service (OWLS) continue to support obese adults in the efforts to achieve a healthier weight. From Sept 2011 - August 12, 483 patients were referred by their GP and 446 people joined the lifestyle programme. On average, 77% of those who attend the intensive 12 week programme lose weight. Of those who stay on the programme for the full 12 months, approximately half maintain a minimum of 5% weight loss.
- Generation Games is a physical activity service for all 50+ in Oxfordshire, delivered by Age UK and commissioned by Oxfordshire Clinical Commissioning group. With a focus on fun and enjoyment, the service offers everything from dance and Tai Chi to seated exercise, bowls and lots more.

What did we say last year?
The aim last year was two-fold:

1. To emphasise the fight against obesity is the most important lifestyle challenge for the County

And

2. To make sure the Health and Wellbeing Board took obesity seriously, working to a re-vamped County Strategy that would bind all partners together through regular network meetings. Getting this strategic work right gives us the right framework for all our work and helps to make our efforts count for more.

All of these things were achieved.

Recommendations

Keeping obesity high on the health agenda
By October 2014 The Health and Wellbeing board should have refreshed the Joint Health and Wellbeing Strategy to include child obesity as a main priority.

Working hand in hand with partners
By October 2014 the Health Improvement Board should ensure that partnerships to tackle obesity and promote physical exercise are thriving. This should include a full role for District Councils.

Commissioning a wider range of services
By March 2014 the Public Health Directorate should have completed commissioning a full range of services to prevent obesity and to facilitate treatment for it, according to need.

Chapter 5 – Alcohol what's your poison?

'Alcohol is a serious issue. We mustn't sweep it under the carpet.'

During the last year there was no sign that levels of alcohol consumption have decreased and hospital admissions for alcohol related disease continued to rise.

This issue is one of the biggest challenges we face and we are still storing up worse for the future.
In trying to prevent the harm alcohol causes we still have one arm tied behind our backs as cut price booze, relaxed licensing laws and a society that lionizes 'shot drinking' work against us.

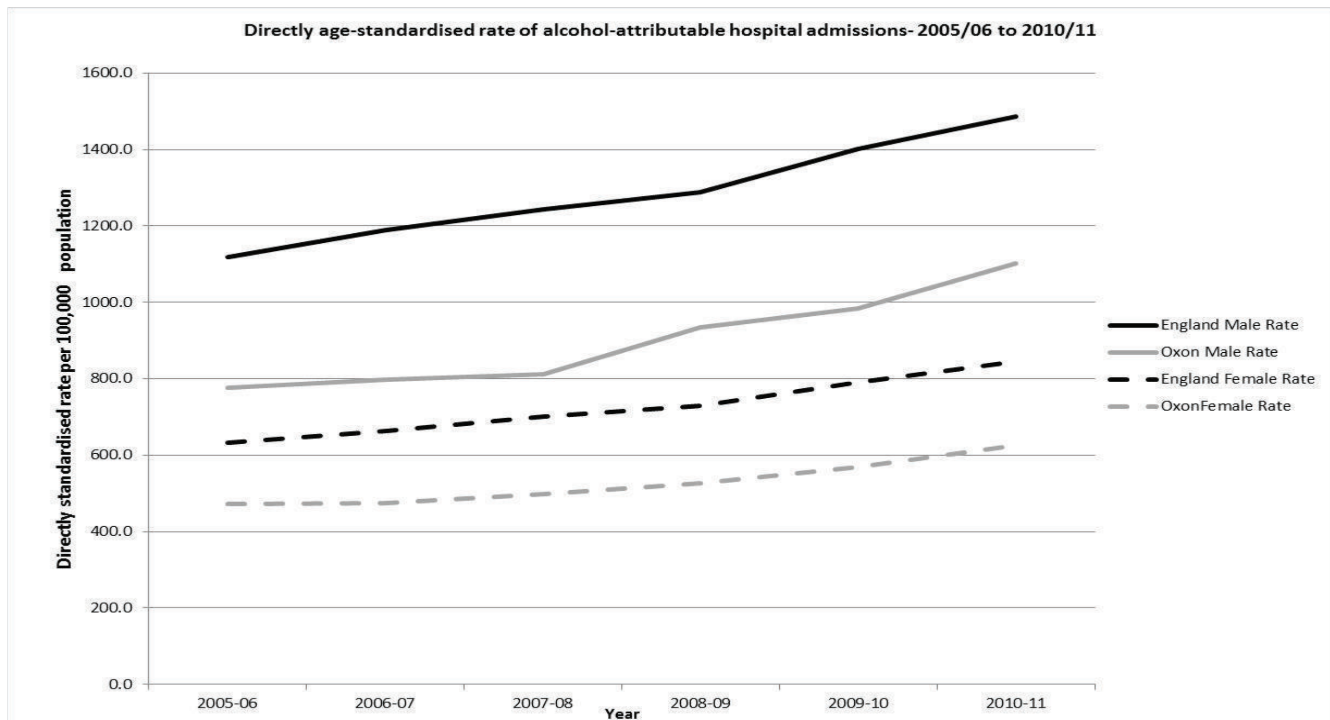
So what's all the fuss about?
Let's recap on the issues:

