OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 5 March 2015 commencing at 2.00 pm and finishing at 4.20 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) District Councillor Mark Booty Councillor Mrs Judith Heathcoat Councillor Hilary Hibbert-Biles John Jackson Dr Matthew Gaw Dr Jonathan McWilliam Councillor Melinda Tilley City Councillor Ed Turner Jean Nunn-Price James Drury (In place of Rachel Pearce)
Other Persons in Attendance:	David Smith, Chief Executive, OCCG
Officers:	
Whole of meeting	Julie Dean, OCC

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Julie Dean, Tel: (01865) 815322 (julie.dean@oxfordshire.gov.uk)

	ACTION
1 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman extended a welcome to Rosie Rowe, Oxfordshire Clinical Commissioning Group (OCCG) who was attending got Agenda item 12 'Primary Care Report'.	

He also took the opportunity to thank outgoing Board members, Councillor Mark Booty and Mrs Jean Nunn-Price for their good work as Chairman of the Health Improvement Board and Chair of Oxfordshire Healthwatch.	
2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies were received from Joanna Simons and Peter Clark.	
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest submitted.	
4 Petitions and Public Address (Agenda No. 4)	
There were no requests to submit a petition or to make an address to the meeting.	
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the meeting held on 13 November 2014 was approved and signed subject to the correction of 'Outcome Based Commissioning' to 'Outcome Based Contracting' in Minute 6/14. The note of the meeting held on 8 January 2015 was approved and signed as a correct record.	))) Julie Dean))
6 Better Care Fund Update (Agenda No. 6)	
The Board noted that Oxfordshire's Better Care Fund (BCF) Plan had been approved by the Government with the need for only minimal support. It was also noted that the OCCG, with support from colleagues in OCC was developing an implementation plan to monitor existing schemes within the plan and scope and project manage new schemes. This would be available by April 2015 and would be circulated by the OCCG to Board members. Furthermore, the governance and reporting structures for the BCF programme was currently being determined which would be taken forward as a programme under the new system - wide Transformation Board, chaired by Stuart Bell, Chief Executive,	))))))) Dr McManners/David Smith)

Oxford Health. An understanding of the implications of the BCF plan, area by area, and the costings of it, would be covered by the Single Plan as it rolled out, also by the introduction of neighbourhood teams during the course of this calendar year. David Smith explained that contracts were currently in negotiation with both major Trusts and would be completed in time for the next meeting in July when more detail would be available.	))))))))
7 Joint Strategic Needs Assessment (JSNA) (Agenda No. 7)	
The Board considered this year's draft Joint Strategic Needs Assessment (JSNA) which monitored trends in local data which impact on the Board's work. It also included recommendations for updating the Joint Health & Wellbeing Strategy (HWB7). John Courouble, the County's Research & Intelligence Manager, joined Dr McWilliam in introducing the draft JSNA. Members of the Board considered a number of topics during their discussion including: - the breadth of this year's JSNA and its comprehensive nature and the immense amount of work and support being given by a plethora of organisations and voluntary and community groups to combat such themes as social isolation and loneliness within the county (by community information networks, good neighbour schemes, for example); - the JSNA will prove to be useful, evidence based information with which to plan for particular scenarios such as housing growth within the county or to plan for the required resources for the projected high numbers of the population who will be 85 and over by 2050; - it will inform issues and problem areas around service requirements, for example, whether there is an imbalance between housing benefit levels and housing rents; and the importance of extra care housing to be built into housing standards so as not to cause a real problem for the future; - previously there has been no linkage between council planning and health planning – this was a good opportunity to look at it in the round for Oxfordshire.	

