Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 3 July 2014 at 10.00 am
County Hall

Membership

Chairman -
Deputy Chairman -

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
	Lawrie Stratford		
District Councillors:	Martin Barrett	Susanna Pressel	Alison Thomson
	Christopher Hood	Rose Stratford	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *18 September 2014*

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	-	
Policy & Performance Manager	-	*Ben Threadgold Tel: (01865) 328219* *ben.threadgold@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

June 2014

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.

AGENDA

1. Election of Chairman for 2014/15

To elect a Chairman for this municipal year - to the first meeting of the next municipal year 2015.

2. Election of Deputy Chairman 2014/15

To elect a Deputy Chairman for this municipal year - to the first meeting of the next municipal year.

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 10)

To approve the minutes of the meeting held on 1 May 2014 (**JHO5**) and to receive information arising from them.

6. Speaking to or Petitioning the Committee

7. Oxfordshire Health & Wellbeing Strategy 2014 - 2015 (Pages 11 - 18)

10:20

At the last meeting the Committee considered a report on the process which had been put in place to refresh the priorities in the current Joint Health & Wellbeing Strategy. The Committee were also asked to comment on the current priorities and the indicators currently used to measure progress and demonstrate improvement (Appendix A to the report).

Dr Jonathan McWilliam, Director of Public Health, will now present the draft Health & Wellbeing Strategy 2014-15 for comment (**JHO7**). The Strategy is due for submission to the Oxfordshire Health & Wellbeing Board on 17 July 2014 for approval.

The Committee is RECOMMENDED to comment on the draft proposals before they are published for the Oxfordshire Health and Wellbeing Board meeting on 17 July 2014.

8. Director of Public Health Annual Report (Pages 19 - 58)

10:40

The Director of Public Health will present his Annual Report for 2013/14 (**JHO8**). This has already benefitted from the useful views of the Health Overview and Scrutiny Committee given at the last meeting.

The annual report summarises key issues associated with the Public Health of the County. It includes details of progress over the past year as well as information on future work.

It is an independent report for all organisations and individuals.

The report covers the following areas:

- An analysis of the opportunities arising from the return of Public Health to Local Government.
- Ensuring the best start in life
- Improving quality of life for all
- Reducing inequalities in health
- Infectious and Communicable Disease

The Committee is RECOMMENDED to comment on the report before it is discussed at the Cabinet meeting on 15 July 2014.

9. Oxford University Hospitals NHS Trust (OUHT) - Update (Pages 59 - 74)

11:10

Andrew Stevens, Director of Planning & Information, will discuss the findings of the recent Care Quality Commission (CQC) inspection. Mr Stevens will also discuss the Trust strategy, business plan and performance (**JHO9**).

Please find below the link to the CQC reports:

http://www.cqc.org.uk/provider/RTH

10. Ambulance response times in Oxfordshire (Pages 75 - 84)

11:50

Aubrey Bell, Area Manager for Oxfordshire at South Central Ambulance Service will discuss the performance of the Ambulance Service in Oxfordshire, with a particular focus on rural areas (**JHO10**).

11. Healthwatch Oxfordshire (Pages 85 - 102)

12:30

Dermot Roaf (Board Member) and Carol Ball (Co-ordinator) of Healthwatch Oxfordshire will attend to present a report on recent projects **(JHO11).**

12. Musculo-skeletal services (Pages 103 - 108)

12:50

Phillippa Mardon, Programme Manager for Planned Care will discuss plans to review and develop planned musculo – skeletal services (**JHO12**).

13. Chairman's Report and Forward Plan (Pages 109 - 110)

13:10

The Chairman will give an oral update on meetings he has attended since the last meeting.

A list of proposed items for the Forward Plan is attached at **JHO13**.

14. Dates of Future Meetings 2014/15

13:25

Please note that the Joint Committee will meet on the following dates during the 2014/15 municipal year:

18 September 2014
20 November 2014
5 February 2015

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.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 1 May 2014 commencing at 10.00 am and finishing at 1.25 pm

Present:

Voting Members:	Councillor Lawrie Stratford – in the Chair
	Councillor Kevin Bulmer Councillor Pete Handley Councillor Mark Lygo Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Martin Barrett District Councillor Susanna Pressel District Councillor Rose Stratford Councillor Yvonne Constance (In place of District Councillor Alison Thomson)
Co-opted Members:	Dr Keith Ruddle
Officers:	
Whole of meeting	Ben Threadgold and Julie Dean (Chief Executive's Office); Director of Public Health

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

10/14 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

District Councillor Yvonne Constance substituted for District Councillor Alison Thomson and apologies were received from District Councillor Dr Christopher Hood, Mrs Anne Wilkinson and co-opted member Moira Logie.

11/14 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest submitted.

12/14 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 27 February 2014 were approved and signed as a correct record subject to 'Councillor Susanna Pressel' being amended to '***District*** Councillor Susanna Pressel' in the list of those present at the meeting.

With regard to Minute 7/14, it was confirmed that further information on the falling ambulance response times across the county would be presented to the next meeting on 3 July 2014.

13/14 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There had been no requests to address the meeting or to submit a petition.

14/14 OXFORDSHIRE HEALTHWATCH

(Agenda No. 5)

Larry Sanders, Chairman and David Roulston, interim Director of Healthwatch Oxfordshire (HWO) presented their report (JHO5) and updating the Committee on the various matters which had arisen since it had been written.

The Committee noted that recent recruitment process had not produced a suitable candidate for the permanent post of Director despite the high level of interest

Mr Sanders highlighted the various projects supported by HWO Project Fund, the findings of the research, which was funded by HWO and carried out by a team of students into the healthcare experiences of students of Oxford University; ongoing work on the initial priorities set by Healthwatch; current work to increase awareness of HWO and to establish contacts; future events to be held during 2014 and matters to be called to the attention of Oxfordshire's Health & Wellbeing Board.

Mr Sanders added that project work to date had mainly concentrated on work with user and carer groups relying significantly on their vast knowledge and experience. The problem was that the information required was not always fully available from people who had experienced problems with systems – consequently HWO were calling for experts by experience' to come forward. To illustrate this HWO were putting together a paper on the unnecessary death of Connor Sparrowhawk who died in the care of Southern Health NHS Trust.

Members of the Committee commented on the value of HWO as an important contributor to the work of the Committee, particularly in light of their decision to prioritise the smaller groups whose needs could often be overlooked. To this end they commended their priorities listed in the report as very pertinent. Mr Sanders was asked if the questionnaire that had extrapolated patient experiences with regard to access to GP services had included people's access to their chosen GP. He

responded that this was a one of the more detailed factors that were planned for future consideration.

Members discussed with Mr Sanders and Mr Roulston how this Committee could work together in an effective way. The Chairman reported that his recent meetings with HWO had gleaned a number of ways of working including regular meetings between the Chairman and HWO, the Committee reinforcing any recommendations made by HWO with the groups involved as it saw fit, and the possibility of Committee members and HWO working together on particular issues of interest to both.

A member suggested that the Benefits system and how the recent changes had affected the mental and physical health of service users and carers could be looked at by HWO . Mr Sanders agreed that it was important to look at it from across the board, adding that HWO had certain statutory powers which would enable it to ask what was being done for people affected by the changes. Part of its role was to bring together the various groups involved in research locally and, if it was shown to affect a significant proportion of people in the county and there was a large volume of response to an issue of concern, to refer it to Healthwatch England as an issue of national concern or to deal with it locally.

Mr Sanders and Mr Roulston were thanked for their report.

15/14 PRIORITIES FOR NEXT DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

(Agenda No. 6)

The Director of Public Health asked for the Committee's views on his early thoughts for the topics to be included in his forthcoming sixth independent Annual Report. The proposed topics were:

- A better start in life – with particular focus on maintaining the pressure for high levels for breast feeding and immunisation services within the county. Also to continue to maintain the current downward trend in childhood obesity levels.

- Improving the quality of life for all –with particular focus on reviewing and thereafter keeping a watching brief on the status of people suffering with mental health problems in Oxfordshire. In the past this had often been highlighted by organisations as a difficult aspect to measure, thus placing it in danger of being overlooked. Other themes to this topic would include adult levels of obesity; a close watch on issues associated with drug and alcohol use; to keep a watch on smoking status and the health conditions which can ensue such as heart disease and cancer etc; and Ageing Well – keeping good physical functioning;

- Reducing inequalities and disadvantages - to look at the increasing diversity of the county with regard to ethnic mix ensuring that Oxfordshire's services

met demands; to keep a close watch on the levels of thriving families and ensure that troubled families continue to get the help they need; to ensure that vulnerable groups were kept high on the agenda, to include the homeless, people who are hard of hearing, carers needs and people living in rural isolation;

- Protecting and maintaining current levels of good health in the county – to include the traditional topics on infectious diseases such as Tuberculosis and to keep an eye on sexual health such as the levels of syphilis; to ensure that health checks in the county were as good as they could be in light of such diseases becoming more resistant to current medicines; and finally to report on what is the role of health prevention in an acute hospital.

Members congratulated Dr McWilliam on an excellent list of ideas and added their thoughts during the ensuing discussion. These included :

- As part of the role of health prevention in acute hospitals to look at the length of time between the first and second outpatient appointment;

- To look at the wider issues of homelessness such as poor accommodation and insecure housing, living in damp environments, bad landlords and air pollution;

- More stress on earlier interventions at school, for example school nurses do not give a service until the child is 3 years old. Also, to give some thought to how parenting classes could be provided from birth and earlier identification of those families who were struggling the most;

- The possibility of doing some work on how having a child in local authority care affects their families and some work around help for young carers.

With regard to the comment on earlier intervention, Dr McWilliam reported that the Health Visitor service was to transferred over the local authorities in September 2015 which would afford a major opportunity to address this. Also in relation to earlier work needed before families get to the troubled families stage, this county was doing some work with Public Health England looking at indicators on the possibilities for prevention before families get to that stage.

In response to a question about the lack of data for the mental health service, Dr McWilliam reported that his department were working with MIND on how to quantify this via comparative data. He added that there was good data available on hospital admissions and GP prescribing, but less of an opportunity to build up data on the less serious levels of mental health such as self-harm. He added that perhaps Healthwatch Oxfordshire could help with this.

Dr McWilliam pointed out that in the last 5 years much sharper tools had arisen with which to measure outcomes in the form of the Health & Wellbeing Board , in

particular its sub - Board, the Health Improvement Board, which was, for example, looking specifically at the effect of bad housing on health than previously. There was also much better access to sharper contracts.

Dr McWilliam was thanked for his report.

16/14 OXFORDSHIRE HEALTH & WELLBEING STRATEGY 2014 - 2015 (JHWBS)
(Agenda No. 7)

Dr Jonathan McWilliam, Ben Threadgold and John Jackson formed a panel to respond to questions on a report (JHO7) which updated the Committee on the process for refreshing the Oxfordshire Health & Wellbeing Strategy, a revised version of which was due for submission to the Oxfordshire Health & Wellbeing Board on 17 July 2014 for approval. It also set out at Appendix 2 the current priorities and indicators which were used to measure progress/demonstrate improvement for performance management purposes at each meeting of the Oxfordshire Health & Wellbeing Board.

The views of the Committee were sought on some initial ideas for the revised version to include:

- Better Care Fund indicators to be included so that progress could be measured in implementing joint plans;
- Partnership issues that are included in the Clinical Commissioning Group 5 Year Strategy;
- Other priorities raised by other groups or organisations or through the period of consultation.

The Committee commented that there was a real question of where realism (due to financial constraints as a result of the ageing population) met aspiration on the plan. It was felt that the current configuration of Health could be a real issue over the next 5 years and would require more integration of Health and Social Care to support it. It was also felt that the Committee should think about creating a tool kit to ascertain where the real issues were for scrutiny.

A member commented that access to services could also be an issue, pointing out that one third of those people using self directed finance suffered from dementia. Those who were the most vulnerable mentally could have problems accessing services and one stop shops were required for everything. Another member added it was important to be clear on outcome-based commissioning for frail and elderly people with mental health problems.

In response to a comment on the requirement for data on age ethnicity, Dr McWilliam pointed out that standard of data was improving continually. Information on ethnicity was gleaned from the census and GPs were now recording information.

A member of the Committee commented that the number of targets in the current Strategy was too high, in particular those on educational attainment. Dr McWilliam responded that these fell into one of the most important categories which was to provide a good start in life.

A member voiced concern in relation to priority 8.3 – 'At least 65% of those invited for Health checks will attend (aged 40 – 74)' – asking why the maximum age was only 74. Dr McWilliam responded that the age limit had been set by the Government. Actuaries would be reviewing the outcomes in the future in order to ascertain whether the health of the population had improved as a result of undertaking the health checks.

The Director for Social & Community Services responded to a question about how it was ensured that the optimum numbers of extra care housing was built into the district council planning process. He explained that there was district council representation on the Health & Wellbeing Board and the targets were agreed by them also. He added that there had been effective working between the County and District planning teams and significant progress had been made since 2009 when there were 200 extra care housing places, currently there were over 900.

The Committee **AGREED** to:

(a) note that a report would be submitted to the 3 July 2014 meeting which will include the draft JHWBS to be presented to the Health and Wellbeing Board on 17 July 2014; and

(b) note the current priorities as set out in Appendix 2 of the report together with the indicators currently used to measure progress / demonstrate improvement: and to note that any suggestions and comments for changing and developing the current list of priorities and indicators would be noted as part of the revision process.

17/14 OXFORDSHIRE CLINICAL COMMISSIONING GROUP (OCCG) STRATEGY 2014-19 AND IMPLEMENTATION PLAN FOR 2014/15 - 2015-16

(Agenda No. 8)

Ian Wilson, Interim Chief Executive, OCCG, gave a presentation which invited the Committee's views on the OCCG's strategic and Implementation Plan. For ease of reference a copy of the 'Plan on a Page' was attached at JHO8. He stressed that the objectives did sound a little aspirational but as the OCCG and Social Care moved towards an even more integrated service, and practices becoming integrated, it made the plans realistic. He added that the Plan centred on the premise that care should be in the community and not in hospital if at all possible. He agreed that issues remained concerning access to GPs which needed addressing in spite of efforts being made in the last two years.

In response to a query asking why the OCCG had less spent on patients per head compared to CCGs in other parts of the country, Mr Wilson responded that the amount spent depended upon the health of Oxfordshire's demographic. Oxfordshire was deemed quite a healthy county compared to most.

In response to a question about how the overall waiting times for planned hospital care would be improved, Mr Wilson explained that issues had emerged in the last quarter and it was the CCGs intention to bring them back. There were 67 specialities

counted within the 18 weeks referral time for treatment and he had received assurances from the Oxford University Hospitals NHS Trust that all but 6 of these would be back on track very soon; and the remaining 6 were working hard to be back by July. He added that Oxfordshire's statistics in this area were comparable with the best in the country.

In response to concerns expressed about the continuing Delayed Transfers of Care problem, Mr Wilson commented that a downward trend had begun to manifest itself for the first time in 4 years due to the multi - agency approach bearing fruit. This multi-agency approach had the effect of bringing a focus to it and there was a determination on all parts to solve the problem. He added that statistics showed that rural areas tended to be higher than those of the rural areas. Realistically then, next year's targets aspired to getting out of the bottom quartile and thereafter to continue the improvement.

A Committee member commented that this was a very commendable but ambitious Plan and its financial sustainability would depend upon achieving the targets it had set. One which would require much focus and a great deal of capability. On being asked if there was a multi – agency contingency plan, Mr Wilson responded that a project management structure would be put in place which would take a much tougher approach to business cases, the testing of them and the driving and implementation of them. He added that generally plans were much more realistic now and lessons had been learned during the first year of operation. The likelihood of plans not being drawn to a conclusion was small. Mr Wilson stated that it would prove very difficult to have an entire contingency plan but the work structure would ensure that risk registers were completed, together with plans to mitigate those risks if they should arrive. With regard to the current financial deficit, the deficit was now thought to be substantially less than previously thought.

A Member asked how far the CCG had progressed with their plans for a 7 day a week Health service. Mr Wilson informed the Committee that a significant amount of progress had been made on this in Oxfordshire as it was deemed to be a very important issue to patients and their relatives. For example, changes were being made to contractual arrangements with providers and with Social Care to enable week-end discharge, when convenient for the families and carers.

Mr Wilson was asked how the CCG were approaching the difficult task of reducing Accident & Emergency activity over the next five years. He advised that three substantive reports had been completed on the subject within Oxfordshire. It had been recommended that one third of patients attending would be dealt with and diagnosed within the community, via, for example, same day GP appointments and via increased use of patient transport. He undertook to send Members links to the reports.

A Member expressed his concern about the downward trend of the statistics relating to the Ambulance Service based on his own personal experience. He also pointed out that if there were concerns, then it would be necessary for stringent performance measures to be put in place quickly. Mr Wilson responded that in his experience that there was a need for non-adversarial confidence and support to be given in such an event and that it would only be a final sanction to put financial penalties in place. With

regard to comments regarding the Ambulance Trust, he stated that he had found the Trust to be highly professional and of a high quality adding that it was a difficult challenge for the Trust to provide a prompt response for patients living in rural areas. The Chairman commented that this issue had been included on the Committee's Forward Plan as a matter of concern and would be looked at again in a future meeting.

It was **AGREED** to thank Mr Wilson for his presentation and to note the regular update from the OCCG (JHO8).

18/14 BETTER CARE FUND

(Agenda No. 9)

Ian Wilson and John Jackson, Director for Social & Community Services presented plans for the proposed use of the Better Care Fund in Oxfordshire and its alignment with other key plans covering Health and Social Care within the county. Plans had now been submitted to NHS England (as an integral part of the OCCG's Strategic and Operational Plans) on 4 April 2014 following agreement by the Oxfordshire Health & Wellbeing Board, Oxfordshire County Council and the OCCG.

A member asked if it would threaten the £37m funding if performance was not reached. John Jackson responded that there was an element in terms of the way the Scheme works which was dependent upon performance, but it did not depend on the success rate as a whole, but the success of each of the different targets set out in the proposals. He added that there had been much debate nationwide about this and it had been concluded that money would not be lost from the system. In relation to 2015/16 monies, this would not be known until national guidance was refreshed.

In response to a question asking what proportion of visits did the short visits of 15 minutes or less amount to, Mr Jackson informed the Committee that it was 20 – 25% and it would only apply to those clients receiving intimate care (approximately half of the 20 – 25%).

A Committee Member asked how did they see the pathway through it for a GP and for a Councillor. Mr Wilson responded that part of the new GP contract was to focus on the top 1% of patients in the most need and then to take steps to cluster services, such as district nurses, social care etc around them. Mr Jackson added that one of the targets in the existing Health & Wellbeing Strategy was to develop integrated working at local level. Social Care teams would work together with community based staff, including GPs, to enable different professionals to come into play. If a Councillor had concerns about a particular service then there would be a single point of contact via Customer Services.

In response to a question about cross boundary issues in Oxfordshire, Mr Wilson commented that there was a significant amount of work in progress on this, particularly in relation to the ambulance services. Apart from the usual cross border issues there was the added complication that two GP practices who were part of the OCCG were situated outside of the border.

The Committee **AGREED** to note the report.

19/14 OXFORD UNIVERSITY HOSPITALS NHS TRUST (OUH) DRAFT QUALITY ACCOUNT 2013/14

(Agenda No. 10)

Dr Tony Berendt, Acting Medical Director, and Dr Ian Reckless, Assistant Medical Director of the Oxford University Hospitals NHS Trust presented the Trust's Quality Account for 2013/14.

Mr Threadgold reported that he had also received a draft Quality Account from Southern Health for comment and that he was expecting more from the other main providers.

Members discussed the means by which their views could be conveyed to the Trust in order to meet the deadlines required.

It was **AGREED** that the full document, and the full documents of the other main providers when they arrived, be circulated to all members of the Committee for comment and that the responses received be compiled by the Officers and sent to the Trust on behalf of the Committee, following consultation with the Chairman.

20/14 PRE-CONSULTATION ON PROPOSED CHANGES TO NON-EMERGENCY PATIENT TRANSPORT SERVICES

(Agenda No. 11)

Ian Wilson and Matthew Staples, OCCG, presented the proposed changes to the eligibility criteria for Patient Transport Services and outlined proposals for the approach to consultation and engagement, to which the Committee's views were sought.

Members of the Committee were content with the approach to consultation and engagement. They asked that the OCCG begin disseminating information about the changes as quickly as possible. That way there would more of a likelihood of people commenting.

Ian Wilson undertook to send a list of proposed consultees to officers for circulation to members of the Committee for further suggestions.

Comments and suggestions made by members during discussion were as follows:

- Consultation should take place with the Older People's champions in the City and in the other District Councils;

- There should be provision of transport in the City for those people who were unable to reach bus stops due to disability, or were unable to use public transport.

- Address the issues with the Ambulance Service first.

- The current criteria as quoted in the paper was more succinct than that quoted in page 69, which is more woolly; and

- Try to combine the best pieces of each criteria into Oxfordshire's.

Mr Wilson and Mr Staples were thanked for their attendance.

21/14 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 12)

The Chairman gave a verbal update on meetings he had attended since the last formal meeting of the Committee. These were:

- An informal meeting with Dr Joe McManners, Clinical Lead of the OCCG;
- Two meetings with Healthwatch Oxfordshire;
- A meeting with Southern Health.

Members also had the opportunity to discuss the Forward Plan and decided to add the South Central Ambulance Service issues into the agenda for the July 2014 meeting. Further suggestions from members for additions to the list were the changes to the Health Advocacy Service and to report back on the Sexual Health Service one year on.

Members were asked by Healthwatch Oxfordshire to give some thought to topics which might be included in their Awareness Day to take place in January.

22/14 DATES OF FUTURE MEETINGS 2014/15

(Agenda No. 13)

The Committee noted the following meeting dates for the 2014/15 municipal year:

- 3 July 2014
- 18 September 2014
- 20 November 2014
- 5 February 2015

..... in the Chair

Date of signing .....

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
3 July 2014

Oxfordshire Joint Health and Wellbeing Strategy 2014-15

Purpose

1. To update the committee on the process for refreshing the Joint Health and Wellbeing Strategy, and to discuss proposed outcomes for 2014/15.

Introduction

2. As reported in May, the Joint Health and Wellbeing Strategy for Oxfordshire is revised annually to take account of findings from the Joint Strategic Needs Assessment, performance issues and other national or local imperatives. The Strategy is a key document for all partners and sets out priorities which are agreed following consideration of the following questions:

    a. Is it a major issue for the long term health of the County?
    b. Are there some critical gaps to which we need to give more attention?
    c. What are we most concerned about with regard to the quality of services?
    d. On what topics can the NHS, Local Government and the public come together and make life better for local people?
    e. Which issues are most important following consultation with the public?

3. The Oxfordshire Health and Wellbeing Board recognise the need to set ambitious targets in the Joint Health and Wellbeing Strategy. This enables the Board members to see progress in addressing important and sometimes difficult issues that need the attention of more than one organisation. Each meeting of the Health and Wellbeing Board includes presentation and discussion on performance for this wide ranging list of outcomes linked to each priority.

4. In order to update the strategy for the year ahead, each of the partnership boards (Adult Health & Social Care, Children & Young People and Health Improvement Boards) will propose new outcomes. They have been reviewing performance against the outcomes set for 2013-14 along with the findings set out in the Joint Strategic Needs Assessment. These proposals will be included in a revised draft Joint Health and Wellbeing Strategy which will be discussed at the Health and Wellbeing Board on July 17th

5. The agreed Joint Health and Wellbeing Strategy will then be published and progress in bringing about change will be monitored closely throughout the year.

Discussion

6. Members of the Health Overview and Scrutiny Committee are invited to comment on the draft proposals before they are published for the Health and Wellbeing Board meeting. These proposals are attached as Appendix A.