- Alcohol consumption has risen in the last 40 years and continues to rise.
- 1 in 5 adults exceed recommended drink levels
- Drinking in young people has increased, with binge drinking large quantities of spirits seen as the yardstick of a good night out.
- Alcohol causes disease – this year's 'Health Survey for England' links alcohol as a cause of more than 60 diseases including cancer of the mouth, throat, stomach, liver and breast as well as causing high blood pressure, cirrhosis and depression.
- The annual cost to the NHS alone has been estimated at £2.7 Billion per year.
- Alcohol led to 8,747 deaths in the UK in 2011 and leads to 304,200 unnecessary hospital admissions per year and rising.
- Alcohol is getting cheaper and is easily available - the unit cost of a shot of booze is less than 50% of the cost in the late 80s
- The health benefits are over-stated. It is an urban myth that some alcohol daily is wholly good for you. It is true that for the over 40s drinking a small amount of alcohol may reduce the risk of heart disease and stroke, but this doesn't apply to the under 40s or to the over 40s who drink more. In addition, any amount of alcohol always increases your risk of cancer.
- Alcohol damages families and social networks. It is a major factor in domestic violence.
- Alcohol fuels anti-social behaviour especially at weekends in towns across our County.
- Alcohol hits the taxpayer hard in terms of emergency services, hospital services and the cost of cleaning up our towns the morning after the 'party'.

Isn't this all a bit 'killjoy' and 'nannying'?
The scientific facts say not. It is simply a factual issue and the problem needs to be plainly stated so we can decide what to do about it.

The **majority** of drinkers are not harmed, but a **worrying minority** are - and they tend to harm society and those around them too.

The chart below shows local hospital admissions due to conditions caused by alcohol. It makes stark reading. These are 'our' people in 'our' local hospitals. They are suffering and the public purse is suffering. It is a practical problem.



Source: North West Public Health Observatory (NWPHO) from Hospital Episodes Statistics (on-line extract) and Office for National Statistics (ONS) mid-year population estimates.

The chart above shows three main things:
1) Hospital admissions related to alcohol are climbing fast locally and nationally
2) Women are less affected by men – but they are still affected
3) The problem in Oxfordshire is less than the National average – but it is still a big problem.

Sometimes it is thought that this is a problem primarily about young people but the figures say otherwise – the average age of people admitted with these problems is 55 to 64, often the result of a lengthy drinking career.

Is there a happy medium?
It's difficult to say. Most people drink moderately throughout their lives with no real problem….. and yet alcohol is undeniably an addictive poison. The problems come from three main places:

- The results of binge drinking in the young and
- The slippery slope of alcohol addiction and slowly increasing consumption over the decades which harms people and their families over a whole 'drinking career'.
- The impact on society which falls on families, employers and public services

There are three things we can do:

1) Put the brakes on supply at National level
In 2012 the National Alcohol Strategy set out possible measures that can be implemented by Central Government to "Turn the Tide" of alcohol related harm. A formal consultation on some of these ideas was held in early 2013. A wide range of partners in Oxfordshire collaborated in responding to the consultation. They supported proposals to introduce minimum unit pricing of alcohol and to ensure that health services have a say in licensing decisions where there is an impact on health and wellbeing. They were opposed to proposals to allow other businesses to be licensed to sell alcohol on the premises, such as beauty parlours

and hairdressers. A response from the Government following this consultation is still awaited at the time of writing.

2) Prevention: Keep putting the message 'out there'
We need to keep up the efforts to promote the message of sensible drinking. This needs to be aimed separately at young people and at adults. During the year we have run campaigns to target men, drink drivers and the military. It is a case of endless drip drip drip…….

We will need to work with schools as they change to Academy status to work out how we keep this work going. We also need to make sure our partnerships are strong across the public sector so that we make the most of our combined muscle. Many partner organisations including the police, the NHS, District Councils and County Council have been through a great deal of change in the last couple of years and a period of consolidation is needed to rebuild our strength.

The importance of **'brief advice'** cannot be overstated too. This happens when a professional gives someone specific advice about their drinking in a quick and efficient manner. It has been proved to work and we have a good training scheme in place in Oxfordshire which we need to push further. So far we have trained staff in the health, probation, social care, youth services, prison, housing and mental health services. Next year GPs will be paid a supplement to provide brief advice too which should be a real help.

3) Minimise the harm that is caused.
This is all about the 'blue light' services working closely with licensees, Local Government, A and E departments, street pastors and a host of others. It is about being careful about granting licences and also about putting safeguards in place to keep people and property safe and minimise the damage done.

Street pastors are a good example of what volunteers can do – helping people who are the worse for wear safely into a licensed cab at 3a.m. with the help of a 'taxi marshal' can make all the difference. *But it's still sweeping up the mess after the party and is second best to prevention.*

What did we say last year?
We said we should clarify the roles of the strategic groups involved in this area, including the Safer Communities Partnership and the Health and Wellbeing Board, and this has been done.

We also said that we should strengthen the work on education and brief advice and we have made good progress here too. However we still need to do more to get the prevention message across and make more people and organisations up to the need to take this issue seriously.