The Board **AGREED** to accept the JSNA as the basis for updating the Joint Health & Wellbeing Strategy and to thank the officers for their work in producing it.	Dr McWilliam
8 Performance Report (Agenda No. 8)	
The Board reviewed current performance against all the outcomes set out in the Health & Wellbeing Strategy (HWB8). Councillor Tilley highlighted the following in relation to the indicators for Children, Education & Families: 2.3 'Maintain the current low level of persistent absence from school for looked after children' – Councillor Tilley commented that work was in progress to meet the target. 2.8 'Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014'. Councillor Tilley pointed out that children in primary schools were not signing up because they were in receipt of school meals anyway. 4.7 'Of those pupils at School Action Plus, increase the proportion achieving 5 GCSEs at A* - C including English and Maths to 17% (baseline 10% 12/13 academic year) – Councillor Tilley reported that work was in progress on this. John Jackson highlighted the following in relation to the indicators for Health and Adult Social Services: He pointed out that most of the red indicators in adult services related to the relationship between acute hospitals and other Health systems, for example on Delayed Transfers of Care (DTOC) and Older People's Reablement. He reported that hard work was in progress to bring the numbers down in the case of DTOC and delays in health funded care arrangements had also reduced significantly. David Smith reported that, in the case of DTOC, a target had been set by the Secretary of State to reduce by 50% in four weeks. Four weeks ago there had been 173 people in hospital. This week the figure had reduced to 122. He added that this was a remarkable achievement but the 50% reduction had still not been met. He also pointed out that the OUHT had achieved the 95% target to see people presenting in A & E in four hours, but was struggling to deliver this on a continual basis. Mr Smith also	

added that the OCCG had put in a bid for £4.5m to the Prime Minister's Challenge Fund to address particular issues one of which was to address avoidable admissions to emergency care, and the outcome of the bid would be known by the end of March. Councillor Biles commented that she would like to see the expansion of first aid units (EMU's) around the county, which would also serve to keep A & E only for acute cases. David Smith responded that the expansion of this model had already been included within the Better Care Fund range of initiatives. Dr McWilliam highlighted the following in relation to the Public Health indicators: 8.2 and 8.3 - Health Checks - there was still not sufficient people picking up to their health checks. Notwithstanding that the service had been recognised nationally as good practice, Public Health Officers were working with GPs, looking at the service in detail to see how it may be improved; 8.4 'At least 3800 people will quit smoking for at least 4 weeks' – Dr McWilliam reported that the contract for this service had been re-let and would start in 1 April 2015; 8.5 and 8.6 – Opiate and non-opiate users successfully leaving treatment by the end of 2014/15 – A new contract would be put in place on 1 April 2015. A gradual improvement in getting people off opiates altogether was showing. 9.1 – 'Ensure that the obesity level in Year 6 children is held at no more than 15% and no district population should record more than 19%' – Oxfordshire was bucking the national trend, but there was a need to continue working on it. 11.1 – 11.4 – Immunisations – Dr McWilliam reported that the Health Improvement Partnership Board was working with the NHS England Area Team to ensure that they did not slip. It was noted that the use of more detailed 'Report Cards' on individual outcomes had proved to be very successful at the Health Improvement Board and that this could be used by the Children's Trust. The Board **AGREED** to note the report.	

9 Process for revising Joint Health & Wellbeing Strategy for 2015/16 (Agenda No. 9)	
The Board noted a briefing which set out the process for refreshing the Joint Health & Wellbeing Strategy for 2015-16 (HWB9).	
10 Healthwatch Oxfordshire Report and Summary of Outcomes/Responses (Agenda No. 10)	
Jean Nunn-Price, Chair of Healthwatch Oxfordshire (HWO), and Rachel Coney, Chief Executive, gave a report (HWB10) updating the Board on the actions taken by commissioners and providers in Oxfordshire in response to recommendations made by HWO and its grant aided partners since April 2014. The report also provided an update on other internal and external HWO activity since the Board's November meeting. Rachel Coney pointed out that they looked forward to making good progress on various patient and public involvement issues relating to Learning Disability Health Check take-ups, CAMHS waiting times (to be taken up with the Children's Trust), cancer treatment time targets, four hour A & E waits, cancelled operations, hospital discharges and the provision of dignity in care. Dr McManners reported that how people were admitted or discharges from hospital was to be a core focus for the CCG. The CAMHS waiting times review would be reporting shortly, its major focus being better targets for the numbers of patients seen in 8 weeks. The CCG had appointed a clinical lead to champion better targets for health checks for people with a learning disability and to seek evidence of good practice to share with those practices with a lower uptake. They responded to questions from the Board in relation to the following: - The replacement of the Public Involvement Network (PIN) representatives – Rachel Coney responded that she was due to meet with two PIN representatives in mid - March, and would be starting the process of recruiting new public representatives for the Health Improvement Board and Children's Trust. - The Enter and View process – Rachel Coney responded that it was a rigorous process with check	