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June 2014

Appendix A

Proposed updates to the Oxfordshire Joint Health and Wellbeing Strategy 2014-15

A. Children and Young People Partnership Board

Priority 1 All children have a healthy start in life and stay healthy into adulthood (Children and Young People Board)	
Proposed outcomes for 2014-15	1.1 Increase percentage of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy from 90% to 92%. 1.2 Reduce the rate of emergency admissions to hospital with infections, maintaining low rates through 2014-15 (currently 152.2 per 10,000)

Priority 2 Narrowing the gap for our most disadvantaged and vulnerable groups (Children and Young People Board)	
Proposed outcomes for 2014-15	2.1 Increase the take up of free early education for eligible 2 year olds in 2014/15 to 1800 (from 1036 in 13/14) 2.2 Increase the take up of free early education for 2 year-old Looked After children to 80% 2.3 Maintain the current low level of persistent absence from school for looked after children. Target for 2013-14 academic year is 3.3%. A target for the 2014/15 academic year will be set in the autumn term. 2.4 Maintain the number of looked after children permanently excluded from school at zero. 2.5 Reduce the proportion of children in need who are persistently absent from school from 19.8% (baseline in 2012/13 academic year) 2.6 Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (for the year 2013/14)) and work to reduce this number in the 2014/15 academic year. 2.7 Identify, track and measure the outcomes of all 810 families in Oxfordshire through the Thriving Families Programme, working with 90% of identified families and turning around 80% of families. 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 (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)

Priority 3 Keeping all children and young people safe (Children and Young People Board)	
Proposed outcomes for 2014-15	3.1 Maintain the reduction in risk for victims of domestic abuse considered to be high risk to medium or low through Multi-Agency Risk Assessment Conferences (currently 83% for 2013-14 based on a single-agency assessment by the Independent Domestic Violence Advisor Service. In

	addition establish the baseline for a new multi-agency measure over 2014-15 3.2 Every child considered likely to be at risk of Child Sexual Exploitation (identified using the CSE screening tool) will have a multi-agency plan in place 3.3 Reduce prevalence of Child Sexual Exploitation in Oxfordshire – a new indicator is to be discussed and proposed following Quality Assurance 3.4 Monitor the number of children who go missing and the proportion who go missing 3 or more times within a 12 month period. 3.5 A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. A new indicator is to be discussed and proposed following Quality Assurance

Priority 4 Raising achievement for all children and young people (Children and Young People Board)	
Proposed outcomes for 2014-15	4.1 Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 85% (currently 83%) 4.2 86% of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2013/14 (currently 81% or 5,791 children for the academic year 2012/13) 4.3 80% (or 4800) of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (currently 78% or 4666 children) 4.4 63% of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2013/14 (currently 61% or 3840 children) 4.5 At least 72% (4400 children)) of young people will make the expected 3 levels of progress between key stages 2-4 in English and at least 73%(4400 children) in Maths (currently 71% for English and 72% for Maths) 4.6 Increase the proportion of pupils attending good or outstanding primary schools from 73% to 75% and maintain the proportion attending good or outstanding secondary schools at 87% (currently 73% primary and 87% secondary). 4.7 Of those pupils at School Action Plus, increase the proportion achieving 5 A* - C including English and Maths to 17% (70 children) (currently 10% or 30 children) 4.8 Reduce the persistent absence rates in primary schools to 2.8% and secondary schools to 6.7% by the end of 2013/14 academic year. (The current rates are 3.2% for primary schools and 7.4% for secondary schools) 4.9 Reduce the number of young people not in education, employment or training to below 4% (currently 4.7% or 937 young people). Reduce the number of young people whose NEET status is not known to less than 8% (currently 11%)

B. Adult Health and Social Care Partnership Board

Priority 5 Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential (Adult Health and Social Care Board)	
Proposed outcomes for 2014-15	5.1 1800 people to receive information and advice about areas of support as part of community information networks 5.2 Support for people with a long-term condition who feel supported to manage their condition – new indicator to be proposed by CCG 5.3 Support to people with mental health conditions to have improved physical health – new measure to be confirmed by CCG 5.4 Access to psychological therapies to be improved so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery. 5.5 At least 60% of people with learning disabilities will have an annual physical health check by their GP (baseline tbc) 5.6 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (baseline rate of 951.4 per 100,000) 5.7 Reduce unplanned hospitalisation for chronic conditions that can be actively managed (such as congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension) for people of all ages (baseline rate of 565.4 per 100,000) 5.8 Possible new indicator to be added on mental health delayed discharge. tbc

Priority 6 Support older people to live independently with dignity whilst reducing the need for care and support (Adult Health and Social Care Board)	
Proposed outcomes for 2014-15	6.1 Delayed transfers of care to be reduced according to the targets in the Better Care Fund plan measured in delayed days per 100,000 population (average per month) 6.2 Reduce the number of emergency admissions to hospital for older people (aged 65+) per 100,000 population (average per month) (baseline 23,389) 6.3 Reduce the number of permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000 population to 546 in 2014/15 6.4 Increase the proportion of older people (aged 65+) with an ongoing care package supported to live at home to 61.9% by April 2015 6.5 60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (currently 44.2% or 3516 people) 6.6 Increase the number of people referred to reablement from their own home (as opposed to a hospital stay) to 1875 in 2014/15 from a baseline of 881 in 2012/13 6.7 Increase the proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services to 80% by April 2015

	6.8 Increase the number of providers in Oxfordshire who are rated by the CQC as compliant in terms of treating people with respect. 6.9 Include the Better Care Fund national patient / Service User experience measure once this is developed. 6.10 Ensure an additional 523 Extra Care Housing places by the end of March 2015, bringing the total number of places to 930 6.11 A measure of bereaved carers views on end of life care will be added when it has been developed.

Priority 7 Working together to improve quality and value for money in the Health and Social Care System **(Adult Health and Social Care Board)**	
Proposed outcomes for 2014-15	7.1 A measure of how the County Council and Clinical Commissioning Group and Oxford Health FT are responding to Better Care Fund national conditions for shared care coordination, 7 day access and accountable lead professionals will be added 7.2 A national measure of patient / service user experience will be added once developed (in line with the Better Care Fund) 7.3 Increase the number of carers known and supported by adult social care by 10% to 17,000 (currently 15,475 are known) **7.4** At least 880 carers breaks jointly funded and accessed via GPs (currently 880)

C. Health Improvement Partnership Board

15	
Proposed outcomes for 2014-15	8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years) and an equity audit should be conducted to ensure all population groups are responding. ***Responsible Organisation: NHS England*** 8.2 Of people aged 40-74 who are eligible for health checks at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%. ***Responsible Organisation: Oxfordshire County Council*** 8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% ***Responsible Organisation: Oxfordshire County Council*** **8.4** At least 3800 people will quit smoking for at least 4 weeks. Report the baseline for women smoking in pregnancy in Oxfordshire. ***Responsible Organisation: Oxfordshire County Council*** ***8.5*** The 2014-15 target for opiate users successfully leaving treatment tbc ***Responsible Organisation: Oxfordshire County Council*** 8.6 The 2014-15 target for non-opiate users successfully leaving treatment tbc ***Responsible Organisation: Oxfordshire County Council***

Priority 9 Preventing chronic disease through tackling obesity (Health Improvement Board)	
Proposed outcomes for 2014-15	9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2013 this was 15.2%) No district population should record more than 19% ***Responsible Organisation: Oxfordshire County Council*** 9.2 Change the physical activity indicator to reflect the number of people who are NOT physically active and set an outcome to reduce this rate. The latest Active People Survey reported that 116,943 aged 16 or older are termed sedentary (doing less than 30 minutes of activity per week). This is a rate of 22.2% against 28.5% nationally. Oxfordshire Sports Partnership have a target of 38000 People no longer inactive by 2017 - moving 1% of the population from zero to doing something per week. ***Responsible Organisation: District Councils through the Sports Partnership*** 9.3 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: NHS England and Clinical Commissioning Group***

Priority 10 Tackling the broader determinants of health through better housing and preventing homelessness (Health Improvement Board)	
Proposed outcomes for 2014-15	10.1 The number of households in temporary accommodation on 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire in 2013-14) ***Responsible Organisation: District Councils*** 10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9%). ***Responsible Organisation: Oxfordshire County Council*** 10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013- 2014 when there were 2837 households known to services). This can now be reported 6 monthly. ***Responsible Organisation: District Councils*** 10.4 To establish a baseline of the number of households in Oxfordshire, who have received significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners. It is hoped that an aspirational baseline target of 550 households will be reached. ***Responsible Organisation: Affordable Warmth Network.***

Priority 11 Preventing infectious disease through immunisation (Health Improvement Board)	
Proposed outcomes for 2014-15	11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England*** 11.2 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 93.7%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England*** 11.3 – At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 55%) ***Responsible Organisation: NHS England*** 11.4 HPV targets - to be advised by Public Health Protection Forum

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT VII

Reporting on 2013/14
Produced: June 2014

Contents

Foreword

This is the seventh Director of Public Health Annual Report and the first since Public Health returned to Local Government.

As well as reporting on the overall state of health and wellbeing of the county, I will:

- Report on the Public Health services that the county council is now responsible for as set out in legislation.
- Reflect on the opportunities afforded by the return of Public Health to Local Government and sketch out some of what the future may hold.

The report begins with an analysis on these opportunities.

This is followed by sections reporting on services, important issues and progress in the following chapters:

1. **The Best Start in Life**
2. **Improving Quality of Life for All**
3. **Reducing Inequalities in Health**
4. **Infectious and Communicable Diseases**

In response to feedback, I have made this report more compact and 'punchier' so that I can report on a wider range of topics of concern.

As ever I am keen to ensure the report is:

- Based on independent science and fact
- Focussed on the major 'gaps' across the county which affect people the most

The report has benefitted as always from the input and views of many people and I am grateful to them. I would like to thank them for their generosity, their time and their trouble and I have acknowledged their contribution at the end of this report.

I hope you enjoy the report and use it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
June 2014

Introduction

Public Health in Local Government: An Analysis of Opportunities and Future Prospects

The Return Home

Public Health has its roots in Local Government and was 'invented' there in its modern form. The first Medical Officer of Health was appointed in Liverpool in 1847, a Dr William Henry Duncan.

The issues of the day were somewhat different but all too familiar, for example:

- Infectious disease
- Poor sanitation
- Overcrowding
- Poor nutrition
- Poverty

These conditions combined then, as now, to weaken the constitution, make people more susceptible to disease and led to a shorter life span.

My forebears advised Councils on how to tackle these issues and began to oversee services which have led to our modern health visiting, school health nursing, social services and environmental health services. As now, links with local Doctors and hospitals were crucial.

It is also important to remember that lifespan was also reduced by frequent warfare on a massive scale, and we should not underestimate the contribution of peace to the health of the public.

Back To the Future

In many ways we are now coming full-circle. The Health of the Public has improved beyond recognition, largely due to improved sanitation, housing, diet, education and an improved average standard of living. Life span has lengthened gradually as a result. 100 years ago the average life span for women was 54 and is now 85. The average span for men was 50 and is now 82.

Councils today continue to fight to improve the lot of local people and there is still much to be done. The roots of poor health do not go away, and although the means of combatting them have changed, there are still many things we can do to improve things further.

Modern medicine has also made a great contribution. We are now in a position to prevent more illnesses than ever before and have powerful drugs to lower cholesterol and reduce heart disease. Improved cancer prevention and treatment have made an impact. The introduction of mass immunisation and screening programmes has been a major success. The modern primary care centre is now as much a public health service as it is a disease-treatment service. We need to work together to continue these efforts.

Success brings new challenges

This success also brings a new generation of challenges which we now face. We have an ageing population, and helping people to achieving **a healthy and productive old age** is a major challenge.

The change in working patterns and changes in the rural economy and housing tenure mean that we now have the issue of **rural isolation** to face as well as the more familiar **'urban' pattern of disadvantage** which is rooted in relative poverty.

Modern prosperity depends upon **mobility and good communications** and the stresses on our transport systems will only grow and the challenges of this are now being faced.

We also live in a cosmopolitan society, and we will need to accommodate **a more multi-cultural county** as demonstrated by the last census.

The role of state funding of services is also constantly under review, particularly in the current financial climate. Whatever the outcome, it is likely that we will need to find ways to **help communities to help themselves**.

It is the role of modern Public Health to take an overview of all these issues and bring scientific advice to those who are charged with finding solutions. In this way, the modern role of Public Health is simply a re-casting of the traditional role for the modern era.

The benefits of working in Local Government

I want to highlight some of the immediate benefits which I have seen over the last year. These have been wide ranging and were not all anticipated and so are well worth reporting. I would list them as follows:

- **The support of the whole Council and Cabinet and a dedicated cabinet member.**
  The whole Council has been very welcoming and supportive of its new statutory Public Health functions. Debate has been strong over a range of issues and I think this has led to a better service which can now be tailored to meet the needs of individual communities. For example, our school health nurses will be able to create a plan tailored to each individual secondary school. In the past, services tended to be 'one size fits all', and we now have more opportunities to shape services to **local circumstances.**

  We have also benefitted from a dedicated cabinet member who has been a strong advocate for the Public Health cause both internally and externally. This has led, for example to much improved communication campaigns with the public on key health messages and has led to a much improved school health nursing service.

- **An oversight role enshrined in law.**
  The Director of Public Health's remit is to take an overview of many services and raise concerns if they are not performing well whether they are run by the Council or not. For example, we have new roles in overseeing and influencing immunisation and screening

services run by the NHS. These are currently performing well, but if they do not, we have the ability to raise concerns in public through the Health and Wellbeing Board and to make recommendations to the Health Overview and Scrutiny Committee to investigate in depth. These are powerful tools and we should not hesitate to use them as fail-safes.

- **The span and influence of the Council.**
  I have continued to be amazed by the breadth and depth of services run by the Council and by its wider influence. For example links with the **Voluntary Sector, Faith communities and the underpinning role of the Lord Lieutenant** have opened up unexpected vistas. This is beginning to bear fruit, especially in more constructive relationships with the voluntary sector in times of rapid change. For example we are currently re-working our relationships with important bodies such as the Oxfordshire Council for Voluntary Action and with the Oxfordshire Rural Community Council.

  The Council also has important links with local business and these too open up wider horizons for the future.

- **The Work Of the Health and Wellbeing Board.**
  The Health and Wellbeing Board has developed well. It's strategy is influential and its Joint Strategic Needs Assessment is a rich mine of information regarding health in Oxfordshire. Its 3 supporting boards (for Adults, Children and Health Improvement) have all been able to take great strides forward during the year. The Board really has helped to bind together Local Government with the different parts of the local NHS. The increased focus on safeguarding and quality has been an important and timely improvement.

- **Separating contracts for Public Health services from large NHS contracts.**
  In the past services for contraception and sexual health were part of larger 'block' NHS contracts. Separating them out has meant we have been able to use the **'sharper' Local Government contracts** to specify services more accurately and to tune them to local needs. Again our new sexual health services and school health nursing services are evidence of this.

- **A longer term financial horizon.**
  NHS accounts are very much run on an annual basis. As Public Health is by definition a long term effort, this always led to difficulties in planning properly for the medium and long term. The Council's four year planning process has been a revelation as it enables us to plan and budget a number of years ahead. This is a boon for Public Health services and we are now able to make outline plans up to 2017/18. Of course, such plans always have to remain flexible as we live in a rapidly changing fiscal environment, but the gains are significant.

- **A dedicated grant for Public Health.**
  It has been very helpful to have a specific grant for Public Health in these early years. Whether or not this is continued, it has given us the opportunity to establish core services under Local Authority contracts and has given a degree of stability and confidence which preventative services need to thrive.

- **Closer working with the Chief Executive and other Directors.**
  Senior colleagues have been quick to recognise the value of Public Health services and, having had a year of consolidation. We are now beginning to explore and exploit the synergies of planning services for the future together to create a Thriving Oxfordshire.

- **Constructive scrutiny and local democracy.**
  During the year we have benefitted from formal scrutiny and from the increased constructive challenge which lies at the heart of Local Government.

  Public Health may have global ideals, but its implementation is fundamentally local and it touches the lives of all. We are all experts in public health and we all have a relevant contribution to make. This is meat and drink to local democracy and I am confident that this local interest and debate will help us to thrive in the years to come. This isn't all easy-going, as opinions differ and difficult choices have to be made. The fact is that we cannot do everything we would like, but I am sure that we are making better, more rounded decisions as a result, and these are more grounded in the needs of local people.

- **Improved partnership working.**
  No single statutory service can go it alone, and partnerships with non-statutory agencies and the public are crucial now and will become more so. Relationships are not too 'cosy' and partners are able to challenge one another constructively.

  Every organisation has a Public Health role and we need to be able to work together with others to take forward our common aims to turn a flotilla into a taskforce.
  We benefit from cordial relationships in Oxfordshire and we should be proud of our ability to work together which will become increasingly important over the years.

  Partnerships between the three tiers of Local Government will be crucial. The strengthened role of districts and city Council in the work of the Health Improvement Board is bearing fruit.

  The Health and Wellbeing Board has also provided a framework for the closer integration of health and adult social care we will need, and partnerships across children's services have been strengthened.

  Local government has also been able to work together with the Universities and local industry to create the City Deal which is something of a landmark.

  Public Health advice nationally and some of our local services are run by Public Health England, which reports to the Department of Health. We have established a very constructive working arrangement with Public Health England and this has enabled us, for example, to improve our drug addiction services and work together on infectious disease issues during the year. This is an important relationship which we need to build upon. The challenge will be to keep these partnerships focussed on the big issues and to use them to broker the important 'deals' we will have to do to hold services together. Local Government's strengthened role in these partnerships has proved to be pivotal.

- **More direct links with and involvement of the public.**
  During the year we have benefitted from improved public involvement in our work. This needs to continue to develop. As well as the direct input of councillors as representatives of the public we have established good working relationships with Healthwatch and our public representatives on the Health Improvement Board have advised on all matters.

- **A focus on quality.**
  There is, rightly, an ever increasing emphasis on the quality of public services. Public Health has brought a new range of clinical services to the council and we have been keen to set up a new system of quality monitoring and assurance to make sure these services are up to the mark. In addition, the Health and Wellbeing Board has had a clear focus on quality, helping to assure quality of NHS services as well receiving reports from our Safeguarding Boards.

- **A Focus on safeguarding.**
  Many public health services affect young people. It has been very useful to be able to develop and strengthen safeguarding arrangements including the prevention of child sexual exploitation through our new service specifications for school health nursing, sexual health and drug and alcohol services. We have also ensured that the conclusions of our safeguarding boards feed into the work of the Health and Wellbeing Board and we have been able to advise the children's safeguarding board about the epidemiology of female genital mutilation.

- **Specific service improvements.**
  As I mentioned above, during the year we have been able to establish improved services for school health nursing and sexual health. Both of these services are expanded and improved. They will need to bed down during the year and we have benefitted from the input of councillors and head teachers in getting the right local feel for services.

- **A new School Health Nursing Service.**
  We have specified that we wish to have one named School Health Nurse working in each of our secondary schools – a significant expansion within the allotted financial envelope. This expansion will be implemented throughout the year and will result in better public health in our schools as well as improving the care of care of children with physical and psychological needs and strengthening safeguarding. Each school will have its own plan designed hand in hand with head teachers.

- **Improved Sexual Health Services.**
  We have modernised our sexual health services while keeping the existing network of community clinics. The public will now be offered a 'one-stop-shop' service for all their needs and we have reduced duplication in the old system. This service will be closely monitored during the year to ensure it bears the promised fruit.

- **The continued importance of the NHS and Partners.**
  Although public health has moved to Local Government, we need to keep close cooperative links with our colleagues in the NHS so that we can develop services together. It will be particularly important to work closely with GPs and their teams.

  During the year we have also begun some exciting work to bring more prevention into the work of Oxford University Hospitals Trust and I commend the Trust for their part in this joint venture. Our public health trainees have been pivotal in making this happen.

Opportunities for the future

Public Health is everyone's business and we all have a role to play. The Public Health team is small and we have to 'punch above our weight' by working with and through others to influence a wide range of policies.

Public Health is a long term approach and we cannot do everything at once, but it is important to set out a broad canvas to shape our future vision.

I wanted to highlight some of these opportunities for the future here, and pick out especially the priorities for the coming year as well as the work of the years to come.

- **Completing our 'core' services.**
  During the next year we will substantially complete the modernisation of our portfolio of core services. Key amongst these will be:
    - Re-commissioning our drug and alcohol services
    - Re-commissioning our services to help people give up smoking
    - Improving the health checks offered by GPs.
    - Developing work on the new 'healthy weight strategy'.
    - Co-commissioning public health services for 0-5s (Health Visitors and Family Nurse Partnership) in preparation for transfer of commissioning responsibility from the NHS in Autumn 2015.

  Each of these will be strengthened to give a better service and each one will play an important role in preventing disease and early death.

- **Keeping up our Watchdog role.**
  We need to stay vigilant to make sure that good services continue to improve. This will mean working with, and if needs be, holding to account the commissioners of services for screening, immunisation and infectious disease control. Many of these services now span different organisations and we will need to continue monitor the situation with impartiality. Examples of this are services for immunisation, breastfeeding and tuberculosis. These are mostly provided by the NHS with help and advice from Public Health England. Our services are currently good: we need to stay vigilant, monitor services closely, work together to make improvements and speak out when we need to.

- **Children's Services.**
  There are real opportunities for giving children in the county a better start in life.

During 2014 the council will prepare to take on the commissioning of Health Visitor services from the NHS and we will work with the NHS to make this a success. Final transfer will take place in October 2015. This is exciting as these services have their roots in Local Government from the time when the Government was shocked at the poor health of its young people in the shape of recruits for the Boer War.

We need to plan how to improve the join-up of children's services, bringing together the work of school health nursing with new safeguarding services, children's social care, early intervention services and preparing the way for Health Visitors. This is good news because the council will now have a strong portfolio of services to give children the start they need and deserve.

- **Services for adults.**
  It has never been more important for adults to reach their 60s and 70s in good shape and so prepare the ground for a healthy old age. This means that both NHS and adult social care services will need to take a preventative approach and plan services together. We have started well on this with strong partnerships with the NHS and we now need to make sure Public Health plays its role too.

  As factors such as loneliness and poor social networks come to the fore as important influences on health in old age, it will be important to work ever more closely with voluntary services to make this work.

  I want to stress the importance of reaching old age with a reasonably healthy weight. Overweight not only causes disease, but it reduces mobility and exacerbates disability too. This makes getting out and about more difficult which in turn increases isolation, lowers the mood and this means that diseases hit harder.

  There is great potential for bringing a Public Health approach to the planning and commissioning of adult social care and this will be a focus of work in the coming year.

- **The 'Broader Determinants of Health'.**
  This is a jargon term which means that factors like the quality of your neighbourhood, the quality of your home, your access to green spaces, the food offered in local shops, your access to cycle paths, the quality of local sports facilities and community centres all have an impact on your health. Many of these factors are heavily influenced by district councils, and it will be important to work more closely with them to keep standards high and make improvements. The district councillors on the Health Improvement Board have a key role to play in influencing this.

- **Health promoting communities.**
  This is something of a Holy Grail. The question is, "How do you encourage and facilitate communities to improve their own health by their own efforts in a times of fiscal tightness". I do not have the answer to this, but it is important that we continue to search for the right levers to pull.

- **The economy, prosperity and skills.**
  A reasonable standard of living is a pre-requisite for good health. Oxfordshire's economy is comparatively healthy and needs to remain so. The work done by all agencies to maintain prosperity and to create real jobs is a key support to good health.
  Having the right skills to fill these real jobs is important too. There will be a boom in science and technology jobs in the county and we need to make sure that our education system is geared up to encourage young people in this direction.

- **New partners and the role of individuals.**
  If we are to strengthen our communities we need to coordinate what we do with a wider ranging group of organisations and individuals.

  During the last year joint work with local industry and with the universities has strengthened. There are opportunities for the Public Health team to work more closely with the universities too, and a promising conference was held locally last month to set the ground work for this. Directors of Public Health working across Thames Valley will have an important role to play in making this happen.

  Philanthropic individuals have always been important, but never more so as state funding becomes tighter. We are seeing this already through practical offers of support to voluntary organisations and local communities. To an extent we will need to let '1000 flowers bloom', as philanthropists are by nature highly individualistic. However, others are keen to support the development of voluntary agencies across the board and find new ways to wean them off state funding.

  Oxfordshire is tremendously rich in creative and talented people who are keen to share their skills and expertise. The work of the Lord Lieutenant, the Vice-Lord Lieutenant and 36 Deputy Lieutenants demonstrates this well. We will need to work in partnership with these individuals in the coming years.