Recommendations

Better Strategic Alignment
Oxfordshire's Safer Communities Partnership should continue to consider work on alcohol as a priority. By March 2014, the work programmes of the Safer Communities Partnership, the Drug and Alcohol Action Team and the Police and Crime Commissioner should be fully aligned.

Brief Interventions
By March 2014 a wide range of professionals should have been trained to offer brief interventions and GPs should be offering this service across the County as part of the NHS Health Checks programme.

Chapter 6 - Fighting Killer Diseases

Killer infectious diseases remain a constant threat to good health. It is a duty of Directors of Public Health in Local Authorities to keep watch over them. Without good monitoring, careful prevention and swift treatment they can easily cause major problems. We should not let the recent decades of the 'age of antibiotics' catch us off guard. Diseases such as these are capable of changing and mutating so it is important we keep our guard up.

Oxfordshire's record shows that this vigilance pays off. New cases of hospital superbugs and HIV are all currently in decline, but without simple measures such as good immunisation and safe sex they would be hitting the headlines again. We will need to be extra vigilant over the coming year as the current responsibilities for communicable disease go into a 4 way split between the new Clinical Commissioning Group, the NHS England in Thames Valley, the County Council and Public Health England. District Councils also continue to have a role in enforcing Environmental Health legislation.

The new responsibilities will look like this:

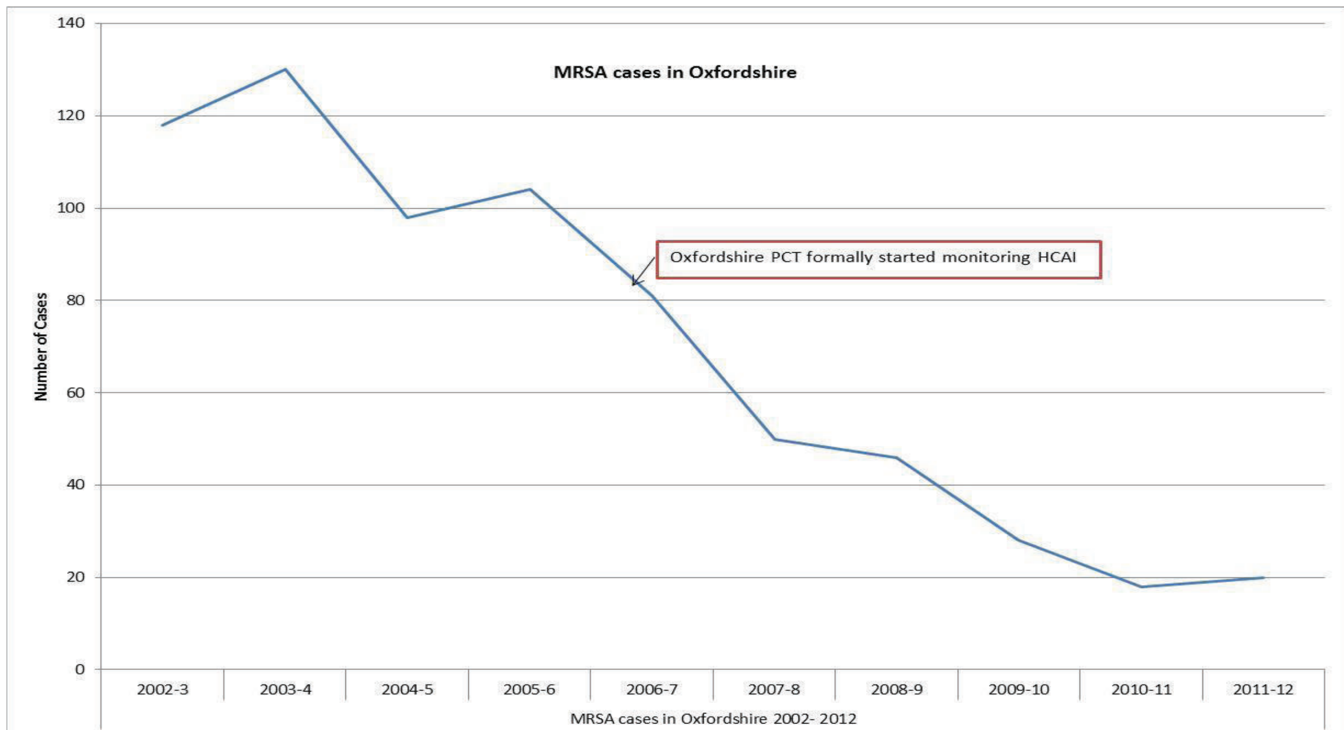
Organisation	Roles and Responsibilities
Oxon Clinical Commissioning group	Responsible for commissioning most hospital services and all community hospital and community nursing services such as District Nurses. Covers infectious disease prevention and control, TB services and hospital superbugs.
NHS England	Responsible for buying expensive specialist services such as HIV care, taking a lead role in co-ordinating the NHS response to major outbreaks and pandemics, buying GP services, which includes immunisation and some screening services
Oxfordshire County Council	Has a Watchdog and oversight role and acting as an 'honest broker' between all organisations to ensure that the local population remains safe and that any threats are dealt with effectively. Promoting Public awareness
Public Health England	Keeps a watching brief on communicable diseases and reporting concerns to local Directors of Public Health. Deals with and co-ordinates response to outbreaks of infectious disease.
District Councils	Through Environmental Health, works with Public Health England to manage outbreaks locally.