lists in place. Volunteers were all DBS checked, had undergone safeguarding training, and did not undertake the visit without a signed consent form and without being specifically invited. People giving their views on the discharge process would be directed online to a link for the form. Opportunities for assistance with focus groups would be offered to voluntary groups or individuals would be advised, if wished, on how to self - complete the form. The Board noted the report.	
11 Health Inequalities Commission - Update and Plan (Agenda No. 11)	
Earlier this year, Dr McManners announced his intention to the Health Improvement Partnership Board to launch a three month, multi-agency Health Inequalities Commission for Oxfordshire asking what Oxfordshire needed to do over the next five years to reduce health inequalities. The Board considered a paper (HWB11) giving the objectives of the Commission and updating members on progress and the next steps. It was suggested that the district councils, HWO and local councillors should be invited to contribute, given the wealth of local knowledge they held. In addition, that the work of governmental select committees could be a fruitful source of information. Dr McManners agreed to do this, adding that NHS England was also a valuable resource in helping to give a national perspective. In addition, the JSNA and the HWB Strategy itself yielded a wealth of information and highlighted what key questions should be monitored and focused upon. Dr McWilliam advised that all organisations were charged with looking for health inequality and this was taken into account when planning their strategies. He added the importance of taking an urban, or rural, or market town focus when considering local detail. The Board **AGREED** to endorse and support the aims, objectives and actions contained in the Plan.	Dr McManners/David Smith
12 Primary Care Report (Agenda No. 12)	
The Board considered a joint report which had been prepared by the OCCG and NHS England (Thames Valley) on the current	

state of General Practice in Oxfordshire and transforming primary care (HWB12).

The Board were advised that the same report had been considered by the Oxfordshire Joint Health Overview & Scrutiny Committee at its meeting on 5 February 2015. The Committee had been pleased to have a constructive discussion with commissioners and providers. It had identified a weakness in the provision of primary care services in areas of growth and recommended that NHS England be considered as a statutory partner when housing growth (large and small planning applications) were considered by Councils. In response to this, James Drury reported that population growth within areas was one of the actions being taken forward by NHS England.

Rosie Rowe, Head of Provider Development (Out of Hospital), OCCG, attended for this item.

Dr McManners introduced the paper pointing out that the Oxfordshire GP service had been nationally recognised as a high quality service but highlighting the pressures on a service which had been designed 50 years previously. He reported that four federal practices had emerged, or were about to emerge in Oxford City, the South East of the county, Abingdon and in private practice (Principal Medicine Limited (PML)), each with their own autonomy and management. All were working to offer services across the various organisations to enable more services to be delivered closer to the patient's own home. He added that more work was still needed to be done on the skill mix and it was envisaged that senior nurse practitioners, paramedics and home workers would work together with primary care teams to deliver locally based services, whilst working in partnership with acute trusts and other services.

James Drury reported that the joint commissioning process between NHS England and the OCCG was now in place.