  Individual philanthropy has a Victorian ring to it and this seems a fitting 'back to the future' note on which to close this section. In the future, individuals, communities and the State will need to work hand in hand. Overall I feel that we face challenges which may be different to those of 100 years ago but which are every bit as pressing. The solutions we have to find will be new ones and I am confident that Public Health is well placed in local government to play an important part in that quest.

1. The Best Start in Life

The Health Visiting service

Why is this important?
Health visiting is a universal service for all aimed at the under three's and their families. There is a national specification for Health Visiting which covers important topics such as parenting skills, breastfeeding and good nutrition. Regular screening reviews are also carried out to spot problems early. Health Visitors also play a key role in child protection. The Health Visiting service is one of the jewels in the crown of a comprehensive Public Health service.

There are currently 114 whole time Health Visitor posts in Oxfordshire – a substantial workforce. The commissioning of these posts will pass to Local Government from the NHS in Autumn 2015 but the terms of this transfer are not yet clear. It is likely that a universal service working to a basic national specification will be required. The important question will be, "How can we improve on this for Oxfordshire?". We are already making plans and working closely with the NHS to get the best out of the transfer and we will join this up with existing council and NHS services.

How does Oxfordshire compare with elsewhere?
The short answer is – very well. We are well staffed compared with elsewhere and the figures for completed reviews of children are better than the England and Regional averages.

The table below shows the key data from quarter 2 in 2013/14.

Indicator	Thames Valley Quarter 2	England Quarter 2	**Oxon Quarter 2**
New birth visit within 14 days	53%	74%	**83%**
Review at 12 months	45%	65%	**89%**
Review at 2-2.5 years	60%	63%	**95%**
Breastfeeding received at 6-8 weeks	48%	41%	**60%**
Breastfeeding status recorded at 6-8 weeks	99%	96%	**100%**

Recommended Next Steps
1. Work with the NHS to ensure a high quality transfer.
2. Make sure the service joins up well with other Local Authority children's services.
3. Build on and improve the figures in the table above.
4. Make sure that the service is both universal and also targeted at those who need it most.

Breastfeeding

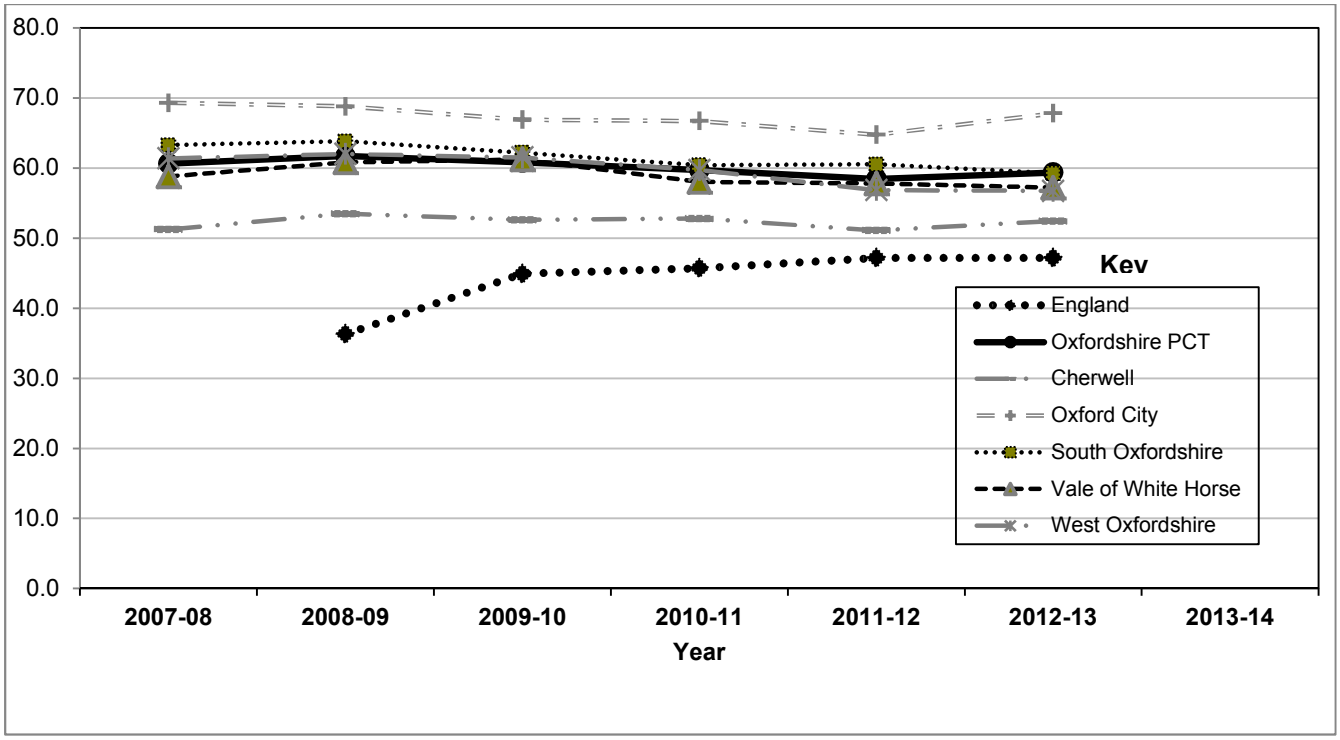
Why is this important?
Breastfeeding provides a great start to life. It gives a baby the best possible nutrition, protects against disease and future obesity and encourages a strong bond between mother and baby.

Breastfeeding is largely the responsibility of the NHS and the Health and Wellbeing Board has chosen this as a priority to keep the rates as high as possible.

How does Oxfordshire compare with elsewhere?
The chart below shows that Oxfordshire's breastfeeding rates at 6 to 8 weeks are more than 10 percentage points higher than national rates at around 60%. This is a good achievement.

However, there is considerable variation between districts, and, while all perform better than the national average, Oxford city outperforms the county average and Cherwell underperforms. There are also wide differences within districts. For example the city contains general practices with very high and very low rates. In general, data from the general practices with the most disadvantaged populations have lower rates – this is an important inequality which casts 'long shadows forward' throughout life. In addition the rates have peaked at around 60% for some years.

While breastfeeding is a skill that often has to be learned and supported, it is not possible for everyone- we need to keep these rates as high as possible, bearing this in mind.



Recommended Next Steps
1. Work with the NHS to keep rates high and keep this topic as a priority target for our Joint Health and Wellbeing Strategy.
2. Understand the opportunities to improve services which may be possible when Health Visiting services transfer to the Local Authority.
3. Look more closely at rates within individual practices and support those with the lowest rates.

4) Work with the Health Improvement Board and the NHS to 'drill down' into the data to target services to best meet local needs.

School Health Nurses

Why is this important?
School Health Nurses are crucial. They work with schools to promote better health, help children with physical and psychological difficulties and play a key role in safeguarding. They also immunise young people in school and carry out the weight checks in reception year and year 6 which have proved so valuable in combatting the epidemic of obesity. The responsibility for this service has now passed from the NHS to the county council.

How does the Oxfordshire service compare with elsewhere?
In April 2014, Oxfordshire County Council commissioned a school health nursing service which redefined the concept of school nurses. Every secondary school will have a full time school nurse with the primary remit of promoting health and wellbeing in the school. The school nurse will work with the staff to understand the needs of the young people and design a Public Health plan accordingly. This service provides support for all young people but is also targeted at those who need help the most.

This gives us the potential to improve the health of every child in the county. The service is proving to be an exemplar for other Local Authorities. We have commissioned a much improved service within the allotted resources and are working closely with Oxford Health Foundation Trust (OHFT) who provide the service, to bed this in.

Recommended Next Steps
1. Work closely with schools and OHFT to develop the service during the next year as the staffing numbers are built up to the specified levels.
2. Work closely with nurses to make sure that high quality plans are drawn up with each school that make a real difference.
3. Work closely with other children's services in the council and the NHS to make sure this service joins up with existing services and health services and strengthens safeguarding.

Childhood Immunisation

Why is this important?
Immunisation is one of the keys to a good start in life. Some of the most feared and potentially life threatening diseases of the past like diphtheria and diseases which can have profound complications like measles and rubella have declined markedly in recent decades because of immunisation.

It is imperative that immunisation levels are kept high as this protects all children and adults as the disease finds it harder to spread in communities.

This topic is particularly important because of the recent health service reorganisation which means that immunisation services are the responsibility of the NHS at Thames Valley level.

The Local Authority has an important watchdog role to make sure uptake levels in Oxfordshire remain high. We do this in three ways, firstly by working with NHS colleagues and promoting immunisation through public campaigns, secondly by monitoring the situation closely ourselves and thirdly having systems in place to hold the NHS to account if needs be. We do this through our Health and Wellbeing Board, and the signs are that this is working well. Our Health Overview and Scrutiny Committee could also scrutinise these services if it chose to do so.

It has been a busy year for immunisation and during the year. New immunisations have been rolled out for Rotavirus in 2 and 3 month olds (which causes gastroenteritis) and Flu in 2 and 3 year olds.

How does Oxfordshire compare with elsewhere?

The table below shows uptake data for key immunisations in Oxfordshire over the last year. It shows that our rates are above the national and regional average and that things are generally satisfactory. Eternal vigilance remains our watchword. The national targets of 95% uptake across the board are in some cases aspirational because many children move in and out of the county during the year and so we are always playing catch-up to immunise the last few children in each age group.

Oxfordshire Cover Data 2012/13 and up to Q3 2013/14						
Target 2013/14	**96.5%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**
	% uptake Diptheria, Tetanus, Whooping Cough, Polio and Haemophilus influenzae type b age 1 year	**% uptake pneumococcal infections age 2 years**	**% uptake Haemophilus influenzae type b (Hib) and meningitis C. age 2 years**	**% uptake Mumps, Measles and Rubella age 2 years**	**% uptake Mumps, Measles and Rubella age 5 years**	**% uptake Diptheria, Tetanus, Whooping Cough, Polio Booster age 5 years**
Oxfordshire 2012/13	96.9	95.3	95.3	95.1	93.2	94.3
England 2012/13	*94.7*	*92.5*	*92.7*	*92.3*	*88.7*	*88.9*
Oxfordshire 2013/14 Q1	97.2	96.4	96.3	96.2	92.4	93.6
Oxfordshire 2013/14 Q2	96.9	95.4	95.1	95.0	93.1	95.7
Oxfordshire 2013/14 Q3	96.9	95.3	95.3	95.1	92.5	93.0
Thames Valley Area Team Q3	*94.7*	*93.2*	*93.7*	*94.0*	*89.1*	*88.9*

Recommended Next Steps

1. Maintain vigilance and work with the NHS to keep the immunisation levels high and gradually improving.
2. Maintain our active monitoring of the situation through the Joint Health and Wellbeing Strategy and take immediate action if performance begins to slip.
3. Identify and target inequalities and work with the NHS to increase uptake in communities with lower than average uptake rates.

Childhood Overweight and Obesity

Why is this important?

The trends of childhood overweight and obesity are a cause for concern nationally and locally. Children who are overweight or obese are more likely to be obese adults and children of obese parents are at greater risk of obesity themselves. In children, obesity is associated with increased risk of increased blood pressure, type 2 (late onset) diabetes, earlier menstruation, exacerbation of asthma, low self-esteem, depression, eating disorders and social stigma, such as bullying, teasing and discrimination.

How does Oxfordshire compare with elsewhere?

Fortunately, childhood obesity rates in Oxfordshire overall below the regional and national rates. In 2012/13, obesity rates fell for the first time since measurements began. This is a good result, but isn't a cause for complacency and we need to ensure this is not just a statistical 'blip'. The National Child Measurement Programme (NCMP) highlights the following in Oxfordshire.
In 2012 – 2013:

- Obesity prevalence in Reception year in 2012/13 reduced from 7.0% to 6.4%. This is lower than the national average which is 9.4%.
- In Year 6, obesity prevalence reduced from 15.6% to 15.2% and remains significantly lower than England.
- Nearly 1 in 5 of the children in Reception were either overweight or obese; in Year 6 this proportion was 3 in 10.
- The percentage of obese children in Year 6 (15.2%) was more than double the percentage in Reception Year (7.2%) showing that obesity gradually increases with age, beginning in childhood.
- In Reception Year and Year 6, all of the districts in Oxfordshire apart from Oxford city have obesity rates lower than the England average. However, in Oxford, nearly 1 in 5 children in year 6 are classified as obese.
- Participation in the measurement programme is lower in Oxford compared with the rest of Oxfordshire.
- There is a relationship between obesity rates and pockets of disadvantage in Oxfordshire. As Oxfordshire is relatively prosperous, these inequalities are sometimes masked by the lower rates in other areas.

During the year the Health Improvement Board has monitored the situation closely and we have strengthened the services the council commissions to help overweight children lose weight. The new School Health Nursing service will also need to play its part in this work through the school plans that are being developed. The Health Improvement Board also

agreed a 'Healthy Weight Strategy' for the county in which partnerships with district councils will be very important as they provide or commission services for leisure, recreation and exercise which are crucial.

Recommended Next Steps

1. Continue to promote the council's Child Measurement Programme in reception year and year 6 so that we can accurately monitor progress through the School Health Nursing contract.
2. Roll out the new Health Weight Strategy across the county.
3. Prepare for the key role Health Visitors will play in getting babies and young children off to a good start through breastfeeding and good nutrition.
4. Work with School Health Nurses to develop plans within schools to help young people eat well and exercise more.

Teenage Pregnancy

I have reported on teenage pregnancy at length in previous annual reports. I wanted to record here the positive news that rates continue to fall across Oxfordshire. The pattern of teenage pregnancies between different localities remains broadly the same. County figures for the last 15 years show a fall in rates from around 31 pregnancies per 1,000 15 to 17 year olds to around 21 pregnancies per 1,000 15 to 17 year olds ,the lowest figures since 1998 when recording began. This is a good result.

2. Improving Quality of Life for All

Factors such as poor mental health, overweight, smoking, excessive drinking, and drug abuse all detract from our quality of life as well as causing disease. This can culminate in an early death. This section explores the most pressing of these issues.

Mental Health and Wellbeing: One in Four Of Us

Why is this important?
One in four of us will suffer from mental health problems of some kind during our lives. Good mental health is essential for ensuring the wellbeing of the population. As well as being an essential component of wellbeing in and of itself, people experiencing more severe forms of poor mental health are far more likely to be smokers, to abuse drugs and alcohol and to be inactive and obese

Anxiety and depression are very common disorders. In spite of mental illness being common, it remains difficult to talk about and is poorly understood which can lead to stigmatisation. People also tend to have poor knowledge of what can be done to treat them. It is therefore vital that we make sure that good mental health and wellbeing are prominent in our Public Health efforts for the population of Oxfordshire.

How does Oxfordshire compare with elsewhere?
Oxfordshire County Council works closely with its NHS colleagues to provide a clear range of services for people suffering with mental health issues. The NHS works closely with community pharmacies, children's centres, schools, the voluntary sector, Universities, and Local authority services to make sure patients get 'joined up' care. For example:

- Oxfordshire Mind runs a telephone information services as well as an online directory to signpost people to mental health services in the county. They also run county-wide support services for people with mental health problems.
- The charity Restore offers creative work, rehabilitation and training for people experiencing mental health problems in Oxfordshire.

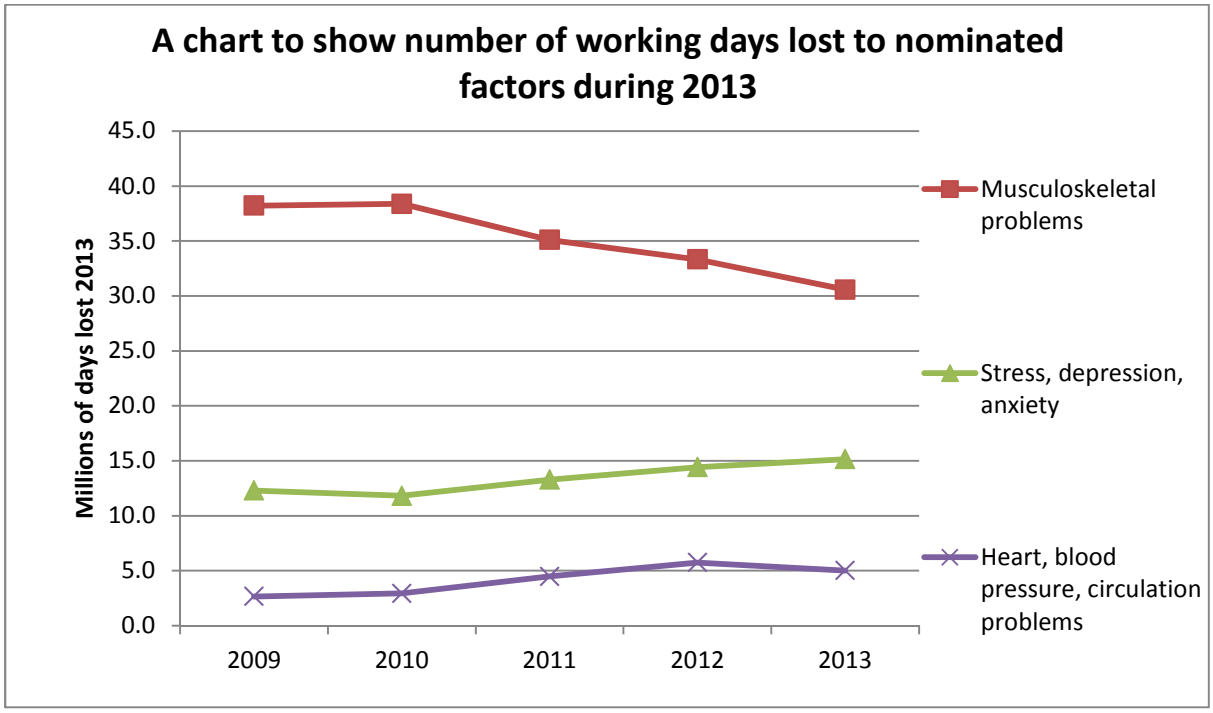
Key tasks for 2014/15 are to promote mental health and wellbeing for men in Oxfordshire and to ensure that training in mental health is available for all front line health professionals.

It is important that this topic is maintained as an important priority for all services.

Recommended Next Steps
1. Develop a public mental health strategy that focuses on prevention of mental illness and promotion of mental health and wellbeing.
2. Ensure that mental health is integrated in to all Public Health commissioning, with particular emphasis on healthy workforce strategies, smoking, drugs and alcohol and healthy weight services.

Health in the Workplace

Why is this important?
National data on sickness absence rates tell their own story and are shown in the chart below.



Musculoskeletal problems (e.g. bad backs, sprains etc.) are the leading cause with 30 million days lost per year, but stress, depression and anxiety are common too – about half as common as musculoskeletal problems, as pointed out in the previous section. Overall it is estimated that the cost to the economy is around £14 billion per year.

What Shall We Do About It?
Not all sickness is preventable but some may be. Looking at the council's own workforce is a useful place to start. The council already has good supportive policies in place, but during 2014 we will try to improve on this by trialling a healthy workforce campaign focussing on:

- Physical activity
- Healthy Eating
- Reducing Stress
- Mental Wellbeing

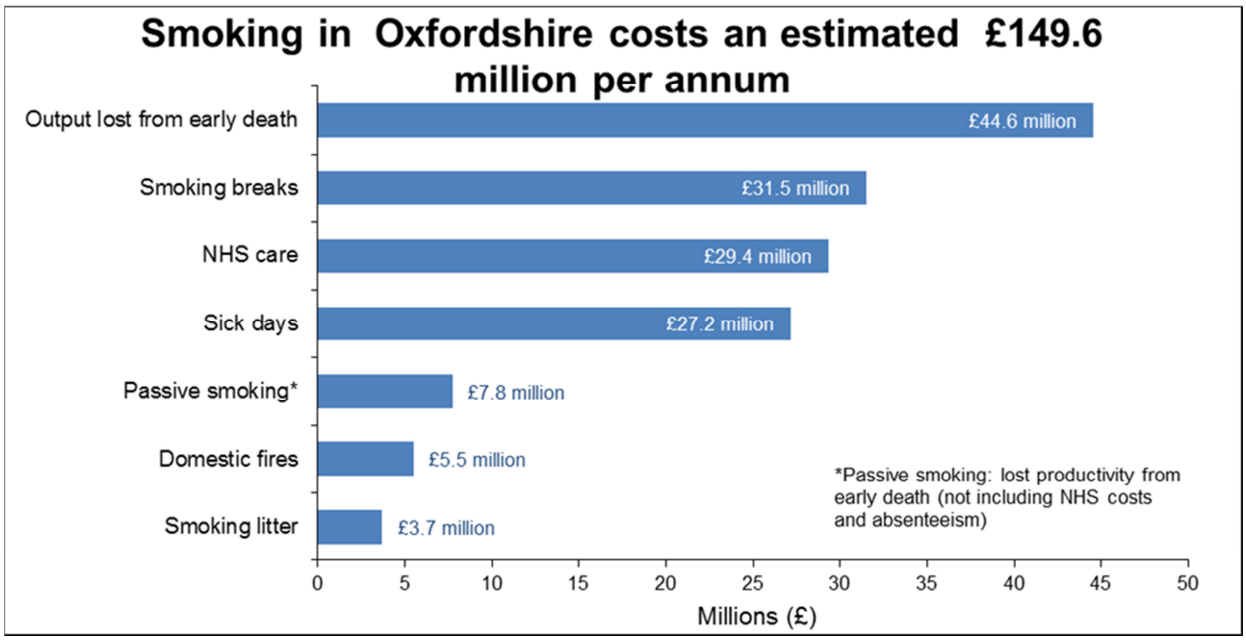
We will then review this and judge whether it was effective and whether this is a model we can offer to other businesses in Oxfordshire.

Recommended Next Steps
1. Roll out and review the Healthy Workforce programme beginning with the county council.
2. Decide whether this programme might be applicable to other employers in Oxfordshire.
3. If it shows promise, discuss this further with colleagues and take the agreed action.

Giving up Smoking

Why is this important?

Smoking tobacco is still the major cause of preventable ill health and premature death in the UK. Every year, over 100,000 smokers in the UK die from smoking-related causes. Despite the well known risks to their health, nearly 15% of adults in Oxfordshire are still smoking. Smoking harms individuals but also the local community. One estimate gives the approximate figure of, £13.8 billion for the total cost to society of smoking in England in 2010.(Cough Up: Balancing tobacco income and costs in society Report, Policy Exchange Thinktank 2010). The same estimate gives a figure of around £150 million per year in Oxfordshire. The table below gives the estimated breakdown.



Although the prevalence of smoking is falling in the county and it is lower than national and regional rates, the benefits of stopping, or not starting in the first place, are still not being realised universally across the population.

The least well-off in our county are twice as likely to smoke that the most well-off, with 30% of routine and manual workers smoking compared to 14% of managerial and professional workers. Most smokers start before the age of 19 and studies consistently show that the largest influence on children's smoking is whether or not their parents smoke. Reducing the prevalence of adult smokers will reduce the role-modelling effect, and prevent more young people from taking up the habit.

What are we doing about it in Oxfordshire?

1. We continue to commission smoking cessation services from GP practices and community pharmacies which support and encourage people to quit and set ourselves tough smoking quit targets to reduce the number of adult smokers. In 2012-13, 3,703 smokers quit for at least 4-weeks.
2. We have piloted a new outreach service to deliver smoking cessation consultation and support in community settings such as Templars Square in Oxford. This has been very

successful at reaching communities at greater risk with 66% of quitters coming from target groups.
3. We support annual campaigns such as Stoptober and No-Smoking Day in conjunction with trained smoking cessation advisors and providers of smoking cessation support in Oxfordshire.
4. Smoking cessation specialists continue to deliver tobacco education, smoking cessation training and advice on tobacco control policy to staff and members of the public in schools and colleges, children's centres and hubs, prisons and detention centres, mosques, inpatient and community mental health settings, in our hospitals and community hospitals, in learning disability settings, workplaces, military settings and many more.
5. We continue to work with the council's Trading Standards team to enforce statutory legislation such as underage sales and tackling smuggled and counterfeit tobacco.

In addition, it has never been easier for people to help themselves. Nicotine gums, tablets and patches are available in many shops and really help people to stop.