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

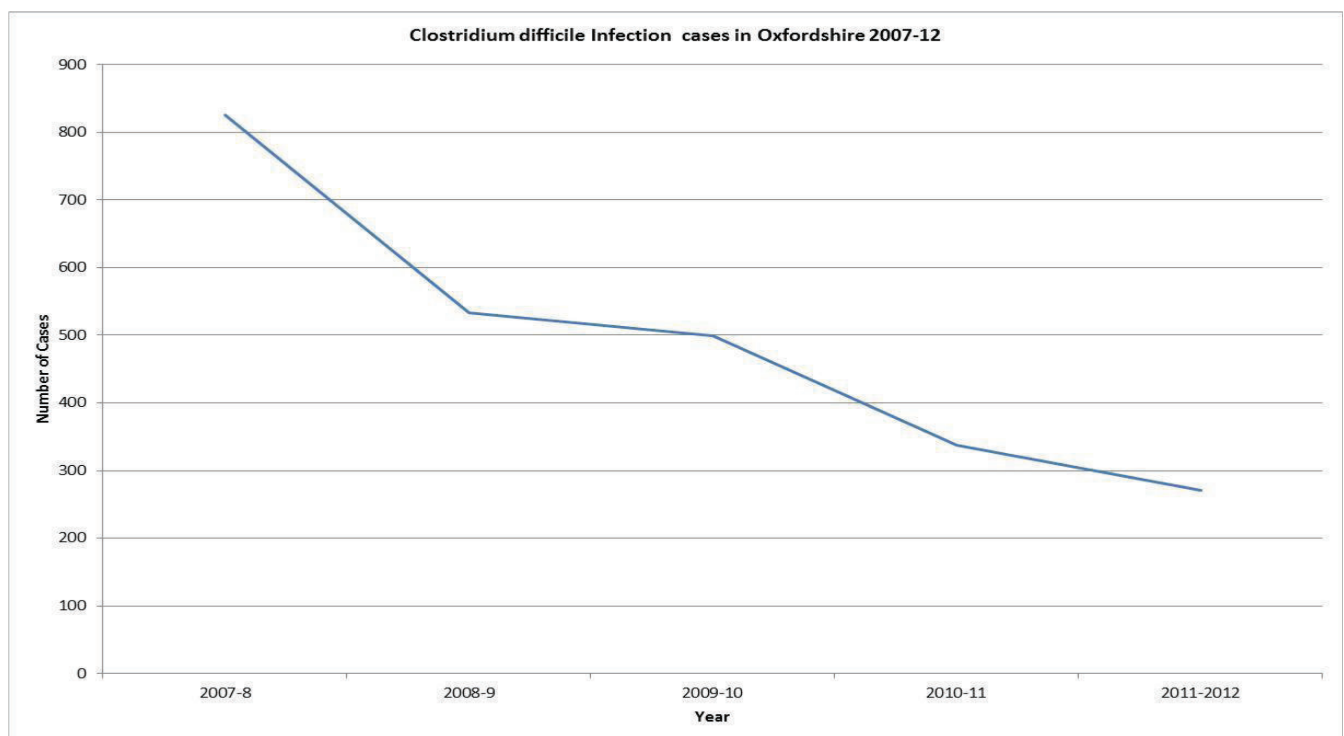
1. Superbugs, known as Health Care Associated Infections (HCAIs) - Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff.)

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. Both of these superbugs are now under control or in decline thanks to basic good hygiene like careful hand washing in healthcare settings. **This is an impressive achievement for healthcare in Oxfordshire.**

The two charts below speak for themselves. In 2011/12 there were 15 cases of MRSA across all of Oxfordshire's residents, no matter where they were treated.
We need to keep an eye on MRSA to ensure that the numbers of cases stay low and don't start to creep up again. This is now the responsibility of the new Clinical Commissioning Group.



Source: Health Protection Agency (HPA)



Source: Health Protection Agency (HPA)

Whilst the number of Clostridium Difficile cases has also fallen, the rate in Oxfordshire is still higher than the national average and we need to make a concerted effort to reduce cases further, so that they are in line with the national average.

2. Tuberculosis (TB) in Oxfordshire

TB is caused by a bug that can infect any part of the body, but most commonly affects the lungs. If not treated properly, TB can lay dormant and re-emerge years after the initial infection. When active lung disease is present, TB is infectious. It is important to identify and treat such cases quickly. Treatment is effective but requires long term antibiotics and completing the course properly is crucial to completely cure the infection and for preventing the bugs becoming antibiotic resistant.

Homeless communities, those suffering from alcohol or drug-misuse, people who are immune-suppressed, and people from countries that have a high incidence of TB are more likely to have Tuberculosis.

In Oxfordshire, the county average rate for new cases is consistently lower than the UK rate- we have around 1/3 fewer cases than the UK average. There were 69 cases of TB reported in Oxfordshire in 2011 compared to 59 in 2010. This increase is largely due to us detecting new cases more effectively. Continued vigilance is essential for maintaining our good progress.