At the request of the Board, Rosie Rowe provided further information on the Prime Minister's Challenge Fund to which the OCCG had submitted a bid for finance to take forward some system-wide ideas such as:

- A web - based directory – which would provide information on local self- management.
- Same day primary care access with reference to a neighbourhood hub, giving immediate care where patients did not necessarily need to see their own GP. This would enable longer time to be devoted to appointments where doctors were seeing patients with complex needs and would also free up time for doctors to visit these patients

at home. A scheme had already been started in the north of the county. • An early visiting service whereby urgent home visits for people with complex needs or frail patients could be undertaken by paramedics and senior nurse practitioners, whilst referring them to Emergency Medical Units (EMU's) if necessary. • Care navigators to support GPs to link in closely with neighbourhood Community Health and Social Care teams (a pilot was underway in Oxford City). • New ways of working such an E consultations and the use of skype were also being trialled. An announcement would be made shortly if Oxfordshire had succeeded in their bid. If not successful the CCG would look at alternative ways of going forward. Discussion then ensued in relation to the following areas: - How GP practices would fare in rural areas when referring patients to hubs if patients did not have available transport – Rosie Rowe explained that rural neighbourhood hubs were currently being trialled in the Banbury/Chipping Norton area to gain a sense of how it might work in a rural setting, adding that, as a result of this, plans may have to be modified. She also explained that it would be purely the decision of practices whether they wished to engage in federation; - The availability of paramedics when there was already an insufficiency of ambulances with paramedics in the county – Rosie Rowe explained that practices which had already federated were already in discussion with Oxford Health and the South Central Ambulance Service to address the additional capacity required adding that recruitment to Oxfordshire was an attractive opportunity via an overall workforce plan. - The lack of broadband or public transport availability from small villages and whether IT systems were being signed up to – Rosie Rowe responded that IT was a key enabler to these schemes and would be speeded up if the bid was successful. Furthermore, IT inter-operability between practices was becoming more possible and would be most helpful for a patient presenting at a hub in need of urgent care. - The importance of cross-border communication in rural areas.	

- Joint commissioners to ensure that information is disseminated as widely as possible during the process to ensure the public are aware of what is happening in their locality. - The question of whether further assistance would be required to carry out safeguarding briefings and support for each practice. Dr McManners undertook to pick this up with the safeguarding leads in the CCG and NHS England. David Smith pointed out that the major challenge for the whole system was how to get capital into primary care premises, the question being should finance be put into improving existing premises or should there be a real increase in resources via expansion? Following the debate, the Board **AGREED** to: (a) note the report; (b) request an update on the outcome of the bid to the Prime Minister's Challenge Fund and in respect of any further plans; and (c) request that Primary Care strategy on the expansion of practices and the joining up of the workforce element be brought back to the Board for discussion.	))) Dr McManners/David Smith)))
13 Pharmaceutical Needs Assessment (Agenda No. 13)	
The Board considered a final draft version of the Pharmaceutical Needs Assessment (HWB13). The Board **AGREED** to accept the report and approve the process for publishing it along with any supplementary information as it was received.	Dr McWilliam (Jackie Wilderspin)
14 Reports from Sub-Groups (Agenda No. 14)	
The Board had before them written reports on activities since the last full Board meeting from the Children's Trust, the Older People Joint Management Group and the Health Improvement Partnership Board.	

Councillor Tilley, Chairman of the Children's Trust, reported that she would be attending a conference in Oxford on 19 March on Female Genital Mutilation. Councillor Judith Heathcoat, Chairman of the Older People Joint Management Group, highlighted a paper which had been presented by Susanne Jones of Oxford Health on plans for further integration with Health and Social Services. Councillor Ed Turner, Vice-Chairman of the Health Improvement Partnership Board, highlighted a useful discussion at the Health Improvement Partnership Board on bowel checks and the quitting of smoking. The Board **AGREED** to receive the reports.	
15 PAPERS FOR INFORMATION ONLY (Agenda No. 15)	
The Board received the summary of correspondence with the Chairman (HWB15) for information.	

..... in the Chair

Date of signing