Recommended Next Steps
1. The Health Improvement Board should continue to prioritise local action to reduce inequalities in smoking and smoking quitting rates.
2. We will re-commission our smoking cessation services in the light of the experience gained above.
3. We will experiment with more targeted ways to help 'hard to reach' groups.

Drug and Alcohol Addiction

Why is this important?
Drugs and alcohol consumption has a huge impact on the individual, on families, on communities and wider society. Problems with drugs and alcohol can lead to loss of employment, family breakdown and criminality, and these problems unfortunately affect us all.

It is vital that we provide information, advice, support and good quality effective treatment for young people and adults alike. This starts with good education within school and making sure schools have access to advice and support.

For adults, it is important that we have well thought through Public Health messages on safe drinking which steer a careful course towards informing and away from nannying.
We also need to provide sound advice, information, support and a range of treatment options for both drugs and alcohol and support for families and carers.
We need to make sure children of drug and alcohol addicted parents have support and access to the services they require.

It is also important that we meet new challenges, such as the challenge of new 'psychoactive substances' known as 'legal highs' which pose a significant threat.

- On average, 2600 individuals receive treatment for problems with drugs or alcohol over the course of a year in Oxfordshire.
- About 1600 of these individuals are addicted to opiates e.g. heroin.
- We support 800 people with alcohol problems and alcohol addiction
- In Oxfordshire services are good at getting people into treatment but need to be more effective in helping people to recover from addiction.

What are we doing about it?

- During the last year we increased drugs and alcohol education in every school in Oxfordshire. Each school now has access to high quality drug education and alcohol education.
- We have revamped the old 'DAAT' (drug and alcohol action team) arrangements now that the vast majority of funding sits in the Public Health Grant. The DAAT has been replaced by a multi-agency group advising the Public Health team.
- Parents' and carers' guides to drugs and alcohol are disseminated through every school- these are very helpful as parents need to keep up with the world of young people. They can be found at http://www.oxfordshiredaat.org/pdfs/PandC%20Guide%20NEW%20PROOF.pdf
- We have specialist drug and alcohol workers in every Early Intervention Hub in Oxfordshire.
- Oxfordshire has good specialist drug and alcohol treatment services across the county. These will be improved when the current contracts end in March 2015.
- Oxfordshire has its own specialist 10 bed residential detoxification service, (commonly called 'drying out') which gives good results – Howard House in Oxford.
- During the last year we have sustained investment in specialist residential rehabilitation (I.e. recovery after giving up) and residential detoxification through new contracts across the country.
- We have made sure that this work is an integral part of safeguarding work across the county.
- Oxfordshire is one of the few Counties where, in partnership with Trading Standards and the Police, we are meeting the challenging and new threat from New Psychoactive Substances or Legal Highs.
- All this will culminate in us producing a new specification for an improved service commissioned by the council. The new service will be up and running during 2015. Public consultation on options for doing this is currently underway.

Recommended Next Steps

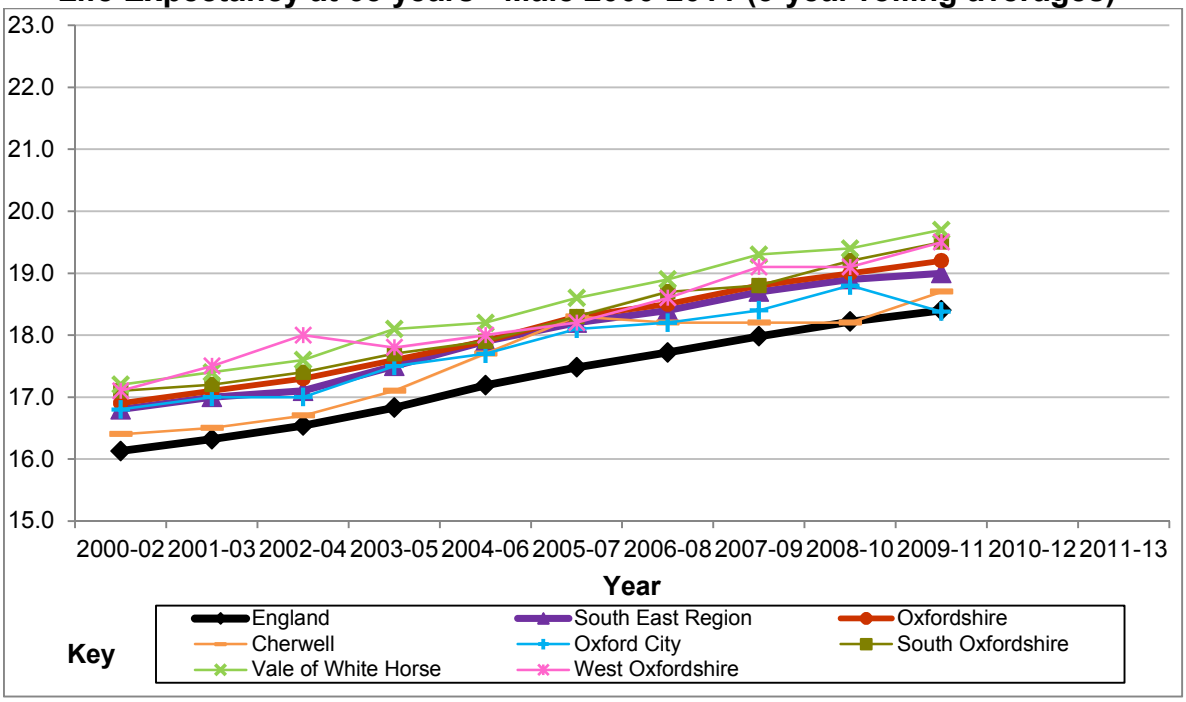
1. Complete a service specification for a new service as key contracts are due to expire at the year end.
2. Ensure that these services will focus on getting people off drugs altogether.
3. Continue to strengthen partnerships especially with GPs.
4. Work with Public Health England to make sure Oxfordshire's indicators improve.
5. Begin to report progress on performance through the Health Improvement Board and through the Performance Scrutiny Committee.

Healthy Ageing

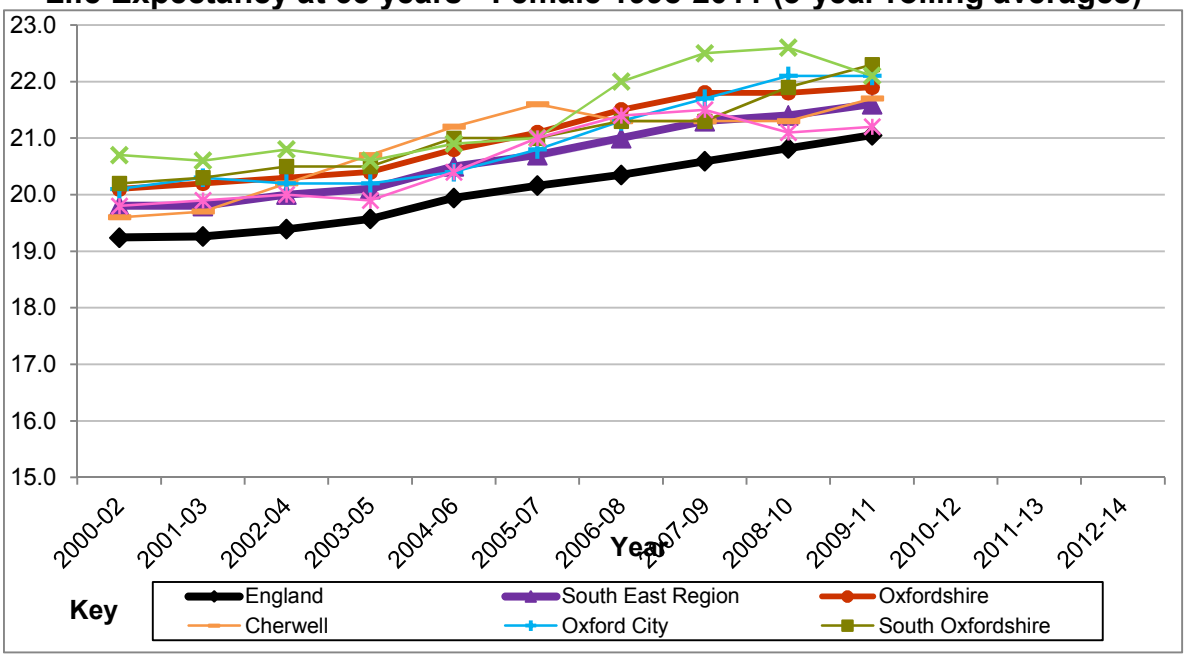
Why is this important?

When the NHS was founded in 1948, 48% of the population died before the age of 65; that figure has now fallen to 14%. In Oxfordshire life expectancy at 65 is now nearly 22 years for women and 19 years for men.

Life Expectancy at 65 years - Male 2000-2011 (3-year rolling averages)



Life Expectancy at 65 years - Female 1998-2011 (3-year rolling averages)



Many people stay healthy, happy and independent well into old age and there is mounting evidence that in the future older people will be more active and independent than today. However as people age they are progressively more likely to live with a medical condition, disability and frailty. In addition around one in ten people over 75 feel isolated and around one in five feel lonely.

A person's health and well-being in later life are affected by many factors over the course of their life, such as education, housing and employment. Many organisations have a contribution to make and initiatives elsewhere in this report will affect people in older age, such as supporting people to maintain healthy weight, manage addictions and give up smoking. It is important that all services which promote healthy lifestyles are accessible to older people.

An important aspect of remaining healthy in old age is identifying health problems early or preventing them altogether. In Oxfordshire there is evidence that people are not making the most of opportunities available to them. For example:

- People aged 40-74 who have not already been identified with a health problem are invited for a health check once every five years. However less than half of the people, currently invited, take up this offer which could identify important health problems such as diabetes, hypertension or high cholesterol levels.
- Only 58% of people aged 60-69 and 56% of people aged 70-74 complete and return tests to check the risk of bowel cancer. Research shows that deaths from bowel cancer reduce by a quarter in those who are screened.
- Flu vaccination can save lives, it is important that people are vaccinated every year. Uptake in the over 65s in 2013/14 was 74.3%.

How does Oxfordshire compare with elsewhere?
In 2013 the Oxfordshire's Older People's Joint Commissioning Strategy 2013-16 was launched with a goal "To enable people to live independent and successful lives". Both the Clinical Commissioning Group and Oxfordshire County Council signed up to promote healthy approaches to ageing including encouraging healthy lifestyles along with a focus on reducing ill health through early identification of problems. There was agreement to invest in community services to achieve better outcomes for people and reduce the need for hospital and inappropriate residential care.

The NHS Health check programme now includes brief advice for alcohol problems and help to detect dementia earlier.

The uptake of flu vaccination in Winter 2013/14 in the over 65s was 74.3% and in the under 65s at risk was 54.5%. The latter figure is a significant improvement on previous years and represents significant work across agencies to raise awareness and to target patients especially by the Clinical Commissioning Group.

The uptake of the NHS's Bowel Screening programme has been identified as a Health and Wellbeing Board target, but unfortunately uptake has not shown the increase we had hoped. We will need to work with the NHS to improve this.

Despite these initiatives there is still much to do.

- We will have to find ways to help communities to help themselves, especially in our rural areas. This will be challenging as resources of the statutory sector are scarce.
- Loneliness remains an important challenge and affects older people across the board in both rural and urban areas.
- We need to build more dwellings suitable for old age – extra care housing is a good example of this. The supply falls well short of the demand.
- There are opportunities for Public Health to work more closely on the integration of adult social care and NHS services. Everyone acknowledges that services need to shift towards prevention and earlier detection of illness but we have a long way to go to make this a reality.
- The role of carers will remain pivotal and the emphasis on giving them more of the support they need and deserve is to be welcomed.
- The role of volunteers, the voluntary sector will be crucial as will the good work of churches and faith groups.
- We will need to continue the search to find new ways to work with citizens to help them reach a healthy old age and to be productive and active for as long as possible. The resources needed will be far more than the State can deploy and solving this conundrum remains our most pressing priority.

Recommended Next Steps

1. We need to keep this issue high on the agenda of all statutory bodies including the Health and Wellbeing Board.
2. We will join up our efforts more across Public Health the NHS and adult social care services to find new ways of preventing ill health.
3. We need to work closely with the NHS, the voluntary sector, faith groups, carers, and Healthwatch to align and coordinate our efforts.
4. We need to build on our 'Community Information Networks' – the current partnership with the Church of England is a very encouraging sign.

NHS Health Checks Commissioned by Oxfordshire County Council

Why is this important?

The NHS Health check is a national risk assessment and prevention programme required by statute. It is commissioned from the NHS by the county council**. Health Checks specifically target the top seven causes of preventable deaths: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.**

The programme requires us to invite all eligible individuals aged 40-74 years old for the check every five years (186,723 people), which means that 20% of this age group are invited per year. The age range is set nationally because it is the most cost-effective group in which to detect preventable disease.

In Oxfordshire, the Joint Health and Wellbeing Strategy set a target for 65% of those invited for NHS Health Checks to turn up for their checks. This is ambitiously higher than the national target. If we achieve this, based on Public Health England (PHE) modelling using the NHS Health Check Ready Reckoner, we could potentially:

- identify over 700 people who require anti-hypertensive drugs
- discover over 1000 people who require a statin
- detect over 200 cases of undiagnosed cases of diabetes and over 500 cases of kidney disease earlier, allowing people to manage their condition sooner and prevent complications
- refer over 2000 people to a weight management programme
- offer 7500 people a brief intervention to take up more physical activity
- generate over 550 referrals to smoking cessation services
- help reduce the increasing health and social care costs related to long term ill-health and disability

Currently, NHS Health Checks are delivered solely through GPs. During 2013/14, all 83 practices signed up to the NHS Health Check with 81 of them carrying it out. At the time of publishing this report, 81 GP providers have been contracted to carry out Health Checks for 2014/15 by means of an through an Approved Provider List. We cannot oblige GPs to do this: it is a commercial arrangement outside of their national contract. Cooperation with the Local Medical Committee (which represents GPs in Oxfordshire when contracting) remains very positive.

During 2013/14, Oxfordshire invited 22.2% (41,368) of the eligible population for an NHS Health Check, and 10.2% (19,001) attended; which equates to an uptake of 46%. This is against an expectation of 20% for invites and 65% uptake. As such, all of the eligible population received an invite, ranking us 2nd across Thames Valley (out of 8). More significantly, 7888 invited Oxfordshire residents did not have their NHS Health Check completed

This is because we deliberately adopted an ambitious target so that we aim high. O results are comparable with the rest of the Country, but we are not content with that and are looking for ways to do better..

The challenge now is to increase uptake. Successful implementation of the NHS Health Check is a key priority for the Health and wellbeing Board in pursuing its goal of 65% uptake.

<u>What are we doing about it?</u>

- We will work with Public Health England (PHE) to develop options for improving the NHS Health Check 'brand'. This will include different approaches to getting people to turn up, including tailoring invitations to different groups and testing new bespoke campaigns, for example through local sports clubs such as Oxford United.
- For the first time we will investigate alternate approaches to commissioning the delivery of NHS Health Checks outside of GP settings, for example through pharmacies.
- If we do this it will be important to make sure our GPs get the results of the checks so that they can take necessary action.
- We will quality assure the programme to make sure it meets the highest standards.
- We will continue to work with our partners in Public health England to support future research and evaluation of the NHS Health Check programme locally.
- We will aim to increase awareness of the programme through a 'drip feed' effect.

Recommended Next Steps
1. The Health and Wellbeing Board should continue to prioritise NHS Health Checks
2. Work with the Clinical Commissioning Group (CCG)to use NHS Health Checks as one vehicle to achieve its priority to *'tackle health inequalities by offering targeted support to address lifestyle behaviours and choices'.*
3. Continued partnership working with the Local Medical Committee, CCG and primary care providers of the programme to achieve increased uptake and high quality. 4) Continue to explore other innovative ways of delivering Health Checks.

A Joint Public Health Strategy Between Oxford University Hospitals Trust and the county council's Public Health Team

Why is this important?
Large hospitals see many patients every day and the scope to improve their health as well as to treat disease is tremendous. This has long been a missing piece in the jigsaw of the county's Public Health. Thanks to the willingness of Oxfordshire University Hospitals Trust (OUHT) and our Public Health trainees we now have the makings of a joint strategy for the first time. This work is overseen by the Health Improvement Board.
The potential is enormous as there are 11,000 staff and over a million patient contacts each year at the Hospital Trust.

This Strategy sets out three major areas of work:

- To build capacity to promote healthy lifestyles to patients, visitors and staff at every opportunity.
- To develop a health promoting environment.
- To embed Public Health approaches within the Trust.

What are we doing about it?
A Steering Group for completing and implementing the action plan is being convened. Early work will include
- Staff training on Health Improvement to become Health Champions through accredited schemes
- A one year pilot of a Health Improvement Clinic for outpatients, family members and staff to get brief advice and to 'signpost' them to relevant local services
- Improving the availability of healthy food in hospital premises and looking for opportunities to increase physical activity.

Recommended Next Steps
1. Consider the progress made in the first year and work with OUHT to build on this.
2. Ensure that campaigns being coordinated across the county are also rolled out in the hospitals if appropriate in order to reach a wider audience.
3. Support the OUHT in establishing its own permanent Public Health presence within the Trust.

3. Reducing Inequalities in Health

Good health is not experienced evenly or equally by all the people of Oxfordshire. This section looks at some of the causes of health inequality and reports on progress made.

The Thriving Families Programme

Why is this important
In last year's Annual Report I described this programme in detail. This year I will concentrate on new achievements and future direction.

Thriving families is part of Oxfordshire's long term priority to identify the families who need help the most and who consume a significant resource from social services, schools, the NHS, the Police and other agencies. The aim of the programme is to work closely with the families to turn this situation around.

Our programme is bearing fruit and is highly rated by the Department for Communities and Local Government and we are one of the top ten programmes in the Country.

The achievements of the programme can be set out as follows:

- We have identified 90% (around 700) of families expected by Government to be living in the county
- We are working with 70% of the identified families
- We are improving the lives of around 62% of the Thriving families in practical ways

However the real strength of our approach is that we are identifying families from every community in the county, urban and rural, and this makes the programme unique. Innovations introduced during the year have been to:

- Work together with Jobcentre Plus to get people back into work.
- Expand the original programme (which focussed on anti-social behaviour, unemployment and poor school attendance) to look at ways to tackle mental health problems, drug addiction problems and domestic violence.
- Working with GPs to 'flag' family members so they can get extra support.
- Working with Public Health England to look at early indicators that might move us from 'treatment' of the problems to prevention.
- Using our database to evaluate and 'cost' the savings made.
- Using the experience to influence the development of all our children's services across the board.

Recommended Next Steps

1. Continue the core work of this programme.
2. Learn from the experience of the last two years to help shape the children's services of the future.
3. Make closer and concrete links with the Clinical Commissioning Group.
4. Evaluate the programme.
5. Find ways of identifying families earlier so that we can begin to prevent problems arising.

A multi-ethnic Oxfordshire

Why is this important?
The last census showed that Oxfordshire now has significant ethnic minority populations. I discussed this issue extensively in my last annual report and will only mention the topic briefly here to ensure that the issue is not lost and that services continue to respond to this issue.
The headlines are:

- The county has a substantially increased ethnic mix compared with 10 years ago. 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.
- However, ethnic minorities, especially those who are fleeing persecution and those who do not speak English well do suffer health inequalities.
- There has been an 'across the board' increase in residents from ethnic minority groups of 57% on 2001 figures involving every district of the county.
- There has been an increase of 46,000 residents from all ethnic minority groups over the last 10 years.
- Over a third of all city residents are from ethnic minority groups and over 10% of all Cherwell residents.
- Some of our schools are now teaching children whose first language is not English and the number of first languages spoken may be over 20 languages.

Recommended Next Steps
1. Continue to monitor the changing ethnic composition of the county through the Joint Strategic Needs Assessment in detail.
2. Use this information to predict health risks more accurately across the county and build this into the plans of all organisations
3. Make recommendations for services based on this analysis.
4. Continue to press for better recording of ethnicity by GP practices.
5. Support the Clinical Commissioning Group's proposed Health Inequalities Commission to find practical ways to reduce these inequalities.

People with deafness and hearing loss
Why is this Important?
Recent reports have shown that deafness and hard of hearing are a 'hidden' health inequality. A report published by Signhealth (the Deaf Health Charity) includes results from a survey of 533 deaf people and health assessments of 300 deaf people, plus in-depth interviews with 47 deaf people. Their findings include:

- 62% of deaf people diagnosed with high blood pressure are likely not to have it under control compared with 20% of the general population.
- 70% of deaf people who hadn't been to their GP recently had put off going as there was no interpreter. Expecting a deaf patient to lip read or writing things down for them is not considered a "reasonable adjustment" for their disability.
- 80% of deaf people want to communicate using British Sign Language but only 30% get the chance.

A report from Deaf Direct written for Oxfordshire County Council highlighted the increase in numbers of deaf people, partly reflecting the aging population but also due to other factors. Their work highlighted:

- Deaf people tend to have worse overall health and report poorer physical health and mental wellbeing
- 63% of people with hearing loss are aged over 65.
- 70% of over 70s have hearing loss and 40% of those aged over 50
- 8% have severe or profound hearing loss.
- In 2012 there were 557 children in Oxfordshire receiving a service from the Education Hearing Impaired Service. Many have additional needs.
- It is estimated that the number of deaf or hard of hearing people will increase by 14% every 10 years.
- Migration patterns may also mean increases in those who use sign language of their native country

What Are We Doing About It ?

Current services include:

- Audiology (private or NHS) for those with hearing loss.
- A sign-language service to allow parents to communicate with their children.
- Cochlear implants for children who are profoundly deaf.
- A newborn hearing screening programme which identifies hearing loss at birth and ensures aids/cochlear implants prior to children developing speech and language skills which enables children to enter mainstream schooling. This service is highly rated.
- Interpretation services commissioned by health and social services available for individuals when they see doctors etc.
- Advice and information services through the voluntary sector e.g. Deaf Direct.

Recommended Next Steps

1. We should take this work in stages. The first step is to acknowledge the issue more widely and report accurate figures in our Joint Strategic Needs assessment.
2. Work with the Clinical Commissioning Group to consider how this inequality might be tackled in practical terms. A key theme will be improved awareness raising about the options already available.
3. More work to identify the needs of deaf people more carefully in care pathways and ensure that they have access to services.

Young Carers

Why is this important?

Children and young people who also have a caring role need extra support so that they will not experience poorer health and wellbeing than their peers. Services in Oxfordshire are of high quality. The need has been well recognised and action is being taken. This should continue.

Oxfordshire County Council has a dedicated Young Carers Team, committed to working with partner agencies, to identify and support this large vulnerable group of children and young people, and their families.

The council's Young Carers Service works with 0-25 year olds, providing a range of support to the young carers identified in the county dependant on their assessed and identified needs. Approximately 1600 young carers are identified at present. The Carers' Strategy can be found at *https://www.oxfordshire.gov.uk/cms/content/oxfordshire-carers-strategy-2013-2016* - The Young Carers Service performance is reported to the Oxfordshire Health and Wellbeing Board.

This is important because the impact of being a young carer affects every facet of one's life from social activities to future education and career prospects.

The county council should be proud that The Carers Trust has commented that Oxfordshire has the "perfect model for delivering positive outcomes for young carers". The Carers Trust and the Department of Health recommend our work nationally as an example of best practice.

The number of young carers being identified in the county is increasing year on year. In 2012 we had 850 young carers on record and as of April 2014 we have 1541 young carers on record. This shows we have identified 371 new young carers in 13/14; a percentage increase of 31.7%.

The main cause of caring is parental mental health (23.4%) followed by sibling learning difficulties (18.0%) and parental physical disabilities (15.5%). 15.1% care for a parent with a physical illness, 13.6% for parents with multiple conditions and 8.8% for siblings with physical disabilities. 4.3% care for parents with substance misuse issues.

Educational Attainment

Our data shows us young carers are not achieving at GCSE in comparison to their non-caring peers. The reasons for this are complex. It does not necessarily mean that being a young carer is the only reason for the poorer attainment.

To address this, the Young Carers Team and Spurgeons Young Carers Project work with schools helping them to achieve our Young Carers Schools Standard Award which is a support package for schools to enable a whole school approach in the identification and support for young carers with a view to addressing issues of poor attainment and attendance.