This topic has also benefited from the close attention of the Health Overview and Scrutiny Committee (HOSC) who regularly assure themselves that all reasonable steps are being taken.

Tuberculosis incidence rate in Oxfordshire

Year	Number of Cases	Rate per 100,000 population
2006	53	8.4
2007	76	12.0
2008	56	8.8
2009	55	8.6
2010	61	9.5
2011	69	10.7

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

Over the past 5 years the rates of new cases occurring, and the number of cases, has remained highest in Oxford City and Cherwell District Council.

TB incidence rate by Local Authority, Oxfordshire, 2011

Local Authority	Cases	Population	Rate per 100,000 population
Cherwell	16	142,300	11.2
Oxford	43	150,200	28.6
South Oxfordshire	Less than 5	135,000	3.0
Vale of White Horse	6	121,900	4.9
West Oxfordshire	Less than 5	105,400	2.8
Oxfordshire	69	654,800	10.7
UK			14.4

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

The main interventions to control tuberculosis are early diagnosis and completing the long course of treatment. Oxfordshire does very well, with 98% of cases completing treatment. This compares favourably with the Chief Medical Officer's target of 85%.

Given the increased incidence of TB in those who are homeless, mobile x-ray screening was undertaken in this group in Oxford this year. No TB was found on screening a large proportion of Oxford's homeless population. This offers some reassurance that cases among this population are being diagnosed promptly by local healthcare services.

3. Other Diseases Preventable by Immunisation

a) Childhood immunisations

Major life-threatening diseases can be prevented by immunisation in childhood. The World Health Organisation (WHO) sets this threshold for good coverage at 95%.
Immunisation coverage in Oxfordshire remains high compared to regional and national rates. A lot of effort has gone into tracking down un-immunised children one by one and by checking new children arriving in the County. Maintaining and improving this position requires constant effort.

b) Immunisation against Measles Mumps and Rubella (MMR)

The rates of measles and mumps infection decreased slightly between 2010 and 2011 in Oxfordshire; there were no cases of rubella. This is the result of relatively high immunisation rates of 93.6% for children who have had 2 doses by the age of 5. This is considerably higher than the national average of 89.1%, however it is still below the WHO recommended 95% uptake rate.

Nationally, Measles has been in the spotlight, with cases increasing across the country. This is in part due to historical poor uptake of vaccination during the 1990s. When looking at our local figures, cases of measles have not increased.

Year	Number of Confirmed Cases
2010	9
2011	4
2012	6
2013 (January to April)	0

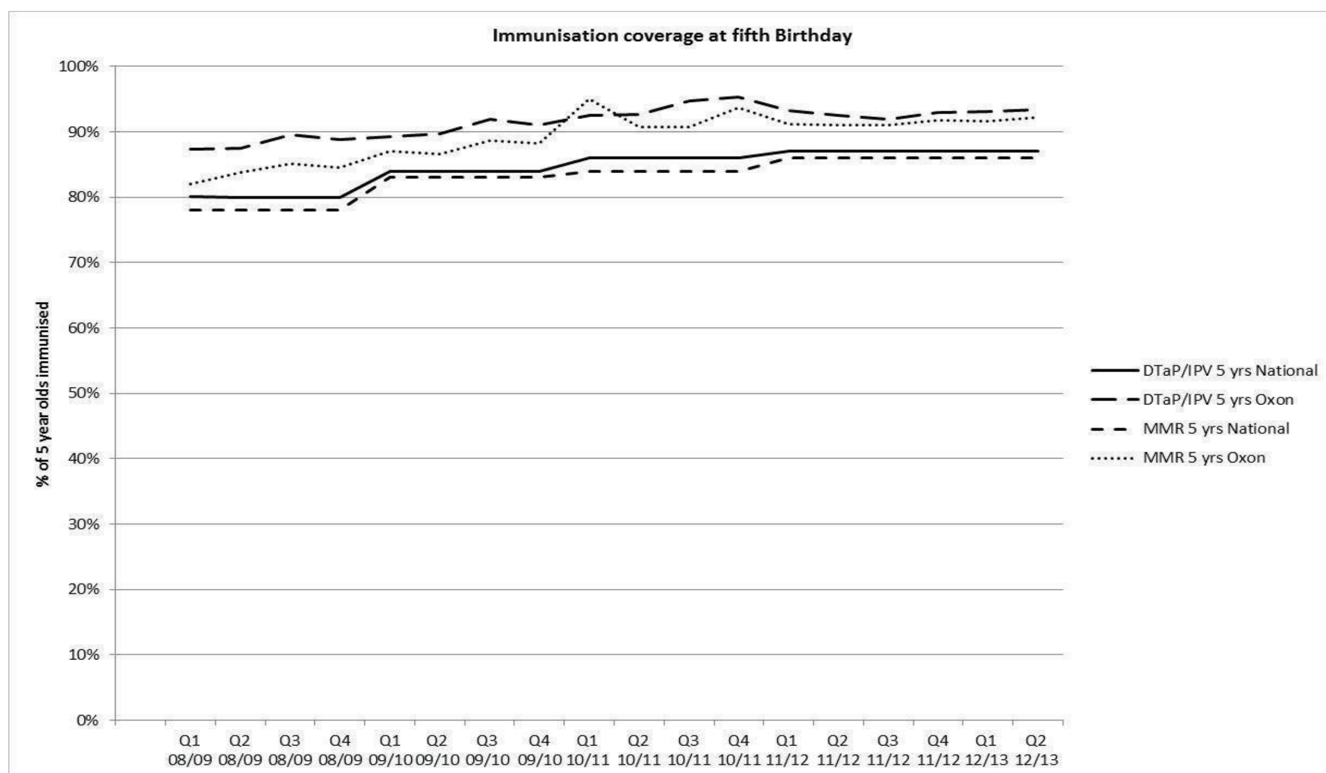
Source: Thames Valley Health Protection Unit