Mental Health

A Young Carers Health Nurse post has been established, to better understand the health needs of young carers in the county. Early finding from this work show that many young carers are presenting with risk factors for their own mental wellbeing (feeling low, stressed, exhibiting risk taking behaviour's, self-harm and eating disorders). This work is being shared with the leads for School Nursing at the Department of Health to inform national practice development.

Recommended Next Steps

1. The Young Carers team have a sound plan in place and this should be supported by all agencies. The number of young carers identified should continue to increase year on year.

2. As well as maintaining the current service we should work with the NHS more on inpatient services helping them to 'Think Young Carer' from admission to discharge.
3. We should also focus more on NHS primary care and community teams helping them to 'Think Young Carer' in their service delivery.
4. We need to ensure that our new School Health Nursing service plays its part in improving the lot of these young people as it develops.

4. Infectious and Communicable Diseases

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

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

General Infectious Diseases

Health Care Associated Infections (HCAIs)
Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile Infection (CDI.) remain an important cause of sickness and death, both in hospitals and in the community. However numbers of infections continue to have been reduced through considerable focussed effort in this county.

Methicillin Resistant Staphylococcus Aureus (MRSA)
MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through invasive procedures or chronic wounds) it can cause blood poisoning (bacteraemia). It can be difficult to treat in people who are already very unwell so we continue to look for the causes of the infection and to identify measures to further reduce our numbers. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it (fig 1).

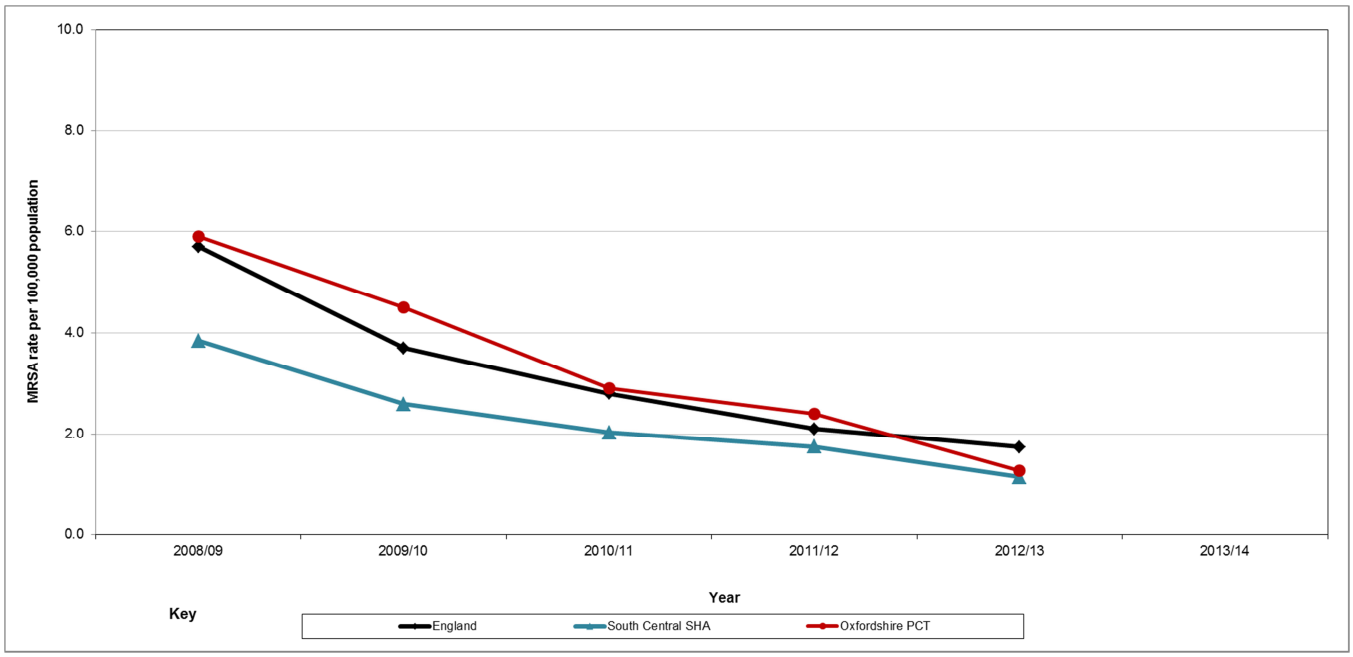


Fig 1. Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 - 2012/13) England, South Central SHA and Oxfordshire

This shows that infectious diseases can be tackled, often by traditional hygiene measures. Nationally there is a zero tolerance policy and the rate of MRSA is still higher than we would like. There have been improvements in the rate of MRSA in Oxfordshire over the past few years from being above the national average to moving below the average.

Clostridium difficile infection (CDI)

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

A focussed approach on the prevention of this infection is resulting in a steady reduction in cases since 2007/08 (fig 2) in line with regional and national trends. However, whilst there has been an improvement in the rates of CDI in Oxfordshire, it is still above National and Regional levels of infection.

The reduction in CDI involves the coordinated efforts of healthcare organisations to identify and treat individuals infected with CDI and also careful use of the prescribing of certain antibiotics in the wider community. There are on-going concerted efforts locally to continue to improve the rate of CDI.

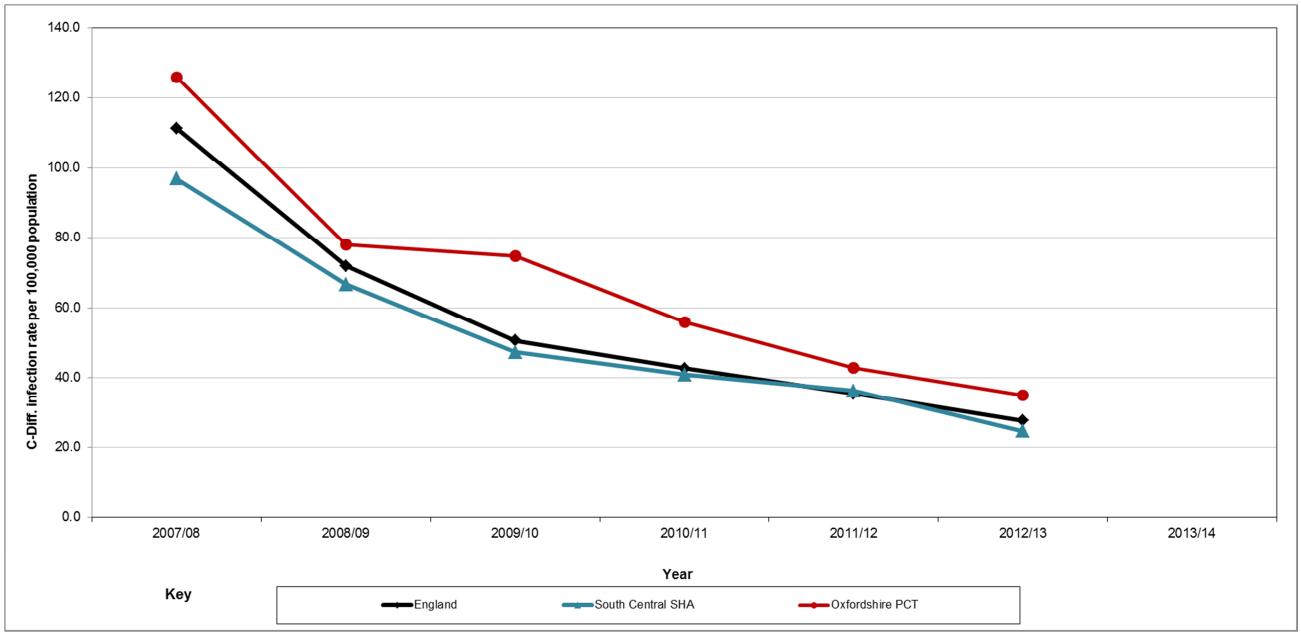


Fig 2. Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2012/13) England, South Central SHA and Oxfordshire PCT

Tuberculosis (TB) in Oxfordshire

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

In Oxfordshire the numbers of cases of TB at local authority level are low. A three-year average is given which shows that the case rate is fairly static (Fig 3).

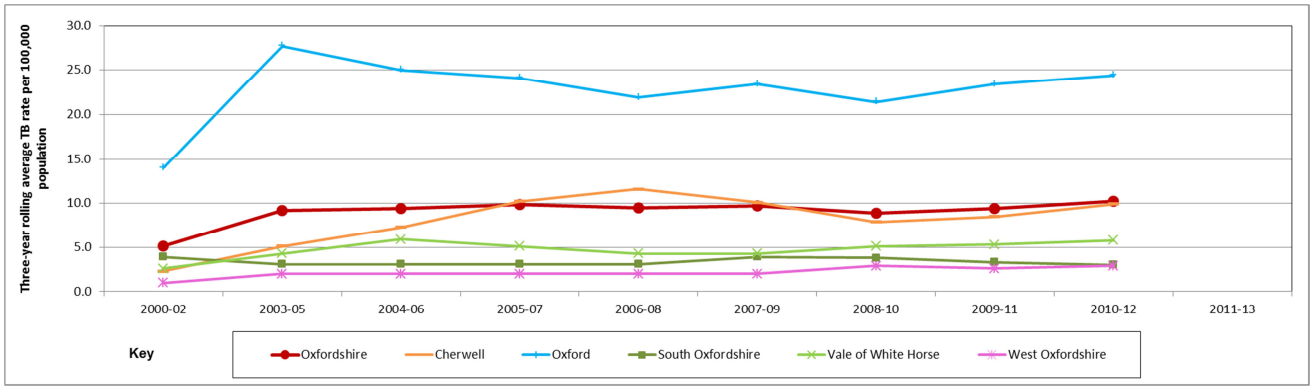


Fig 3. Tuberculosis (TB) - Rate per 100,000 population (2004 to 2012) Oxfordshire and districts within Oxfordshire

The levels of TB in the UK have stabilised over the past seven years. However, despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK is higher compared to most Western European countries.

The rate of TB in Oxfordshire is lower than National and Thames Valley PHE Centre levels (covering Oxfordshire, Buckinghamshire and Berkshire). In the UK the majority of cases occur in urban areas amongst young adults, those coming in from countries with high TB burdens and those with a social risk of TB. This is reflected in the higher rate of TB in Oxford compared to other districts in the county.

TB should not be underestimated and has not gone away. Recent experience has shown that resistant strains of TB can spread rapidly from person to person through ordinary social contact.
Given the importance of TB, it is one of the key priorities of Public Health England who are working to support local services.

<u>Recommended Next Steps</u>

The Director of Public Health should report infectious diseases in subsequent annual reports.

Sexually Transmitted infections

It is vital that we maintain and improve services to prevent and treat sexually transmitted diseases. These will not go away and we need to keep up our vigilance, especially as these services are now spread over a wide range of agencies. The county council has several roles in this. Firstly a watchdog role to ensure that all services are good, a commissioning role as a major commissioner by statute of these service, and lastly a partnership role, playing our part to make services work smoothly together.

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 450 people living with HIV in Oxfordshire (fig 4). We would expect the chart to show an upward trend because people are now living longer with the disease and so the number of people will 'accumulate'. The national report 'HIV in the United Kingdom: suggests that a quarter of people with HIV have yet to receive a diagnosis. In Oxfordshire, this equates to another 112 people bringing the total estimated cases for Oxfordshire to 562.

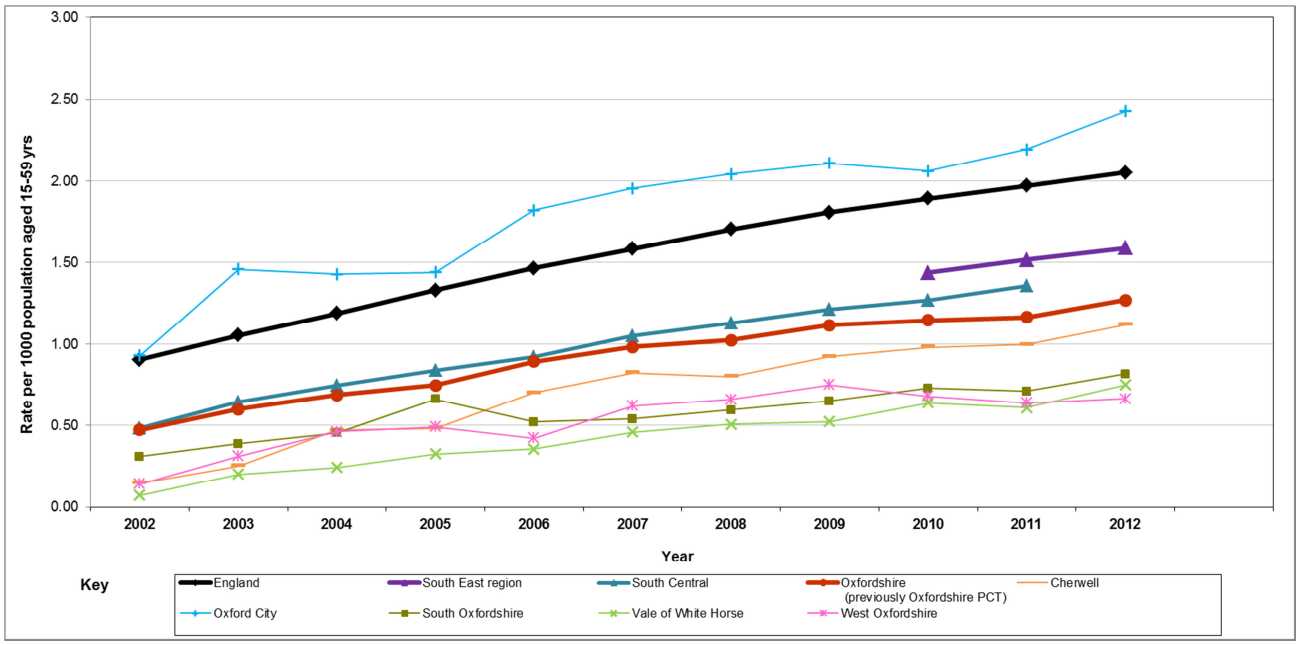


Fig 4. Prevalence of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 years England, South East region, Oxfordshire and Oxfordshire districts

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 three ways:

- 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 routine testing at our sexual health clinics.
- Through community testing, we have introduced 'HIV rapid testing' in a pharmacy 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 fast tracking to the sexual health service for 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.

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'. Total rates of STIs in Oxfordshire are below the national average except in the city which is a reflection on the younger population who live there (fig 5).

The increase in the rates in the city can be attributed to a combination of factors. There is a large student population and higher proportion younger people living in the city who have been targeted for Chlamydia and STI testing. This increases the number of cases found which is a good thing. Similarly there have been increased diagnoses of Gonorrhoea due to improved testing methods. This is also good news. The keys to fighting these infections are:

1. Use safe sex methods and don't get the disease in the first place – and this applies to all age groups
2. Find and treat the disease fast to prevent the spread

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

- Gonorrhoea – is below national average for Oxfordshire as a whole and all districts except in Oxford city. This follows a typical 'urban' profile of higher levels.
- Syphilis - is falling and below national average in all areas of the county except in Oxford city.
- Chlamydia –levels are lower than national average – but we continue to have difficulties in persuading young people to come forward for testing despite, best efforts.
- Genital Warts – rates are now lower than national average which is an improvement. Oxford city is significantly higher (reflecting the younger age group) but the trend is generally stable.
- Genital Herpes – rates are lower than national average except in the city which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population in the city.

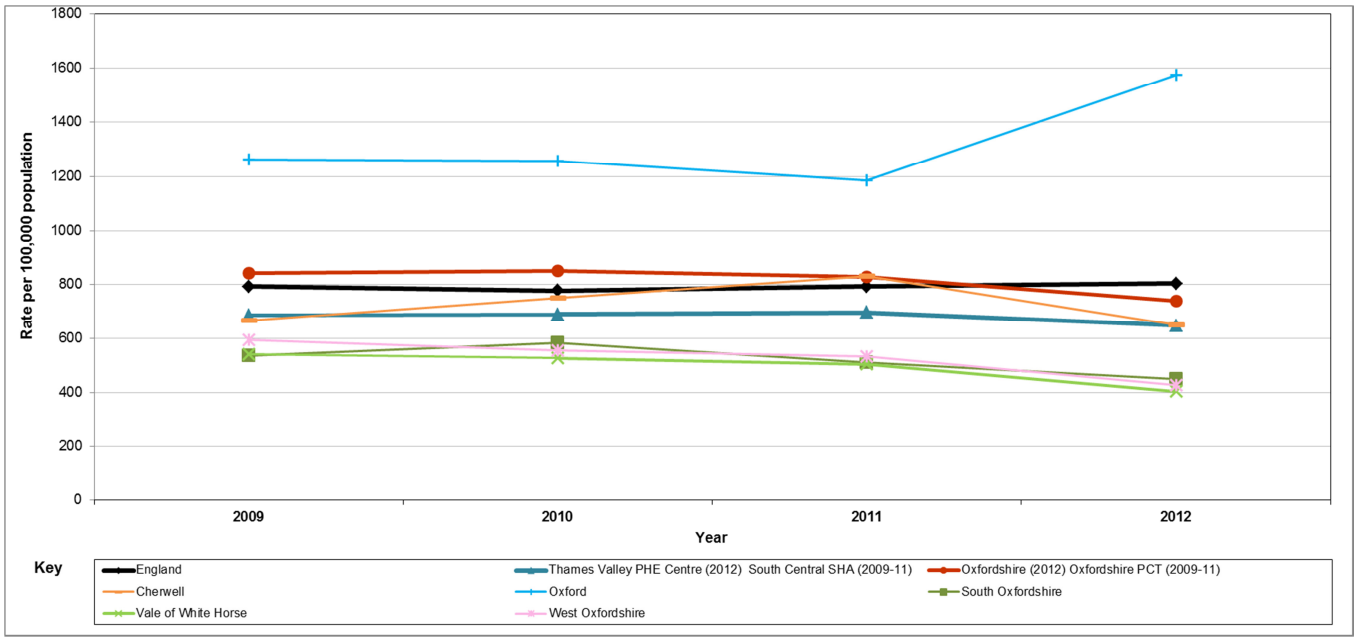


Fig 5. Rate of diagnosis of acute sexually transmitted infections (STIs) per 100,000 population (all ages) - 2009 to 2012 England, Thames Valley Public Health England Centre, Oxfordshire and districts within Oxfordshire

This year Oxfordshire County Council has commissioned an integrated sexual health service as part of a network of NHS, Public Health England and Local Authority services which prevent and treat STIs. We need to fine –tune the service along with all others in the light of changing disease patterns and make sure that services in the city are working well.

Recommended next steps

1. Ensure the successful implementation of the new integrated sexual health service and monitor the service closely and adjust it if necessary.
2. Monitor all services in the city closely across general practice, pharmacies, school health nursing, sexual health clinics and the sexual health service HQ at the Churchill Hospital. Take any action needed in the light of this monitoring.
3. Continue to prioritise and target young people and vulnerable groups in promoting safe sex awareness.

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Oxford University Hospitals

Oxford University Hospitals NHS Trust – Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

1. Introduction

1.1. This paper provides an update to the Oxfordshire Joint Health Overview and Scrutiny Committee on the Oxford University Hospitals NHS Trust. The paper covers the following topics:

- The Trust strategy for 2014/15 to 2019/20
- The Trust business plan for 2014/15 to 2015/16
- The outcome of the recent CQC inspection
- Trust performance against key national standards
- Progress on the Trust's foundation trust application
- An update on the Cotswold Maternity Unit
- An update on the Horton General Hospital
- Other key developments

2. Trust strategy

2.1. As part of its foundation trust application, the Trust Board has recently signed off an updated integrated business plan (IBP). The IBP represents the Trust strategy for the period 2014/15 to 2019/20. The Trust strategy is summarised in the paragraphs below

2.2. Our mission is to improve health and alleviate pain, suffering and sickness for the people we serve.

2.3. We will achieve this by providing high quality and cost-effective healthcare. We will develop the people who work for us and continue to support the search for better treatment.

2.4. Our core values are excellence, compassion, respect, delivery, learning and improvement.

2.5. Summarised as 'Delivering Compassionate Excellence', these values are used by staff and leaders throughout OUH and with partner organisations as a basis for improving the quality of the care we provide.

Our values determine our vision to be:

> at the heart of a sustainable and innovative academic health science system, working in partnership to deliver and develop excellence and value in patient care within a culture of compassion and integrity.

2.6 This vision is underpinned by OUH's founding partnership with the University of Oxford.

2.7 Collaboration and partnership are central to OUH's delivery of patient care, education and research. The Trust provides a broad range of care for a local population and specialised care for a wider population. Both roles are interdependent if it is to achieve its vision and continue to deliver education and research.

2.8 The Integrated Business Plan describes changes in local services to respond to evolving needs and in specialised services to respond to a national agenda which is expected to drive some centralisation.

2.9 The patient is at the heart of everything OUH does. The Trust is committed to delivering high quality care for patients irrespective of age, disability, religion, race, gender or sexual orientation, with services that are accessible to all but tailored to the individual.

2.10 Central to the Trust's vision are its staff. OUH aims to recruit, train and retain the best people to enact its values and achieve its vision.

2.11 OUH works to achieve excellence in healthcare by enabling support, respect, integrity and teamwork; by monitoring and assessing its performance against national and international standards; by learning from its successes and setbacks; by improving what it does through innovation and change; and by working in partnership and collaboration with all the agencies of health and social care in the area it serves.

2.12 The Trust is committed to being an active partner in healthcare innovation, research and education. It aims to be an effective link between research in basic science and healthcare provision, helping to turn today's discoveries into tomorrow's care.

2.13 OUH's vision and values inform its strategic objectives which in turn form the basis of this Integrated Business Plan.

2.14 OUH's strategy has been developed from consultation with organisations, groups and members of the public as part of its preparation to apply for Foundation Trust authorisation. Public involvement in developing the Trust's strategy will be strengthened post-authorisation through the involvement of public and staff members via the Council of Governors, following the Trust's Membership Strategy.

2.15 The Trust has six strategic objectives from which its priority work programmes flow.

SO1. To be a patient-centred organisation providing high quality, compassionate care with integrity and respect for patients and staff – *"delivering compassionate excellence".*

SO2. To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – *"a well-governed and adaptable organisation".*

SO3. To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services – *"delivering better value healthcare".*

SO4. To provide high quality general acute healthcare to the people of Oxfordshire including more joined-up care across local health and social care services – *"delivering integrated local healthcare".*

SO5. To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – *"excellent secondary and specialist care through sustainable clinical networks".*

SO6. To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits – *"delivering the benefits of research and innovation to patients".*

2.16 The strategy is informed by an assessment of the environment within which the Trust operates and in particular seeks to ensure that the Trust makes a full contribution to the Oxfordshire Joint Health and Wellbeing strategy and the commissioning strategy of the Oxfordshire Clinical Commissioning Group.

2.17 The strategy is underpinned by:

- Robust 5 year financial plans that seek to address the difficult financial environment in which the Trust and the local health and social care sector will be operating
- An assessment of the risks that the Trust will face, together with actions to manage and mitigate those risks
- A strategy that underpins the Trust's workforce and leadership development
- A description of the Trust governance arrangements including how the Trust will intend to use its foundation trust council of governors and membership to secure effective engagement and accountability as a way of delivering higher quality care to patients and the local population

2.18 A full copy of the IBP is available on the Trust website.

3. Business Plan

3.1 The Trust business plan for 2014/15 to 2015/16 sets out the Trust objectives for the next two years. The plan describes the key actions for years one and two of the Trust strategy as set out in its five year integrated business plan. It seeks to advance the Trust strategic objectives and is shaped by the Trust values which are both encapsulated in the phrase "delivering compassionate excellence". The Trust is a large and complex organisation and this is reflected in the breadth of actions set out in the business plan. However, within the plan the highest priorities for the Trust for 2014/15 to 2015/16 are set out below.

Quality

3.2 To continue to strengthen the safety and quality of the Trust's services by:

- Improving the overall patient experience
- Further developing the process for reviewing all deaths in hospital.
- Extending the use of risk summits
- The internal peer reviews

Performance

3.3 To ensure that the Trust is enhancing the services received by patients by sustainably achieving the key performance standards:

- The Emergency Department 4-hour wait
- The 18-week referral to treatment time
- Cancer waits.

Finance

3.4 To achieve better care through better value by:

- Achieving the Trust's financial plans
- Delivering the Cost Improvement Programme.

Transformation

3.4 The scale of challenge presented by the changing pattern of patient need and the financial constraints both locally and nationally means that to achieve the above priorities, the Trust must change radically the way that it delivers services. Therefore, at the heart of the Trust's Business Plan for 2014/15-2015/16 is the theme of transformation. During the next two years this transformation will be advanced by:

- Further strengthening patient and staff engagement
- Working with Oxford Health NHS Foundation Trust and other key partners to deliver more integrated patient care pathways
- Using the Electronic Patient Record to deliver benefits that strengthen the safety, quality and efficiency of patient care
- Securing a step improvement in the administrative processes that underpin responsive and efficient patient services
- Ensuring that patients receive the same level of care 24-hours a day and seven days a week
- Achieving Foundation Trust status to enable the Trust to work more closely with patients, public, partners and staff to achieve its goals.

4. Care Quality Commission

4.1 The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 25th and 26th February 2014. A team of 51 inspectors visited the Trust's four hospital sites for two days and conducted further unannounced spot checks on the 2nd and 3rd March.

4.2 Both prior and during the inspection, the Trust provided a large amount of documentation to the CQC. As part of the inspection, the CQC spoke to patients, visitors, carers and staff to gain a view of the eight service areas and to rate each of these in relation to five domains:

- Were services safe?
- Were services effective?
- Were services caring?
- Were services responsive to people's needs?
- Were services well-led?

4.3 The CQC also held two public meetings, one in Oxford and one in Banbury to hear from local people and to try and get to the heart of patients' experiences.

4.4 The report of the inspection was presented at the Quality Summit arranged by the CQC on 12th May 2014. The Quality Summit was attended by invited members of the Trust Board and external stakeholders, including commissioners, the County Council, NHS England and the Trust Development Authority.

Report findings

4.5 The CQC published its inspection reports for the Trust on Wednesday 14th May 2014. There was a report for the Trust overall and four further reports for each of the Trust's hospital sites.

4.6 The Trust as a whole has received a `good' rating overall and a rating of `good' for each of the five domains.

4.7 The CQC inspection was a comprehensive and thorough review of the way services are provided. The clear and overriding message from the report is that the inspectors observed caring and compassionate staff throughout the four hospitals and noted many examples of good team working. The detailed inspection reports offer a clear endorsement of the hard work put in on a daily basis to make sure compassionate and excellent care is provided to patients. The full reports are available through the following link: http://www.cqc.org.uk/directory/rth

4.8 The CQC assessed services on each site and rated them overall against the five domains, across eight core service areas, as defined by the CQC (where they are provided). All were rated 'good' except for A&E and Surgery at the John Radcliffe site, which were rated as 'requires improvement'.

Table 1: Summary of rating for each service assessed per hospital site

	Churchill	Horton	John Radcliffe	NOC
Services	Medical Care	A&E	A&E	Medical care
	Intensive/Critical care	Medical care	Medical care	Surgery
	End of life	Surgery	Surgery	Outpatients
	Outpatients	Intensive/critical care	Intensive/critical care	
		Maternity & family planning	Maternity & family planning	
		Children's care	Services for children and young people	
		End of life care	End of life care	
		Outpatients	Outpatients	

4.9 In the Trust-level report, the following **areas of good practice** were identified:

- The system the Trust used to identify and manage staffing levels was effective and responsive to meet the needs of the hospitals.
- There were good care pathways for patients attending the A&E department following a stroke.
- Services were innovative and professional.
- There was a strong sense of improving the outcomes for frail elderly patients and those with dementia on the medical wards. The psychological medicine service was supporting staff to understand the care and support needs of these patients. Wards on level 7 were being redesigned to make it more accessible for patients with dementia.
- Caring compassionate staff throughout the four hospitals.

- Managers had a strong understanding of the risks in service and improvements required. Incident reporting and monitoring was well managed and the learning from incidents was evident. There was a strong commitment, supported by action plans, to improve the service.
- Staff worked well between teams. The value of an effective multidisciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts had been being made to improve the effective discharge of patients within medical areas. The hospital was working closely with commissioners, social services, and providers to improve the transfer of patients to community services.
- Two gerontologists worked in trauma wards to provide medical input and an integrated approach to trauma patients who were older people with co-existing illnesses.
- The nurse consultant in trauma care. This was the first such appointment in the UK and enabled the facilitation and coordination of shared care for complex trauma patients.
- The acknowledgement of excellence of junior medical staff within the trauma directorate by leaders.
- The trauma service in general was praised by patients and staff. It was well-led with well-supported staff and happy patients.
- There was good learning from incidents within critical care which translated into training and safer practice.
- The approach to caring for adolescents, within an environment designed to meet their needs and a clear team approach.
- Involvement of young people in developing art work which was made in to posters to promote the values that are important to the young people themselves.
- Patients within maternity expressed a high degree of satisfaction about the care they were receiving and the staff who supported them.
- Patients had the expertise of specialist midwives such as diabetes, breast feeding to ensure they received appropriate care and treatment.
- Patients received care in a compassionate way which included a designated bereavement suite and pastoral care in the maternity unit.
- There was good multidisciplinary team working for the benefits of mothers and their babies
- There were processes in place throughout the hospitals which took into account patients' diversity. These included interpretation service and information provided in different formats according to the patients' needs.
- The trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

4.10 The Trust-level report also specified the following areas where the Trust **must improve**:

- The Trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.
- The Trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The Trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.
- The trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.
- The Trust needs to ensure that staff receive suitable induction to each area that they work within the trust.
- The Trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

4.11 In each of the reports specific to each site, there were areas that the CQC had stated '**should improve'**.

Development of the CQC Action Plan

4.12 The Trust was required to submit an initial action plan in relation to the six areas identified as compliance actions by 12th June 2014.

4.13 In addition each site has a list of areas that 'should be improved'. A further plan will be developed in relation to these other actions and provided to the CQC by 31st July 2014.

Next Steps

4.14 A series of engagement events have been arranged for each site, led by the Trust's Chief Executive, with involvement from other Executives, to disseminate the key findings and messages from the Trust's CQC's Inspection. This is to ensure that the positive aspects of the reports are communicated and celebrated and also that the areas for improvements are recognised and there is engagement with staff to enable this process.

4.15 Work is being undertaken with the Communications Team to use various methods to disseminate the inspection results. This will include use of the intranet, but also a display of posters in the entrance of the hospitals that publicise the Trust's results, including the identified areas for improvement and the Trust's plans to address these.

4.16 In developing this action plan, it is proposed that a series of 'short' Listening into Action events take place to enable staff to put forward suggestions and ideas for improvement. In addition, relevant senior clinical staff members will be leading on the development of the actions that are required to address concerns identified in their service.

5. Performance

5.1 In recent months, the Trust has experienced challenges in its performance against key national standards including the A&E 4 hour wait standard and also some 18 week wait and cancer standards. The paragraphs below outline the causes of these problems and the action that is being taken to address these issues.

A&E 4 hour performance

5.2 As the HOSC will be aware, the A&E 4 hour performance is influenced by a complex set of inter-related factors, which fall into three categories:

- The number of patients presenting at the A&E department
- The efficiency of the patient journey within the hospital
- The efficiency with which the patients can be discharged from the hospital to the relevant community setting

5.3 During 2013 the Trust took a number of actions to secure the required level of performance. These included:

- Opening up on a substantive basis significant additional capacity including 85 beds and 12 ambulatory places.
- Appointing additional consultants to ensure the availability of senior clinical decision makers throughout the week.
- Appointing additional staff in navigator/discharge co-ordinator roles to support patient flow
- Increasing the availability of relevant clinical support services such as psychological medicine, radiology and pharmacy.
- Other steps to redesign patient pathways.

5.4 Despite these measures the Trust and the wider system has not achieved the 95% target since November 2013.

5.5 The Trust has continued to work with its wider health and social care partners to try to address both the numbers of patients arriving at A&E departments and also the delayed transfers of care. However, despite strong collaborative working between all partners the activity within the accident and emergency department has continued to increase and the delayed transfers of care have remained at a consistently high level. Work to address these two key issues needs to continue. Nevertheless the Trust is redoubling its efforts to seek to make further improvements in the patient flow within the hospital. Further measures being taken include:

- Strengthening the input from surgical specialties into the emergency department
- Enhancing the use of the transfer lounge functionality
- Admitting expected referrals and transfers direct to the appropriate ward
- Enhancing paediatric input into emergency pathways
- Developing a separate pathway for patients with dementia

- Enhancing medical leadership within the A&E department overnight
- Strengthening still further the availability of senior clinical decision makers
- Increasing the capacity of the Trust's supported hospital discharge service

5.6 The impact of these measures will be closely monitored. The Trust has set itself the target of achieving the 95% standard on a monthly basis from August 2014.

18 week performance

5.7 Performance against the standard for admitted patients deteriorated in October 2013 and for non-admitted patients in January 2014. The key problem specialties are ENT, ophthalmology and orthopaedics for both admitted and non-admitted, and, additionally, plastic surgery, neurosurgery and gynaecology for admitted patients.

5.8 Key factors behind the performance difficulties at specialty level have been:

- During 2013/14 there was a significant increase in activity with elective activity running at 108,132 patients compared to 97,701 patients in 2012/13, an 11% increase.
- High levels of emergency activity caused a loss of elective neurosurgery capacity resulting in performance dropping below the 90% standard.
- There has been a significant increase in spinal referrals in part as a result of other centres withdrawing from high complexity surgery.
- As part of a scheme to review and refurbish theatres at the John Radcliffe Hospital, two theatres were judged to be no longer fit for purpose and could not be upgraded as the space was required in order to ensure that the remaining theatres provided an adequate environment. This led to the loss of twenty operating sessions per week.
- Areas of waiting list management that required strengthening were identified in a number of specialities

5.9 A number of actions have been taken to address the problems identified above. These include:

- Strengthened waiting list management procedures
- Agreeing temporary contracts with other providers
- Providing additional operating lists within the Trust during weekends across all sites
- Opening additional capacity
- Restricting the catchment for spinal referrals to the Trust's core catchment area
- Undertaking a major capacity re-profiling project in outpatients

5.10 The actions identified above have led to a 22% reduction in the overall waiting list and a 52% reduction in the numbers of patients waiting over 18 weeks. The outpatient project referred to above will create an additional 34,000 new outpatient slots.

5.11 ENT, gynaecology and plastic surgery are now achieving the admitted patient standard. The Trust is forecast to achieve the non-admitted standard across all specialities in June 2014 and the admitted standard in July 2014. The key risk to this latter standard will be orthopaedics and spinal surgery.

Cancer standards

5.12 The Trust is required to meet a number of cancer standards. Performance against the two week wait, the two week wait for breast cancer, the 31 day subsequent drug treatment, the 31 days subsequent surgery and 31 day general standards have been good.

5.13 However the Trust has had significant problems in consistently meeting, in recent months, the 62 day treatment standard and the 31 day subsequent radiotherapy standard.

5.14 Key underlying causes of the problems in relation to the 31 day subsequent radiotherapy standard include:

- A loss of radiotherapy capacity as a result of the need to upgrade the Trust's linear accelerators in order to be able to provide modern treatment modalities.
- An increase in patients from Milton Keynes who are no longer able to be treated at Northampton

5.15 Problems contributing to the performance challenges against the 62 day standard were predominantly linked to issues within Urology and lung cancer pathways and included:

- A lack of thoracic theatre capacity (linked to the previously mentioned closure of two theatres at the JR), and a reduction in bronchoscopy capacity linked to the need to relocate the procedure room in order to address clinical governance concerns
- An increase in urology referrals, complex pathways within the speciality and delays inherent in determining definitive treatment in the context of multiple treatment options being offered.

5.16 Actions being taken to address each of these issues include:

- Increasing radiotherapy capacity by extending the working day and the working week
- Relocating the bronchoscopy unit and purchasing additional scopes which will enhance capacity
- Redesigning the urology patient pathway

5.16 The Trust is forecasting that the 31 day subsequent radiotherapy standard will be delivered from July onwards and the 62 day standard from August onwards.

5.17 It should be emphasised that the Trust has been monitoring the clinical impact of these performance challenges to ensure that they do not result in a deterioration in clinical outcomes.

6 Foundation trust application

6.1 As part of its foundation trust application, the Trust submitted to the Trust Development Authority its updated integrated business plan and long term financial model together with all other relevant supporting documentation.

6.2 On 9 June 2014 the Trust Board had a meeting with the Trust Development Authority to review progress with the Trust's application for Foundation Trust status. The key outstanding issue that needs to be resolved before the Trust is in a position where it can progress is to address the performance challenges identified in the section above. It is hoped that the Trust Development Authority will be in a position to refer the Trust to Monitor after a review of operational performance in September. The Monitor assessment phase of the application process is then expected to take between 4 to 6 months.

7. Cotwsold Maternity Unit

7.1 As members of the HOSC will recall, in 2013 the Trust judged it necessary to close the Cotswold Maternity Unit in Chipping Norton to births for a temporary period in order to enable a review to take place. This followed a number of concerns primarily centred on the high transfer rates from the Unit.

7.2 The recommendations following the review have now all been completed. The paragraphs below provide a progress report on the Unit.

Activity

7.3 Since the 1 July 2013 there have been a total of 93 births as of the end of May 2014. We anticipate the number of births by the end of the first year after reopening will be in excess of 100 which is as predicted. The table below shows the number of births.

Births from 1 July 2013 to 31 May 2014	**Numbers**
Primigravida (First baby)	34
Multigravida	59
Total	**93**

7.4 There has been a month on month increase in the number of births in the unit and if this trend continues the anticipated number of births for April 2014 to March 2015 will be approximately 150.

7.5 The Transfer rate from the CMU to the Horton or John Radcliffe Hospital is around 25% which is line with the Birthplace study.

Staffing

7.6 The staffing at the unit has been reviewed and additional midwives and midwifery support workers were appointed. A substantive team leader has been appointed. The team is working well together and staff morale is very good. Close working relationships have been developed with the surrounding

community teams, Banbury, Bicester and Witney. Meetings between the teams have enhanced communications, closer partnership worker and learning which is beneficial for the women and the staff.

Midwifery Students

7.7 There has been good collaboration between OUHT and Oxford Brookes University to ensure excellence in the development of the midwives of the future. The senior midwifery management team meets quarterly with representatives from OBU to ensure OUHT receives regular feedback from the Midwifery Link Lecturers and students. The feedback from student has been very positive and they value the opportunity of working in the CMU.

Clinical Governance Arrangements

7.8 Monthly meetings are held to monitor activity, numbers of births and to review transfers and discuss identified cases; the meeting is chaired by the senior midwifery manager. These meetings feed into the Directorate and Divisional governance structures ensuring any concerns are identified quickly and actions taken. A Supervisor of Midwives also attends the monthly team meetings to offer support and advice as required.

7.9 The Senior Midwifery Manager and Head of Midwifery visit the unit on a regular basis to offer support to the team leader and meet with the staff. The Divisional General Manager and Head of Midwifery visit the unit as part of their Quarterly visits to every area within the maternity service; these visits have been welcomed by the staff.

User Involvement

7.10 A user group has been established which is chaired by one of the CMU midwives. The group have focused on improving the environment and the League of Friends continues to be very supportive of the unit and have agreed to consider additional resources to improve the environment further. Update reports are sent to the Chairman of the League of Friends and the team leaders have attended a couple of their meetings.

Partnership Working

7.11 The midwives have arrangements in place to meet with the local GPs and Health Visitors which has improved communication and provides opportunities to share information about changes within the surgery, unit or local/national guidance. The team leader is also in the process of meeting with all the GP surgeries. Midwives and the Maternity Support Worker are working collaboratively with the ACE children centre by providing pre-birth classes at the centre; this is part of the parent education package.

Women's Expectations

7.12 Feedback from the women is very positive and women who deliver in the evening or at night are offered the opportunity to remain in the unit overnight.

Conclusion

7.13 The midwives and maternity support workers at the CMU have worked very hard to promote the unit and are committed to ensuring the unit is successful and supported the local community.

8. The Horton General Hospital

8.1 The paragraphs below provide an update on developments at the Horton General Hospital:

Care Quality Commission

8.2 As noted earlier, the Horton Hospital received an overall rating of good from the recent Care Quality Commission inspection. The Hospital was rated as good across all five of the domains (safe, effective, caring, responsive to people's needs and well led) and also across the eight service areas which were inspected (accident and emergency, medical care, surgery, intensive/critical care, maternity and family planning, services for children and young people, end of life care and outpatients).

8.3 As with the overall Trust report, the report on the Horton identified areas of good practice as well as areas requiring attention. These will be taken forward in the coming weeks and months as described earlier in this paper.

Emergency abdominal surgery

8.4 The arrangements for emergency abdominal surgery pathways continue to bed down. A meeting was held on 3 June 2014 comprising representatives of the stakeholders sitting on the Community Partnership Network to review these arrangements and to assess the potential for other measures that can be taken to strengthen the local service at the Horton and to minimise the need for patients to travel to Oxford except where this is clinically appropriate.

Rowan Day Hospital

8.5 As noted in a recent statement by Dr Paul Park, North Locality Clinical Director at Oxfordshire Clinical Commissioning Group: "adjustments are being made to care provided at the Rowan Day Hospital. For a long time now the day hospital function has been more centred on social care rather than acute medical care and intensive rehabilitation. With the increase in older people with complex health needs the day hospital will focus on providing ambulatory care for older people to help reduce admissions to the in-patient facility at the Horton General Hospital or John Radcliffe Hospital in Oxford.

8.6 There is also a plan to develop a new discharge lounge at the day hospital so that patients can be moved from bed based care to a comfortable lounge setting when they are medically fit to leave. Patients will be able to vacate their inpatient bed at the beginning of the day and wait in the lounge for their medication and transport to their onward place of care, be it home, a care

home, or community hospital. It is hoped that this will help to reduce the high number of delayed transfers of care in the county.

8.7 Local GPs are referring patients with social and rehabilitation needs to social services day care and to the counties single point of access, which provides GPs and other healthcare professionals with a quick and easy way of referring patients to community health services, e.g. community therapy and community nursing. Via the single point of access packages of health and social care are put in place for patients to support them in a community setting or in their own home".

8.8 The CQC identified the way that the Day Hospital operates as an example of good practice.

Rapid access clinic for children

8.9 A rapid access clinic for children, aimed at bringing down waiting times, opened in March. GPs will be able to refer urgent cases, who they do not think should wait for a normal clinic appointment, to this new clinic which runs every Thursday afternoon. The clinic, run by an experienced paediatrician will include urgent referrals of patient from GPs, as well as follow up of patients who were admitted to the ward.

Cancer services for children

8.10 In May, children with cancer in the north Oxfordshire and the surrounding areas will be able to access some elective treatments at the Horton surrounding, instead of having to travel for treatment to Oxford. Young haematology and oncology patients will now have the option to attend the Horton for:

- Blood and platelet transfusions
- Routine antibiotics or prolonged courses of antibiotics or antivirals
- VZIG (immunity-boosting drug) administration
- Dressing changes and blood samples
- Elective reviews of well children

Children's surgery

8.11 The new paediatric ENT surgical operating lists are well established and the range of procedures being undertaken is being expanded. The dental service now has a morning dental list every Thursday and an additional afternoon list every other Thursday.

Outpatient capacity

8.12 The business case for the development of a bespoke children's paediatric outpatient facility in the area currently housing management offices is being progressed. Relevant provision has been made in the Trust's 2014/15 capital programme. The building works are provisionally scheduled to start in June and complete in late summer early autumn.

8.13 Detailed modelling work is being undertaken with each of the relevant Trust services to identify the range and volume of outpatient activity that could be transferred from the Trust's Oxford sites to the Horton General Hospital. The outcome of this work will then lead to a detailed option appraisal of schemes to enhance the outpatient capacity at the Horton.

Interventional ultrasound department

8.14 The scheme to expand and enhance the interventional ultrasound department at the Horton has begun and is due to be completed in September 2014.

9. Other developments

Finance and contracting

9.1 The Trust achieved its financial plans for the financial year 2013/14.

9.2 The Trust has reached agreement with its key commissioners for contracts for the financial year 2014/15. In order to help the local health and social care system manage the activity and financial pressures with which it is currently faced, the Trust has agreed contractual arrangements with Oxfordshire Clinical Commissioning Group that seek to manage risk across the system in an9

9.3 To achieve its financial plans in 2014/15 will require the Trust to deliver a cost improvement programme in the region of £45m.

Public health strategy

9.4 The Trust public health strategy that was approved by the Trust Board at its March meeting has now been approved by the county wide Health Improvement Board. The action plan associated with the initial phase of the strategy is being firmed up and implemented.

9.5 To help promote the strategy, the Trust public health and foundation trust membership teams combined to sponsor the Oxford United versus Accrington Stanley football match on 26 April 2014. As well as recruiting additional foundation trust members, the teams gave out over 1,000 pieces of fruit for free to football fans as part of the promotion of health lifestyles.

Collaboration with Oxford Health

9.6 The Trust is in discussion with Oxford Health Foundation NHS Trust to explore ways in which relevant services, which are run by the two Trusts, can be better integrated to provide more joined up patient pathways to improve the quality of patient care and to avoid unnecessary duplication and waits as patients move across organisational boundaries. These discussions are also looking at the need to strengthen integration with GP and social care services.

Network Connectivity with the County Council

9.7 The Trust's IM&T department provides access to the IT network for the whole of the NHS across Oxfordshire. Over the last two years they have also provided network capability to all GP practices and more recently they have provided WiFi access and improved access speed across the Trust as well as access to Eduroam, and to the County Council. The team were recently asked by Oxfordshire County Council whether it would be possible to replicate this service for their council workers in GP Surgeries. The benefits of having WiFi means improved safeguarding as social work staff do not need to carry around as many paper files if they can access information remotely. This has now been achieved.

10. Conclusion

The Health Overview and Scrutiny Committee is asked to note the contents of this report.

Mr Andrew Stevens
Director of Planning & Information
Oxford University Hospitals NHS Trust
17 June 2014

South Central Ambulance Service NHS
NHS Foundation Trust

Report to Oxfordshire County Council PHOSC
20th June 2014

Response Standards and Demand – Full Year 2013/14

South Central Ambulance Service NHS Foundation Trust achieved the required performance standard for all Red calls, both corporately and at CCG level for the first time ever.

Within Oxfordshire, demand has risen by 7%. The increase of acuity of calls Red(potentially life threatening) has risen by 9%.

From April 1st - May 15th 2014 we have seen an increase of 24% in Red calls and a 6% increase in total calls compared with the same period last year.

Both of these factors demonstrate significant pressure on performance delivery particularly coping with very difficult conditions resulting from flooding last year.

Whilst not commissioned to achieve this standard at any geographical level below "Cluster", SCAS continues to work closely with individual CCGs and their associated Health and Social Care economies to consider and introduce methods and processes to improve our ability to respond quickly to all our patients irrespective of where they are across our whole geography.

The table below shows our response performance, by year, for Oxfordshire as a whole and by individual Oxfordshire District Council areas.
The information shows the percentage of "Red" calls with a response within 8 minutes (the national standard is 75%) and the percentage of occasions a suitable transporting vehicle on scene within 19 minutes (the national standard is 95%).

	2012/13				2013/14				2014/15 (2 months)			
	Red 8	Red 19	Red Incidents	Average Growth	Red 8	Red 19	Red Incidents	Growth	Red 8	Red 19	Red Incidents	YOY Growth
Oxon	76.84%	95.15%	18917	26.10%	74.54%	95.21%	20588	8.83%	74.95%	95.33%	4095	28.61%
% Reds			25.20%				25.70%				29.40%	
Cherwell	84,45%	97.48%	4283	30.80%	82.58%	96.13%	4893	14.24%	83.61%	95.04%	970	33.43%
Ox City	91.18%	99.24%	5503	31.60%	91.61%	99.18%	6469	17.55%	91.96%	99.69%	1281	27.34%
S Ox	57.25%	90.65%	3150	16.30%	52.55%	91.46%	3232	2.60%	51.47%	90.87%	647	26.37%
VoWH	69.22%	92.46%	3071	26.40%	67.96%	94.02%	3451	12.37%	70.68%	95.17%	663	26.05%
West Ox	66.45%	91.42%	3141	18.20%	52.38%	89.43%	2678	-14.74%	51.97%	90.13%	557	28.34%

Oxford, Cherwell and Oxford City Districts performed well however the increase in demand has again shown itself in a reduction in performance in South Oxfordshire, West Oxfordshire and Vale of White Horse. Although demand continues to increase resources have been put into these areas further progress is still required with rural areas remaining our biggest challenge in the face of sustained increases in overall demand.