We cannot be complacent and must be vigilant against outbreaks, which spread quickly within school environments and amongst unimmunised children/young people

c) Immunisation against Diphtheria, Tetanus, Pertussis (whooping cough), Polio, and Haemophilus Influenzae B (a type of meningitis); (DTaP/IPV/Hib)

2011 immunisation coverage rates remain high in Oxfordshire with 98.0% of babies being vaccinated before the age of 2 with these vaccines, well above the recommended 95% coverage rates but slightly lower than 98.7% achieved in 2010.
There has been a rise in cases of pertussis (whooping cough) in Oxfordshire in 2011, which mirrors both the national pattern and the usual three year cycle of the disease.
Oxfordshire's good progress is shown in the chart below.

Childhood Immunisations



Source: - Health Protection Agency (HPA)

A warning about immunisations.
From the 1st April 2013, immunisation will move from being a County responsibility to a Thames Valley responsibility. The Thames Valley arm of NHS England will be responsible for immunisations. Local Directors of Public Health will work with them and will also act as watchdog to make sure that standards do not decline. The Health and Wellbeing Board and the Health Overview and Scrutiny Committee will help to oversee this. However, keeping immunisation rates high requires constant attention and there is a real risk that standards may fall. This will be monitored carefully and early action taken if required.

4. Sexually transmitted infections

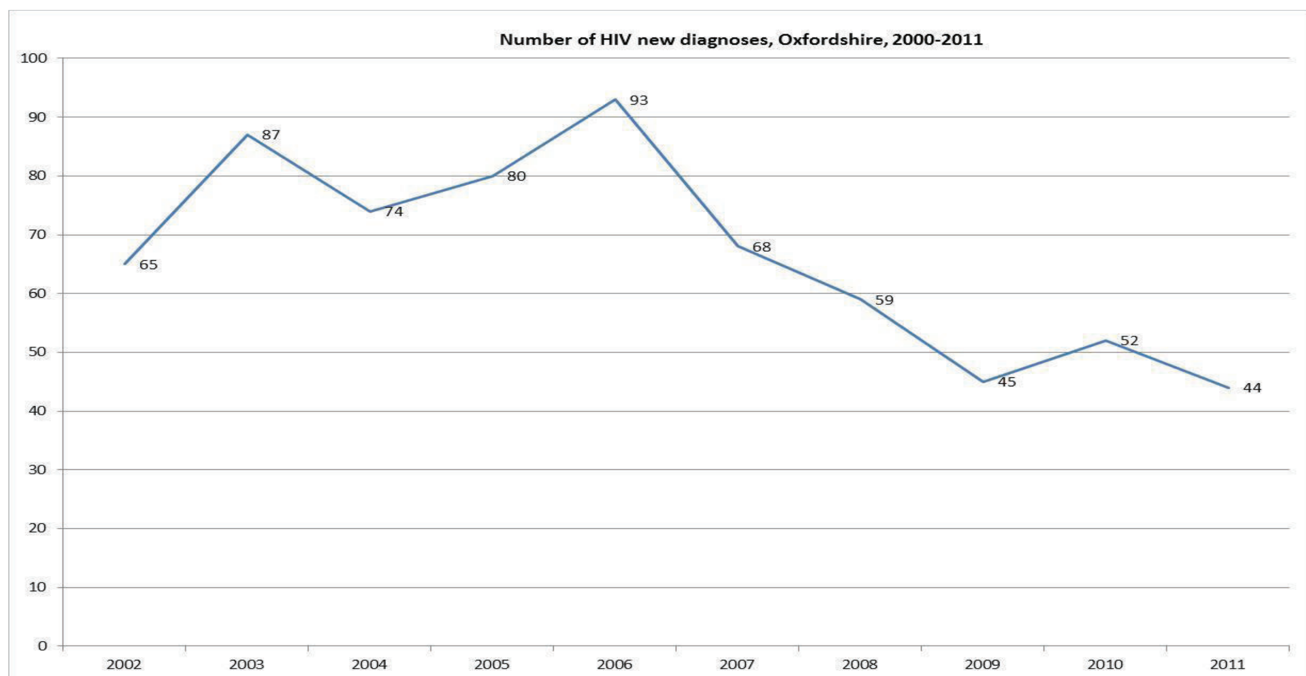
a) **HIV & AIDS**
HIV remains a significant disease both nationally and locally. During 2011, Oxfordshire saw a drop in the number of new diagnoses.
There are now approximately 500 people living with HIV in Oxfordshire. The national report 'HIV in the United Kingdom: 2010'[3], suggests that ¼ of people with HIV have yet to receive a diagnosis. In Oxfordshire, this equates to another 125 people bringing the total estimated cases for Oxfordshire to 625.