Long Waits
We are now reporting on “Long waits” with all calls missed undergoing detailed analysis and action plans against the demand curve. (Please see long wait slides)

There has been a continued improvement in our ability to provide our patients with the right care first time. This is evidenced through a steady increase in the number of patients handled locally within their primary care setting, rather than inappropriately transferring them into an Emergency Department (ED). A greater focus on Hear and Treat is being undertaken. Our See and Treat patients i.e. those managed in a Primary Care setting has continually increased from 34% in 2011/12 to 43% year to date.

We continue to strive for greater efficiency, methodologies and processes.

This includes:

- Continued review of staff rotas in the light of current demand profiles and deployment of crews.
- Introduction of Electronic Patient Records (EPR) during 2014/5 will replace the current paper forms and send electronic copies to hospitals, GPs.
- Integration of 111-999 pathways within SCAS Emergency Operations Centre.

Community First Responders (CFR).

The development and deployment of community first responders (CFRs) across Oxfordshire continues to support our front line operations. Whilst these volunteers are no substitute for our fully qualified staff they are able to respond to certain time critical life threatening calls within their neighbourhood making a real difference by saving seconds and minutes whilst paramedics are on route which can make the difference to the outcome.

A recent restructure of the (CFR) department has included an increase the establishment with the aim of even greater focus on high priority areas following the result of detailed analysis. We have also introduced 2 staff responsible for the development of Public Access Defibrillator (PAD) sites whilst setting an ambitious target of increasing our CFR volunteers by 50%. A publicity campaign has been launched with newsletters, advertisements in the County press and Oxford Mail.

Recent Investment has been made by SCAS to introduce a new paging system with new pagers issued to all CFR volunteers. The new system has the following benefits:

- Speed up message sending and handling improving mobilisation times
- Increased coverage to 99% of county
- Able to track volunteers very accurately
- Enabling volunteers to move location whilst remaining available
- Enabling volunteers to be diverted to a more serious calls if required

A local benefactor who gave £50,000 towards PAD sites in West Oxfordshire has enabled a phased roll out of PAD's in 24 villages. West Oxfordshire District council has agreed to further fund 50% of the cost of a PAD if parish councils fund the other 50%. So far 30 villages have expressed an interest.

South Central Ambulance Service (SCAS) long term plan is to introduce a static defibrillator in all secondary schools whilst training more than 400 people in Cardio Pulmonary Resuscitation (CPR) and use of an Automatic External Defibrillator (AED) within the last 6 months.

Individual campaigns by members of the public are raising funds for static and PAD sites in and around Henley, Wallingford and Thame

Co-Responders
Work continues in forging closer links with the fire service and other military responders with Co-responding schemes extending to 4th year medical students.

The introduction of Hospital Ambulance Liaison Officers (HALO) working in Emergency Departments during winter pressure periods has been a real success with a significant reduction In delays in Ambulances queuing and improved coordination between Ambulance and ED staff.

Aubrey Bell
Area Manager
Oxfordshire
South Central Ambulance Service.

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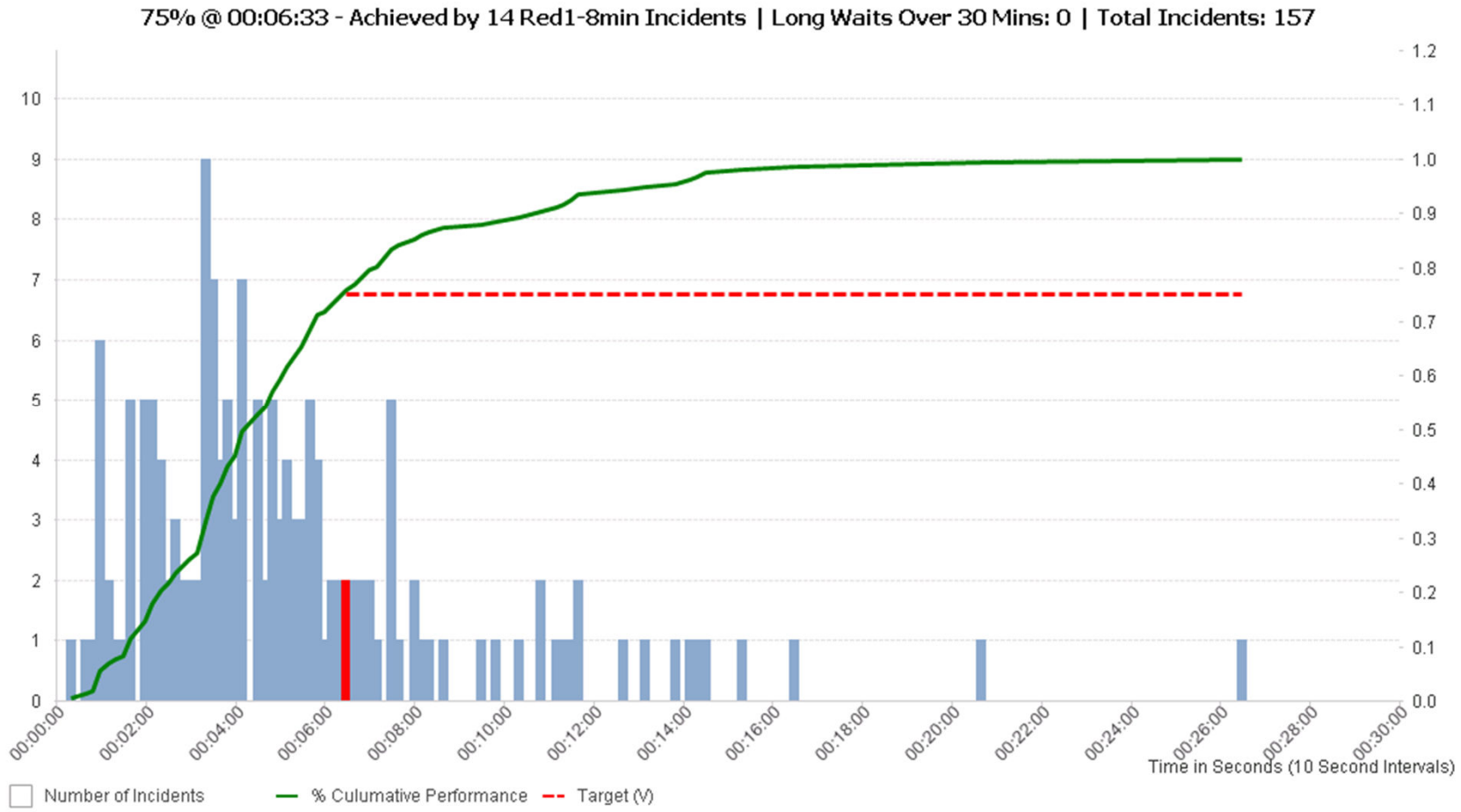
South Central Ambulance Service NHS
NHS Foundation Trust

Oxfordshire CCG – Red 1 – April 2014

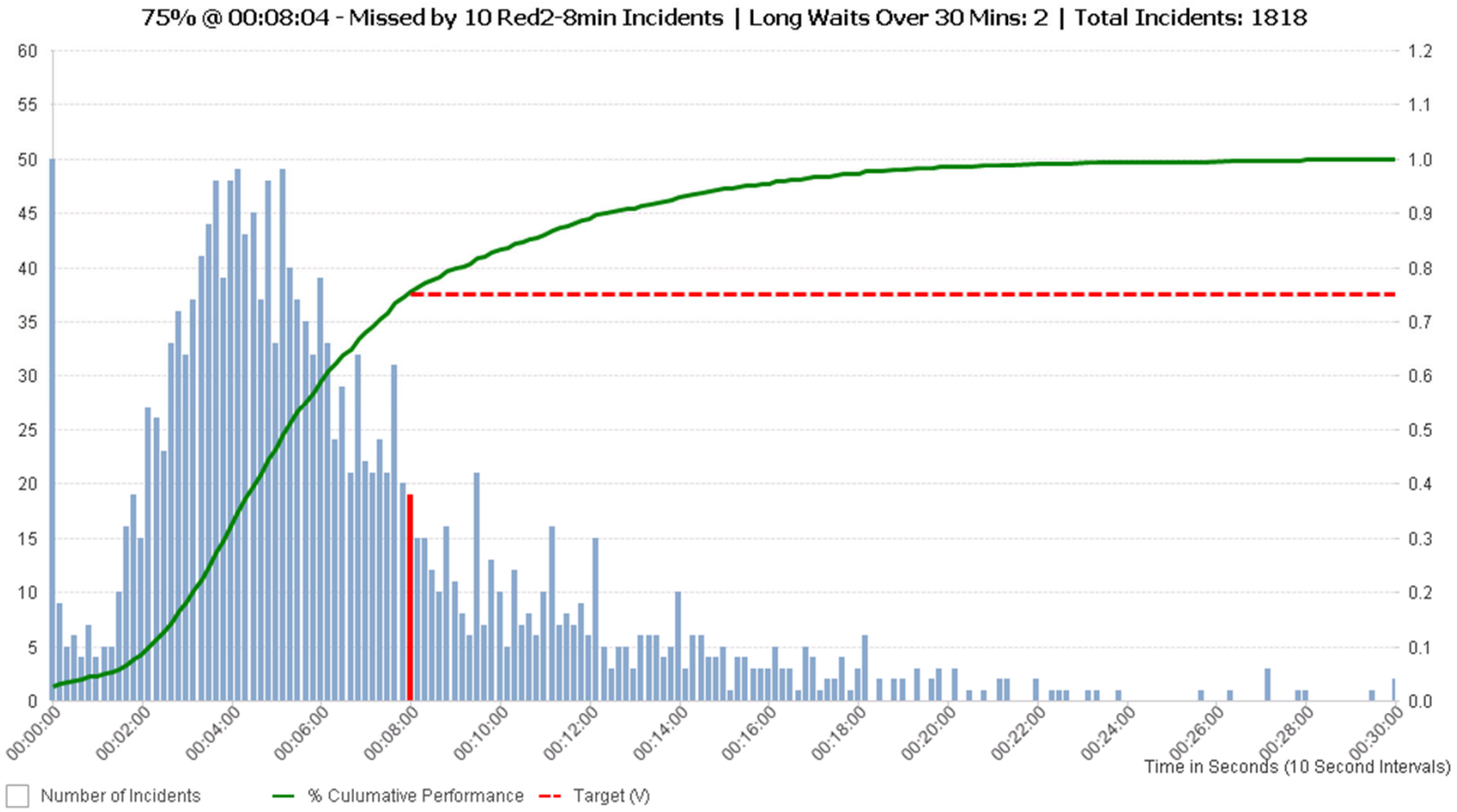


Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

South Central Ambulance Service NHS
NHS Foundation Trust

Oxfordshire CCG – Red 2 – April 2014



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

South Central Ambulance Service NHS
NHS Foundation Trust

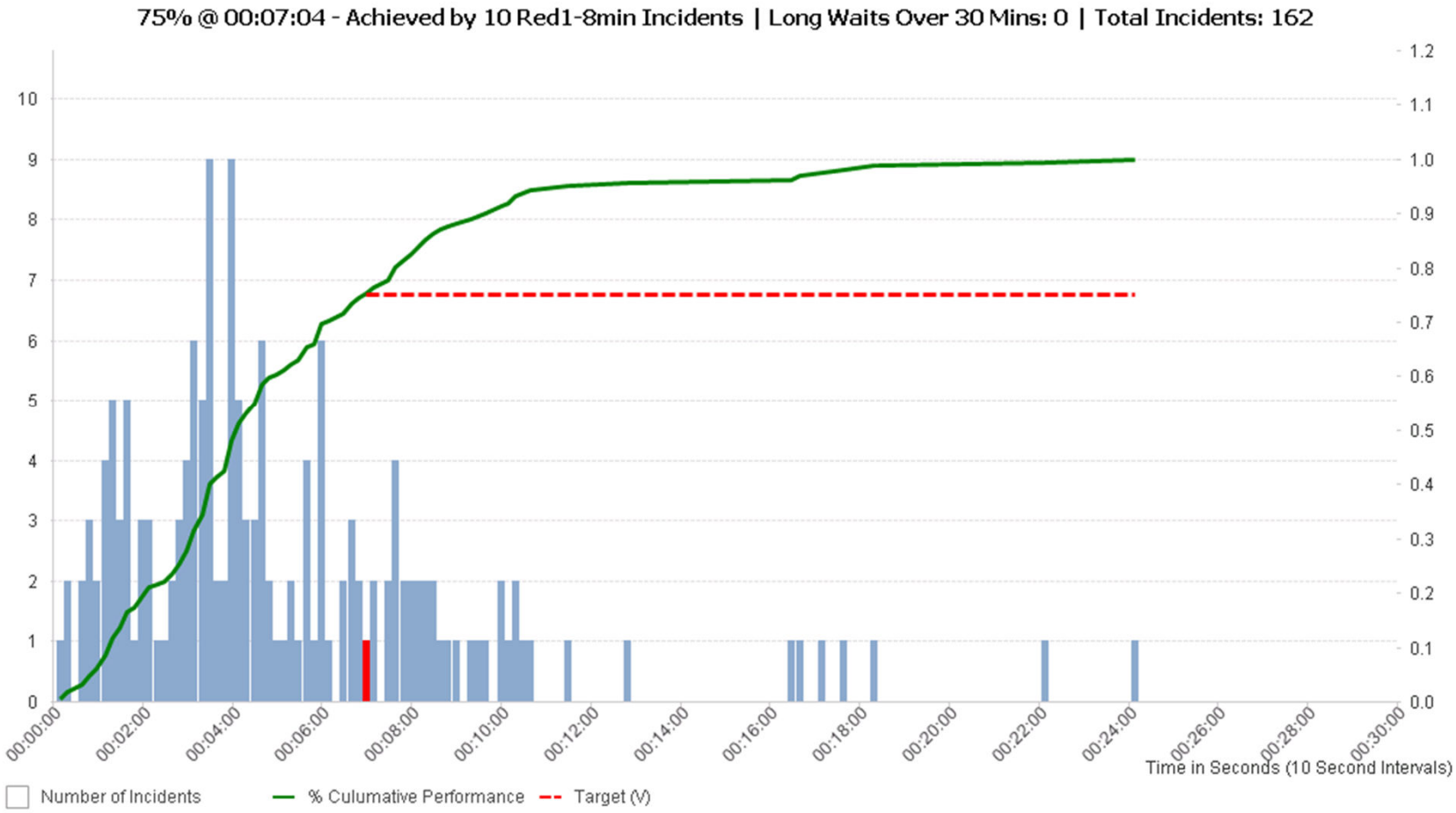
Oxfordshire CCG – Long waits over 30 minutes – April 2014

Red 1 Incidents over 30 Minutes		
Incident Number	**Duration**	**CCG Name**

Red 2 Incidents over 30 Minutes		
Incident Number	**Duration**	**CCG Name**
S1404051185	0:30:06	Oxfordshire CCG
S1404271714	0:31:51	Oxfordshire CCG

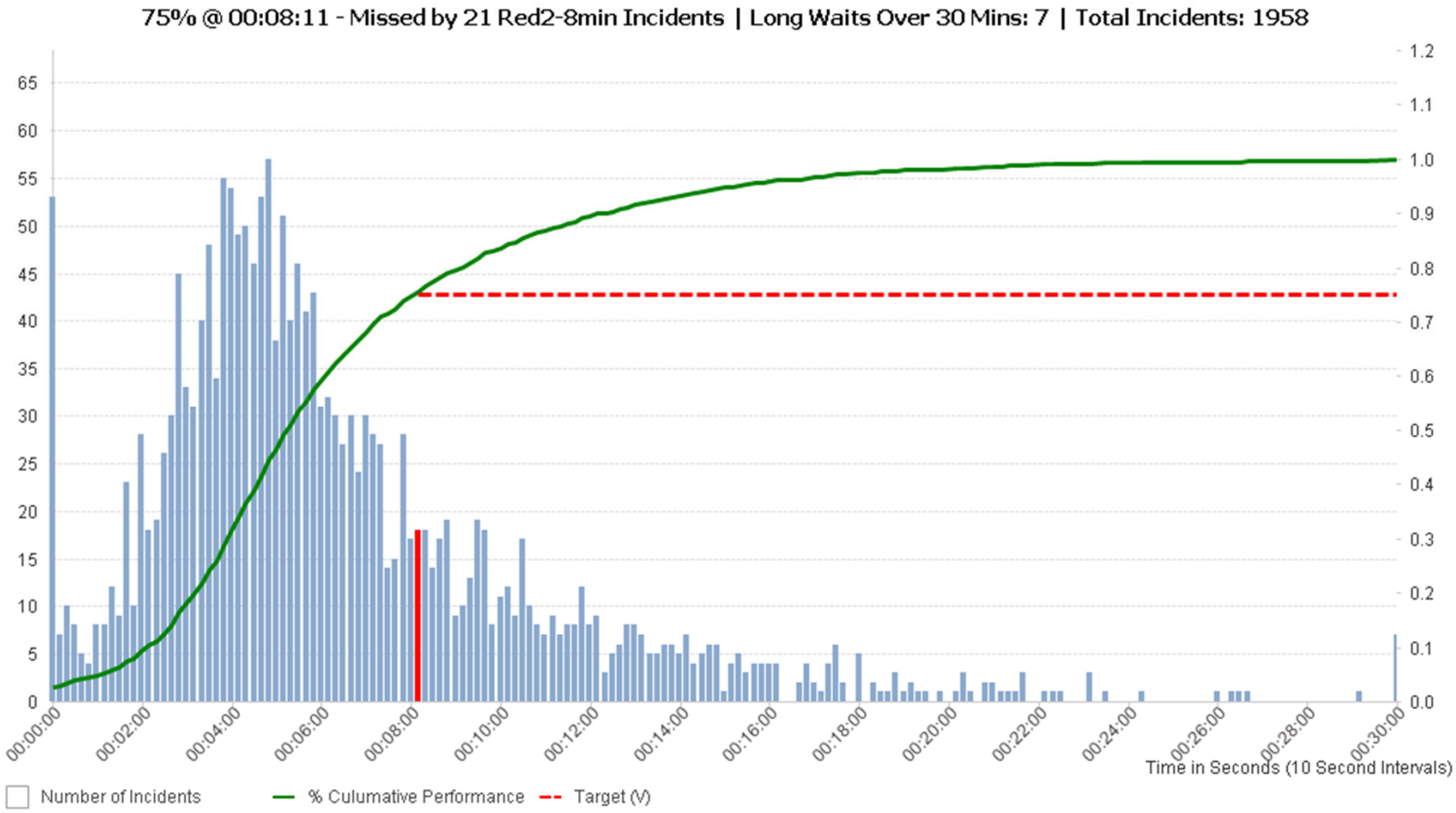
South Central Ambulance Service NHS
NHS Foundation Trust

Oxfordshire CCG – Red 1 – May 2014



South Central Ambulance Service NHS
NHS Foundation Trust

Oxfordshire CCG – Red 2 – May 2014



Get involved

South Central Ambulance Service NHS
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Oxfordshire CCG – Long waits over 30 minutes – May 2014

Red 1 Incidents over 30 Minutes		
Incident Number	**Duration**	**CCG Name**

Red 2 Incidents over 30 Minutes		
Incident Number	**Duration**	**CCG Name**
S1405050725	0:31:39	Oxfordshire CCG
S1405111234	0:53:59	Oxfordshire CCG
S1405121197	0:33:22	Oxfordshire CCG
S1405160528	0:34:20	Oxfordshire CCG
S1405211529	0:41:58	Oxfordshire CCG
S1405290063	0:39:36	Oxfordshire CCG
S1405291047	0:31:39	Oxfordshire CCG

Healthwatch Oxfordshire

Update for the Health Overview and Scrutiny Committee – 3rd July 2014

1 Delivery of Healthwatch Oxfordshire

1.1 The original grant for the delivery of Healthwatch Oxfordshire (HWO) was awarded to Oxfordshire Rural Community Council (ORCC) until 31st March 2014. Following the subsequent tender process the grant for the next two years was awarded to a Community Interest Company called EASI Healthwatch CIC which was specifically created to act as a vehicle for the delivery of HWO. EASI Healthwatch CIC took over responsibility for the delivery of the service from 1st April 2014 with arrangements made to complete the transition of the service from ORCC to the CIC. All members of the Board of Healthwatch Oxfordshire were appointed as Directors of the CIC.

2 Chief Executive

2.1 David Roulston was appointed as an interim Director in November 2013 pending the recruitment of a permanent successor. Interviews for the new Chief Executive have been concluded at the time of compiling this report and an excellent candidate has provisionally accepted the role with a view to taking up the post in July 2014.

3 Project Fund

3.1 A project fund of £30,000 was established by Healthwatch Oxfordshire to support project work and research into different areas affecting people in respect of health and social care. The purpose of the fund is to enable HWO to better understand the experiences and needs of people in Oxfordshire and to identify good practice and areas for improvement in local Health and Social Care services.

3.2 The Project Fund is overseen by a sub-committee of the HWO Board and projects funded in the last financial year included:

3.3 Research in partnership with the Patients Association into people in Oxfordshire's experience of access to GPs.

3.4 Research by Oxfordshire Family Support Network into the health service experiences of people with learning disabilities and their families.

3.5 Research by Oxford Asian Women's Project into the health and social care experiences of Asian women in Oxford with a particular focus on primary care, mental health and domiciliary care

3.6 Research by Oxford Mental Health Forum into young people's perception of the information available to them about mental health support services.

3.7 Research by Community Glue to provide information and gather perspectives from a range of organisations about the introduction of Personal Health Budgets based on the personal experience of service users and carers, projects in other parts of the country and evaluations.

3.8 A project with Sign Lingual to explore the underlying communication issues affecting deaf people in accessing health and social care services.

3.9 A project by My Life, My Choice to explore the experiences of people with learning disabilities of their healthcare treatment at their local GP surgery.

3.10 Partial funding support for a Quality of Life survey to be undertaken by Oxford City Council's neighbourhood team.

3.11 The reports arising from the above projects are at different stages of completion. The first reports published arise from the projects conducted by Oxfordshire Family Support Network, Oxford Mental Health Forum and My Life My Choice. Some of the findings and details arising from these reports are highlighted later in this report for consideration by members of the committee.

4 Research into the Healthcare Experiences of students of Oxford University

4.1 As Committee members will recall HWO commissioned a project last year to collect intelligence about Oxford University Students' experience of and impact on local publicly funded Health Services.

4.2 This involved a survey of 317 Oxford University students in November 2013 with a report subsequently compiled in February 2014 which was shared with Oxford University Student Welfare and Support Services Director, Oxford University Hospitals NHS Trust (OUHT) and Oxfordshire Clinical Commissioning Group (OCCG).

4.3 There were 4 main findings from the report:

4.3.1 High usage of A and E services –a surprisingly high number of students surveyed (13.88%) claimed to have used A&E services whilst at Oxford. Of particular concern was that over 20% of males surveyed had used A and E services.

4.3.2 Problems of access for UK students: In comparison with UK students problems with knowing how to access public services was far more prevalent amongst international students. More than half of the international students surveyed had no idea how to access listed health services (such as GPs and the 111 service) and the numbers of international students using services was lower. This provided a strong suggestion that information about local health services for international

students is inadequate and accordingly they do not know how to properly use services.

4.3.3 Mental health services: From a comparison of students' perceptions of quality and access to the services they used, mental health services came out lower than their perception of other health services. It also came out as more polarised with many responses extremely positive but also many negative responses. The research recognised that further research needs to be undertaken concerning the different types of mental healthcare provision and how improvements could be made.

4.3.4 Centralisation: each college at Oxford provides certain health services such as a privately employed nurse and NHS GPs present once or twice a week. However the system is decentralised with no college mandated to do anything and little or no centralised authority or provision for student healthcare. This came up both in the analysis of current services and issues surrounding this were raised in many of the personal comments made by respondents.