Finding people with HIV infection is important because HIV often has no symptoms and a person can be infected for years, passing the virus on before they are aware of the illness. Trying to identify these people is vital. We do this in two ways:

[3] 2010, Health Protection Agency, HIV in the United Kingdom: 2010 report.

- Through Antenatal screening programmes - There are approximately 7,000 deliveries per year in Oxfordshire and 99% of pregnant women are screened for HIV, this identifies an average of 9 women as being HIV positive per year.
- Through community testing, we have introduced 'HIV rapid testing' in three chemists as an initial step. This test gives people an indication as to whether they require a full test; the rapid test takes 20 minutes and gives fast results, although a full test is required to confirm diagnosis.

HIV is now considered to be a long term disease and prognosis, once diagnosed, is good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly decreased.



Source: HARs data set, Health Protection Agency (HPA)

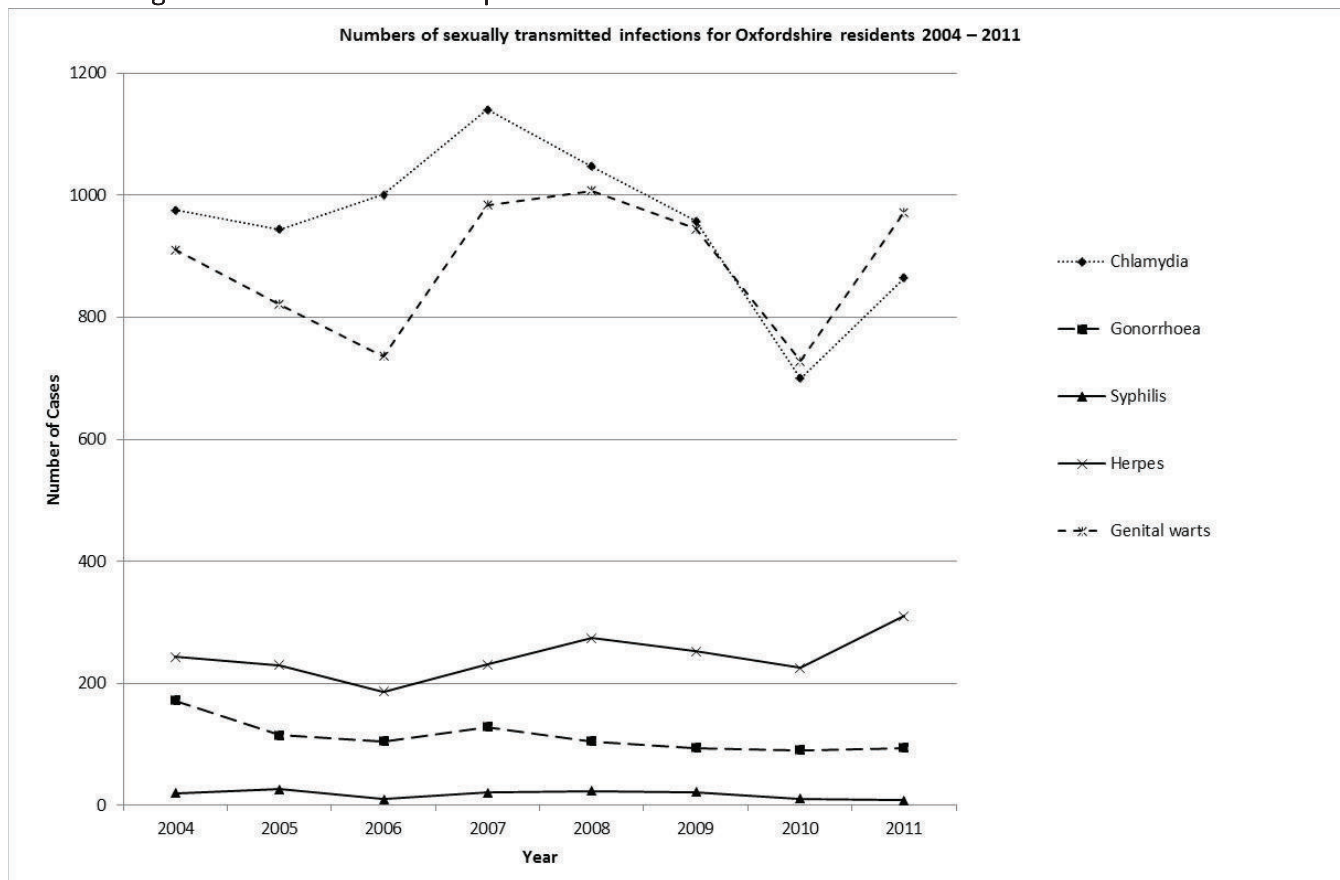
b) **Sexual Health**

Sexually Transmitted Infections (STIs) are continuing to increase in England with the greatest number of cases occurring in young heterosexual adult men and women and men who have sex with men. STIs are preventable through practising 'safe sex'.

The different types of STI each show a mixed picture which is generally good. Looking at each disease in turn gives the following picture:

- Gonorrhoea – is falling and below national average in all areas of the County
- Syphilis - is falling and below national average in all areas of the County
- Chlamydia –levels are lower than national average – but we have had difficulties in persuading young people to come forward for testing despite, best efforts.
- Genital Warts – rates are slightly higher than national average, Oxford City is significantly higher (reflecting the younger age group) but the trend is stable.
- Genital Herpes – rates are lower than national average except in the City which has higher levels but not significantly so. The total number of cases in the year is small (125). Again this reflects the predominantly younger population in the City.

The following chart shows the overall picture:-



Source: Health Protection Agency - Sexually transmitted infections (STIs) annual data tables

What did we say last year about killer diseases?

Last year the recommendations were all about maintaining vigilance and not letting the situation slip – this has mostly been achieved. We do need to continue to monitor the situation around STIs closely.

Much credit should also go to our local Health Protection Agency team (now a part of Public health England), who provide an excellent service and are great partners. This recommendation will need to be repeated for next year as responsibility for different killer diseases will go to the GP Commissioners, the NHS at Thames Valley level or to the County Council.

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

Recommendations

<u>Maintain vigilance and priority after reorganisation</u>

The Director of Public Health and the local Health Protection Agency must work closely during the forthcoming year to maintain surveillance of communicable diseases during 2013/14 and take appropriate steps to control these diseases and any new emerging killer diseases.

Active surveillance and monitoring of the NHS will be important as the Clinical Commissioning group and Thames Valley Area Team take up their new responsibilities.

The Health Improvement Board should be charged with overseeing the situation and escalating concerns immediately to the Health and Wellbeing Board and the Health Overview and Scrutiny Committees. This should be in place by September 2013.

The need to refocus on sexual health prevention and promotion

The Director of Public Health should review sexual health services and agree a plan which will include the re-commissioning of services by April 2014

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 and should make strong recommendations to all of the organisations responsible to make improvements when this is required.

Acknowledgements

This document relies on the time and talent of colleagues whose contribution is acknowledged with grateful thanks.

Alison Baxter
Catherine Bird
Mark Booty
Pasquale Brammer
Sarah Breton
Alison Burton
Lorna Caldicott
Paul Cann
Ian Davies
Ch Spt Tim de Meyer
Clare Dodwell
David Etheridge
Glyn Evans
Arash Fatemian
Vanessa Hayward
Hilary Hibbert- Biles
Ian Hudspeth
Donna Husband
John Jackson
Paula Jackson
Christine Jones
Huw Jones
Mary Keenan
Kate King
Amanda Le Conte
Jim Leivers
Sara Livadeas
Sue Lygo
Benedict Leigh
Noel McCarthy
Joe McManners
Jo Melling
Val Messenger
Tim Mills
John Mitchell
Catherine Mountford
Phillip Newbold
Ronan O'Connor
Matt Prosser
Sam Read
Stephen Richards
Sian Rodway
Tim Sadler
Joe Santos
Sue Scane
Joanna Simons
Kay Stenning
Paul Smith
Val Smith
Patrick Taylor
Martin Tugwell
Matthew Tait
Patrick Taylor
Fenella Trevillion
Peter Von Eichstorff
Helen Wake
John Walton
Linda Watson
Alan Webb
Jackie Wilderspin

With special thanks to Angela Baker without whom this report would not have been possible

Documents and Sources of Information used to produce this Report

Census Data 2001 and 2011
Data from Govt Departments including Office of National Statistics
GP Consortia Information packs – March 2011
Health Protection Agency Infectious Disease data
Joint Strategic Needs Assessment versions 1 - 4
Learned journals
Oxfordshire Children and Young Peoples Plan indicators
Oxfordshire County Council Data Observatory
Oxfordshire PCT Performance data
Oxfordshire Safer Communities Partnership performance framework
Oxfordshire Safer Communities Partnerships Alcohol Strategy Group basket of indicators for Oxfordshire
Public Health Surveillance Dashboard
The Child Poverty Needs Assessment for Oxfordshire

HOSC Forward Plan – Proposed Programmed Items

5 December 2013

- Acute Commissioning Strategy (CCG)
- Delayed Transfers of Care (OCC, CCG, OUHT, OH)
- Care Quality Commission Update (CQC)
- Community mental health update on progress and future plans (OH)

27 February 2014

- Oxford Health
  - District Nursing
  - Health Visitors
- Health advocates and the metal health advocacy service (CCG)
- Community Responder Service (SCAS)
- A&E waiting times (CCG, OUHT, OH)

1 May 2014 (Provisional Date - to be agreed by Council)

- Drug addiction expert review panel (PH, CCG and providers)
- NHS England one year on (NHS England)
- Public Heath obesity strategy (PH)

Annual progress and priorities reports

- South Central Ambulance Service
- Oxford University Hospitals Trust
- Oxford Health Foundation Trust

This page is intentionally left blank