4.4 OCCG have conducted a further analysis of student data following receipt of the report and this correlates with the findings concerning the demands placed on the A and E service

4.5 A follow up study has been undertaken in conjunction with the Student Consultancy as a more qualitative analysis looking in greater depth at students' experiences of A and E and mental health services. This report is at the stage of being finalised and will be issued for comment shortly.

5 Research focus area 1 – Oxfordshire Family Support Network

5.1 The purpose of this project and associated report was to contribute to the debate about how extremely vulnerable people with learning disabilities, autistic spectrum disorder and mental health needs or challenging behaviours can be better supported and safeguarded by providing information, advice and support to their families. In order to compile the report three focus group meetings were held with local families (one of which was held with Bill Mumford, the Director of the National Winterboune View Joint Improvement Programme) and a series of focussed interviews were undertaken.

5.2 There are a range of findings with regard to the commissioning of the services provided for this group and understanding the needs of the families and young people using these services. The full detail of recommendations arising from the report can be found in appendix 1 to this report.

5.3 The report highlights the failures in respect of the current system and calls on local commissioners to work with families and services users to create services which meet their needs by working with them as 'experts by experience'. Particular areas which require more detailed consideration include the following:

5.3.1 The problems associated with the transition between children and adult services.
5.3.2 The frequent failures to provide information and support to enable families to make informed choices about which services to use.
5.3.3 A proposal to undertake scoping work on developing a peer-to-peer network of support and advocacy for families with the suggestion that Oxfordshire could be a potential pilot area to test out a peer advocacy and support model.
5.3.4 The importance of services and commissioners working with families to seek solutions rather than perceiving families as part of the problem.

5.4 HWO will wish to see progress in changing the methods of commissioning in response to the findings outlined in this report and the report has highlighted a range of issues that require further scrutiny.

6 Research Focus Area 2 – Oxford Mental Health Forum

6.1 The report associated with this project arises from an extensive online survey to find out about the information and support available on mental health for young people in Oxfordshire. The survey collected a total of 406 responses from a range of sources which included schools, young people (aged 16-25), professionals and parents/carers.

6.2 The executive summary and recommendations from the report can be found in appendix 2 to this report. Particular areas addressed in the report include the following:

6.2.1 There are many information gaps for young people about mental health issues and it is important that this is addressed through a focus on early intervention and increasing mental health awareness and understanding amongst young people, their parents/carers and the staff who support them.
6.2.2 Many of the people surveyed highlighted problems with long waiting times to access mental health services.
6.2.3 Young people need practical help and support in addressing mental health related problems.
6.2.4 A very high proportion of the parents/carers who took part in the survey had concerns about their child's mental health and they experienced difficulties in gaining access to the information and guidance and support they needed.

6.3 HWO has received confirmation from OCCG that they are starting work this year to review the way that services for children and young people are commissioned and that the report will help inform this approach. Oxford Health has also provided a detailed response to the report highlighting actions which are being taken on a range of fronts to address some of the matters covered in the report which include the following:

6.3.1 They have been awarded the contract to provide school health nursing from April 2014 and the model to be adopted will mean that from September 2014 there will be a School Health Nurse (SHN) in every state school in Oxfordshire.

6.3.2 The SHN will have an integral role in ensuring that a health plan is developed in each school to include the mental health and wellbeing of students.

6.3.3 A pilot project initially involving three schools is about to be run to put the Primary Child and Adolescent Mental Health Services (PCAMHS) into secondary schools on a weekly basis. This will enable schools to book young people into sessions as well as staff being able to discuss any concerns they may have about mental health of pupils. A move is also underway to enable 16 and 17 year olds to self-refer to the service this year in addition to the arrangements for GPs, schools, children's centres and youth workers to refer people to the service.

6.3.4 Emergency and urgent referrals are being seen within the respective targets of 24 hours and 7 days but there is an acknowledgement of an increase in waiting times for routine referrals to the service.

6.4 The report mirrors evidence found elsewhere of an increase in demand for services and increased waiting times.

7 Research Focus Area 3 – My Life My Choice

7.1 The report arising from this project was compiled based on the results arising from facilitated discussions with eleven self-advocacy groups across Oxfordshire.

7.2 The recommendations arising from the report can be found at appendix 3 of this report. Particular areas addressed in the report include the following:

7.2.1 People with learning disabilities suffer notable health inequalities when compared with the population as a whole. A recent inquiry into the premature deaths of people with learning disabilities found that three times as many people with learning disabilities die before the age of 50 compared to the general population.

7.2.2 Annual health checks represents a significant opportunity to address this inequality however in Oxfordshire only 45% of those eligible had a health check in 2012/13 compared to the national average of 53%. The target set by Oxfordshire's Joint Health and Wellbeing Strategy was 50% for 2012/13 and 60% for 2013/14 but the report raises concerns about whether this target will be met.

7.2.3 There is a general lack of knowledge about learning disability amongst those working in healthcare services. This needs to be addressed and people with a learning disability given respect as 'active protagonists in their own healthcare'.

7.3 The report also adds to the body of evidence that is being compiled in relation to access to GPs by people in Oxfordshire.

8 Initial Priorities Set by Healthwatch Oxfordshire

8.1 The following four initial priorities for attention were set by the Board of HWO:

- Access to GPs
- Setting up representative groups for relatives in care homes
- 15 minute visits in domiciliary care

- Whistleblowing

8.2 In order to explore the issue of GP access a survey was conducted throughout Oxfordshire and over 830 responses received back. The report arising from this report is being finalised and is due for publication at the time of compiling this report.

8.3 HWO is in discussion with a range of different parties about the establishment of representative groups for relatives in care homes with a view to compiling a subsequent best practice guide to promulgate the establishment of such groups more widely in care homes.

8.4 HWO welcomed the additional £800k which has been found to do away with 15 minute visits for personal care. HWO has been in correspondence with the County Council regarding the implementation of this new approach and will be designing a study for later in the year to look at the impact of the change in policy. Among the points arising from this correspondence are the following points:

8.4.1 An instruction has been issued to County Council staff asking them to stop commissioning 15 minute home care visits for undertaking certain personal care tasks.

8.4.2 A recent analysis of their records has indicated that about 770 people a receiving a 15 minute visit of some form. A review is being undertaken to establish how many of these visits involve some form of personal care.

8.4.3 The County Council will be writing to all clients who receive a 15 minute visit to book a review with them.

8.5 HWO has arranged a whistleblowing conference for the 9th July 2014. As mentioned previously the reason for HWO setting this priority was to seek reassurance that whistleblowers in health and social care services in Oxfordshire are being actively listened to and their concerns are acted upon. 4 high profile whistleblowers will be speaking at the conference including Helene Donnelly who is a former A and E nurse who was called to give evidence at the Francis Enquiry. HWO hopes that the conference will attract a wide range of attendees and support its objective for delegates to increase the awareness of whistleblowing and seek to put in place actions which will enable staff to speak out safely.

9 Engagement with the voluntary sector

9.1 HWO has arranged a conference to bring together representatives from the voluntary sector to consider the range of issues faced in the commissioning and delivery of health and social care locally and to help it shape its future priorities in respect of areas requiring attention in respect of the commissioning and delivery of health and social care. The conference will also compile evidence of the practice adopted in relation to discharge of people from hospitals and care homes to support the first national enquiry being undertaken by Healthwatch England. This Inquiry is taking evidence until the end of July and arose from evidence submitted

by local Healthwatch organisations of unsafe discharge. The inquiry will concentrate on the particular experiences of older people, people with mental health issues and people experiencing homelessness.

10 Care.data

10.1 HWO contacted Healthwatch England earlier in the year regarding concerns which had been raised by patients and other patient groups regarding the introduction of the care.data programme. This echoed concerns which had been raised by a range of other local Healthwatch organisations and Healthwatch England subsequently raised concerns about the failure to adequately inform the public about this measure. HWO has welcomed the use of Healthwatch England's statutory powers to raise such concerns and the subsequent delay of the programme to enable better engagement and information for members of the public.

10.2 HWO has issued a preliminary position statement highlighting particular concerns it has about the programme together with suggested actions which could be taken in response. We have also arranged a public debate in Oxford on 10th September on the subject of care.data to enable the public to become better informed about the programme and raise issues of concern for clarification. The debate will be attended by representatives from Medconfidential and NHS England and Dame Fiona Caldicott has agreed to chair the discussion.

11 Additional matters for consideration by the Health Overview and Scrutiny Committee

11.1 HWO has received expressions of concern about the status and future use of community hospitals. These include the ongoing debate regarding the status of the Horton General and the recent decision to close 10 community beds at Didcot Community Hospital. This issue has been raised in the context of the use of community hospitals to address issues like delayed discharges, the impact of Winter pressure and the desire to deliver care 'closer to home' as envisaged in OCCG's future strategy. HOSC is due to consider community hospitals at its meeting on 18th September and HWO would encourage the committee to include such considerations as part of its scrutiny.

11.2 Finally it has come to the attention of HWO that the current policy in Oxford is that people sleeping rough in the city who are admitted to hospital are not being prioritised for hostel beds upon discharge. We understand that this is based on a priority being placed on reducing the number of rough sleepers on the streets in Oxford but are concerned (amongst other considerations) this could displace people who were in hostel accommodation prior to being admitted to hospital and leaves them at risk of a return to the streets following discharge from hospital. This is of concern with regard to the future health needs of those affected but also in the light of emerging evidence contributing to Healthwatch England's Special Inquiry looking at the subject of unsafe discharges from hospitals and care homes.

11.3 HWO recognise the complexities and interplay of homelessness, delayed discharges and the severe lack of accommodation within the city however we feel that this issue should be the subject of further scrutiny given the potential issues raised in respect of increased risk and the challenges raised for healthcare staff in discharging people safely from their care.

Appendix 1 – recommendations arising from the report compiled by Oxfordshire Family Support Network

Recommendations for Healthwatch Oxfordshire

1. Healthwatch uses its powers to verify the quality and safety of local provision on behalf of some of the most vulnerable Oxfordshire people with learning disabilities, mental health needs and challenging behaviours

2. Heathwatch continues to hold Oxfordshire County Council (OCC) and Southern Health accountable for the commissioned services and keep the local Winterbourne Concordat on track

3. We recommend that Healthwatch particularly monitors what is happening to young people under the age of 25 - and especially those who are under 18 years of age

4. Careful monitoring of the use of physical restraint

5. Healthwatch uses its role to monitor health inequalities for people with learning disabilities, mental health needs and challenging behaviours who may also have a dual diagnosis of autism

6. Ensures families are signposted to advocacy support

Recommendations for Oxfordshire County Council

a) Commissioning

1. Oxfordshire County Council must commission services for people with learning disabilities, mental health needs and challenging behaviours that are safe and of good quality - indeed that Oxfordshire can be proud of. The global principles of open contracting should be employed.

2. OCC must ensure that commissioners have a close working relationship with providers that enable them to be sure of how the providers are performing. The key performance indicators need to be robust, meaningful and with a focus on providing personalised approaches with positive outcomes for people using these services

3. OCC should work with families and people with learning disabilities to define what the characteristics of good services should be like and to identify innovative approaches and locate gaps in commissioning so that people are not held in secure units simply because there is no opportunity to move on

4. Work with experts by experience with learning disabilities and family carers to monitor quality and develop good training for staff

5. Crucially, OCC should not allow providers to continue providing services on the basis that they are “too big to fail” as it is simply too risky for vulnerable people with learning disabilities

6. The recent experiences of failing services demands greater local accountability from service providers in the future

b) Understanding the needs of young people

1. Work closely with NHS England and Oxfordshire Clinical Commissioning Group to identify what is happening to young people and where they are so that no young person goes out of county without close monitoring and regular follow up

2. Ensure that Southern Health has a transition policy in place as a matter of urgency

3. Use health checks at 14 as a minimum to aid earlier identification of young people with mental health needs and behaviours that challenge

4. Develop a menu of local provision that is suitable for these young people, including respite care and residential treatment facilities. This requires highly skilled staff that can use a range of interventions, including Positive Behavioural Support and also community-based facilities that enable young people to develop skills, meaningful activities and that support families effectively

c) Using the SEND Reforms to drive change

1. Improve the Local Offer under the Special Educational Needs and Disability (SEND) Reforms so that young people with learning disabilities and autism and their families are supported well through transition to adult services when they have mental health needs and challenging behaviours

2. Use the Single Assessment Education Health and Care plans to capture the needs of vulnerable young people with particularly complex needs and put action plans in place to support them at the earliest possible stage

3. Ensure that the Local Offer of information gives clear information about the appropriate use of the Mental Capacity Act and Best Interests meeting and that families are informed about the planned reforms to Deprivation of Liberty Safeguarding

Recommendations for Oxfordshire Clinical Commissioning Group (OCCG)

1. OCCG explores with partners the need for an in-patient facility for under 25s and works with families and people with learning disabilities to commission innovative support

2. Works with experts by experience to improve training in the awareness of the needs of people with learning disabilities, challenging behaviours and mental health needs

3. OCCG ensures better training in learning disability and mental health for GPs and in the Mental Capacity Act

4. To similarly provide better training in the appropriate use of the Mental Capacity Act for nurses and other clinical staff

5. Ensure that there is a clear understanding of person-centred approaches and that these are embedded in clinical practice across Oxfordshire

6. Commission for person-centred, quality support that leads to better outcomes including development of a specialist transition nurse role

7. Development of enhanced models of crisis care support

Recommendations for NHS England

1. Ensure the commissioning of high quality services that are designed and commissioned with the involvement of people with learning disabilities and their families using the global contracting principles referred to in the full recommendations

2. NHS England to work with Local Authorities and local Clinical Commissioning Groups to ensure that the local community know who are supported in secure units, where they are and their ages. We want to see unstinting efforts made to provide effective treatment and support that is subject to close local scrutiny by Healthwatch, CQC and local safeguarding services. We recommend that person-centred services are developed in local communities using highly skilled staff as part of the menu of support

3. Ensure better information transfer between in-patient and community-based health and social care services including integrated IT systems. A particular weakness was identified when information needs to be transferred between private hospitals and NHS facilities.

Appendix 2 – Executive Summary and Recommendations Arising from Report Compiled by Oxford Mental Health Forum

Executive summary

An extensive online survey was carried out to find out more about the information and support available on mental health for young people in Oxfordshire. The survey collected responses from schools, young people (aged 16-25), professionals, and parents/carers. There were 406 responses to the survey in total, which included feedback from 15 schools, over 300 young people, 44 professionals and 21 parents/carers. The following commentary provides the findings from the research, along with key recommendations for each group.

Overall core recommendations:

For secondary school head teachers and mental health providers:

▫ Provide a greater focus on early intervention and increased mental health awareness and understanding.

In particular:

- Introduce regular talks on mental health in schools;

- Increase the training and resources to better equip and support staff in schools.

Actions: Oxford Mental Health Forum and Healthwatch Oxfordshire to contact head teachers and local mental health providers to work collaboratively to roll-out mental health talks from local mental health support groups/providers (such as the Samaritans, Oxfordshire Mind, Oxford Health NHS FT) in all secondary schools in Oxfordshire and help to identify and address training and resource gaps to better equip and support staff in schools.

For local commissioners and service providers:

▫ Reduce waiting times and improve access to mental health services.

Actions: Healthwatch Oxfordshire to work with the Oxfordshire Clinical Commissioning group, CAMHS (Oxford Health NHS FT), TalkingSpace (Oxfordshire Mind and Oxford Health NHS FT), and GPs to tackle the long waiting times for accessing mental health services, including establishing ways of increasing efficiency of referral processes/systems.

For secondary schools, commissioners, and service providers:

▫ Provide more practical help and support for young people suffering from mental health problems/difficulties.

Actions: Schools and local mental health providers to ensure young people are provided with both spoken and printed material containing practical guidance on looking after mental wellbeing and information on how to go about gaining help when suffering a mental health problem. In addition, local commissioners to focus on providing more practical-based therapy options including CBT and Mindfulness, and to ensure that sufficient support is available to meet demand.

For mental health providers:

▫ Improve/consolidate the resources available for professionals for increased accessibility.

Actions: Increase awareness and accessibility of Oxfordshire Mind's: The Mind Guide to mental health services in Oxfordshire: a comprehensive guide to mental health services in the county. Oxford Mental Health Forum and Healthwatch to help promote the guide and work with increasing signposting of other resources aimed at professionals, including the newly launched MindEd e-learning portal supported by the Department of Health, via local providers including Oxford Health NHS FT and Oxfordshire County Council.

For secondary schools, GP services, and mental health providers:

▫ Ensure that there is sufficient support available for parents/carers.

Actions: Stakeholders and providers to help promote parent/carer groups such as the Oxfordshire Rethink Carers service, Oxford Health CAMHS parent group, and parent/carer support groups in schools, along with resources such as printed materials aimed at providing help and support to parents/carers. GPs to try and help identify if parents/carers need support themselves when seeking help for their child for mental health related problems.

Secondary schools

Key findings:

▫ Overall, schools feel that they do not have enough resources to be able to provide appropriate information and support to young people on mental health;

▫ The main barriers/difficulties identified were: not having enough resources to be able to provide the help and support needed; and a lack of training.

Recommendations:

▫ Organise more talks for students in schools from mental health providers, such as Oxford Health NHS FT, Oxfordshire Mind, or the Samaritans.

This was identified as a popular form of information and support that young people said they would have found helpful looking back to their first years at school. It was also identified as the top form of support that parents/carers felt their child would have benefitted from. Only three of the fifteen schools who took part in the survey said they provided this form of support.

▫ Provide more training on mental health to equip and support staff in schools: Identify training and resource gaps in schools and develop a programme of training to be delivered to address the gaps identified.

There have been recent reports in the national media calling for mental health to be included on the timetable in schools1. One of the key findings identified from this survey is the lack of resources and training available, which is fundamental in being able to facilitate improved integration of mental health information and support in schools.

▫ All schools should have counselling available.

Given the increasing levels of mental health issues reported, the increase in resources needed for schools, and that one-to-one support is the most popular form of support identified by young people as the type of support they would find most helpful; it is vital that all schools have access to counselling services available.

Young people

Key findings:

▫ 16% of the 324 young people who took part in the survey had not previously received or been given any information on mental health, or were unsure whether they had.

▫ Approximately half of those surveyed who had previously received information on mental health, found the information they received helpful (53%). The top sources were: online, school, mental health specialist, GPs. A greater percentage of males gained information online; a greater percentage of females than males gained information from their GP.

▫ 60% received all of the information that they needed (a slightly greater percentage of females than males).

▫ For those who had previously received help and support for a mental health problem, less than half (49%) found the information and support they received entirely helpful. The most common problems reported included the length of time for obtaining the help and support needed, and a lack of practical help and advice.

▫ When asked what forms of information and support young people would have found most helpful looking back to their first years at secondary school: One-to-one support with a professional was the most popular, followed by online material, a school visit from a mental health support group such as Oxfordshire Mind or the Samaritans, and printed material. A large proportion of respondents to this question, nearly half (46%), felt that they would not have found a mobile/tablet app helpful.

Recommendations:

The priorities for addressing young people's needs are:

▫ Reduce waiting times/increase ease of access to mental health services and ensure continuity of care.

▫ Provide more practical advice and support in helping to address mental health related problems.

▫ Focus on early intervention and increased mental health awareness and understanding, including offering wider support aimed at prevention and looking after mental wellbeing.

▫ Ensure sufficient mental health support is available both within and outside of school.

▫ Ensure there is a range of forms of information and support available for young people on mental health to address different needs, in particular, one-to-one support, online material, talks in schools and printed material.

Professionals

Key findings:

▫ The most common mental health problems/concerns encountered by professionals were young people who were feeling unhappy/depressed, worried/anxious, and problems related to self-harm or thoughts of self-harm (95% of professionals had encountered these problems). Young people who had been affected by bullying, feeling very stressed, feeling very angry, and relationship difficulties also ranked very highly.

▫ Over 75% of professionals who took part in the survey had encountered some form of difficulties or barriers in being able to provide mental health information or guidance and support needed to young people.

Recommendations:

▫ Reduce waiting times for referral for accessing mental health services, along with increasing ease of access.

The most common difficulties/barrier encountered by professionals was the difficulty in accessing other services if a referral was needed and a delay in being able to provide a referral if a referral to another service was needed (70% of respondents highlighted these two issues as the main difficulties/barriers).

▫ Improve the resources available, including increasing accessibility and availability.

Only 25% of the professionals surveyed felt that overall they had enough resources available to be able to provide appropriate information and support on mental health to young people. Several professionals suggested there should be more or improved material available on local services, mental health conditions, and information on medications.

Parents/carers

Key findings:

▫ 70% of parents/carers that took part in the survey specified that they currently had worries or concerns about their child's mental health. Only 33% felt able to give their child advice and support themselves, without additional help and support.

▫ From those who had been able to seek help, less than half found the information or guidance and support obtained helpful (40%). Over 90% had experienced difficulties in gaining access to the information or guidance and support needed.

Recommendations:

▫ Improve waiting times/ease of access to services.

The most common difficulty experienced by parents/carers in obtaining help and support for their child was the time it took to be able to gain access to the help and support.

▫ Ensure support is available to parents/carers themselves.

Several responses from parents/carers highlighted the wider impact mental health problems can cause, not least for the young sufferer, but the family as a whole, and the frustrations and difficulties parents/carers can experience when trying to obtain help and support.

Appendix 3 – recommendations arising from report compiled by My Life My Choice

With just over half those questioned being satisfied with the service provided by their GP's, there is room for improvement. User-led training in working with PWLD would be one way to ameliorate this situation.

▫ 68% of those questioned said that they have received an annual health check. This is a far higher figure than NHS statistics for 2012/13 (see page 36) and should be treated with caution. It is not known when respondents had their last health checks and many respondents have difficulty in differentiating between a health check & a regular GP visit.

Further and continuing MLMC involvement in partnerships with Health Care professionals, and much greater priority given to health checks by Health Care professionals would be highly desirable (see message from Health Champion page 36).

▫ The appointments system is fraught with difficulty. User-led training for administrative staff could help them improve on this & would potentially encourage PWLD to book appointments on their own behalf.

▫ Much work has taken place with regards to 'reasonable adjustments' and the Report found favourably in this respect. However, more could be done in respect of developing accessible (Easy Read) printed information and instructions for medication.

▫ On the whole there is some very good practice around PWLD feeling 'heard' by their GP's and the family carer/support worker being involved in the process. There is still some room for improvement around communication and inclusion of the person with the LD in these discussions. This, coupled with the fact that around half of our Group Members feeling that their GP's could know more about Learning Disabilities would also indicate that user-led training would be highly desirable.

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Oxfordshire
Clinical Commissioning Group

Health Overview and Scrutiny Committee July 3rd 2014
Developing Musculo-skeletal services

Purpose:

The purpose of this paper is to inform HOSC members of a project being initiated by Oxfordshire Clinical Commissioning Group to review and develop planned musculo-skeletal services (see Scope, below, for inclusive services). This paper provides a high level summary of the project to give members information on how it will be managed and how the CCG will engage to inform future developments.

Introduction:

Oxfordshire Clinical Commissioning Group (OCCG) is currently reviewing the services that collectively meet the needs of patients with a musculo-skeletal related condition. Currently these component services are provided under different contracts with various providers and have not been designed to work together as an integrated model of care. *Collectively these services received approximately x referrals in 2013/14 (to be determined and reported verbally on 3rd July).*

It is anticipated that by focussing on the complete pathway, OCCG, working both with patients and our health partners will be able to explore the issues that occur within individual services as well as understand any delays and inefficiencies that exist between various steps in the service pathway. It is the CCGs intention that a process of redesign via engagement with key stakeholders (especially GPs and patients) will inform a new fully integrated musculo-skeletal service to address the complexities inherent within the current system, improve patient experience and reduce unnecessary costs and delays.

This work will also enable a review of the effectiveness of wider support services and offers the potential to deliver care in more appropriate settings. The primary driver for this project is therefore quality of service, whilst the secondary driver is value for money.

Objectives:

1) Implement an integrated pathway, eliminating inefficiencies
2) Ensure care is provided by appropriate clinicians in the right place, first time
3) Improve the quality of service delivery
4) Reduce acute admissions (Outpatient and Inpatient)
5) Increase staff morale

Scope:

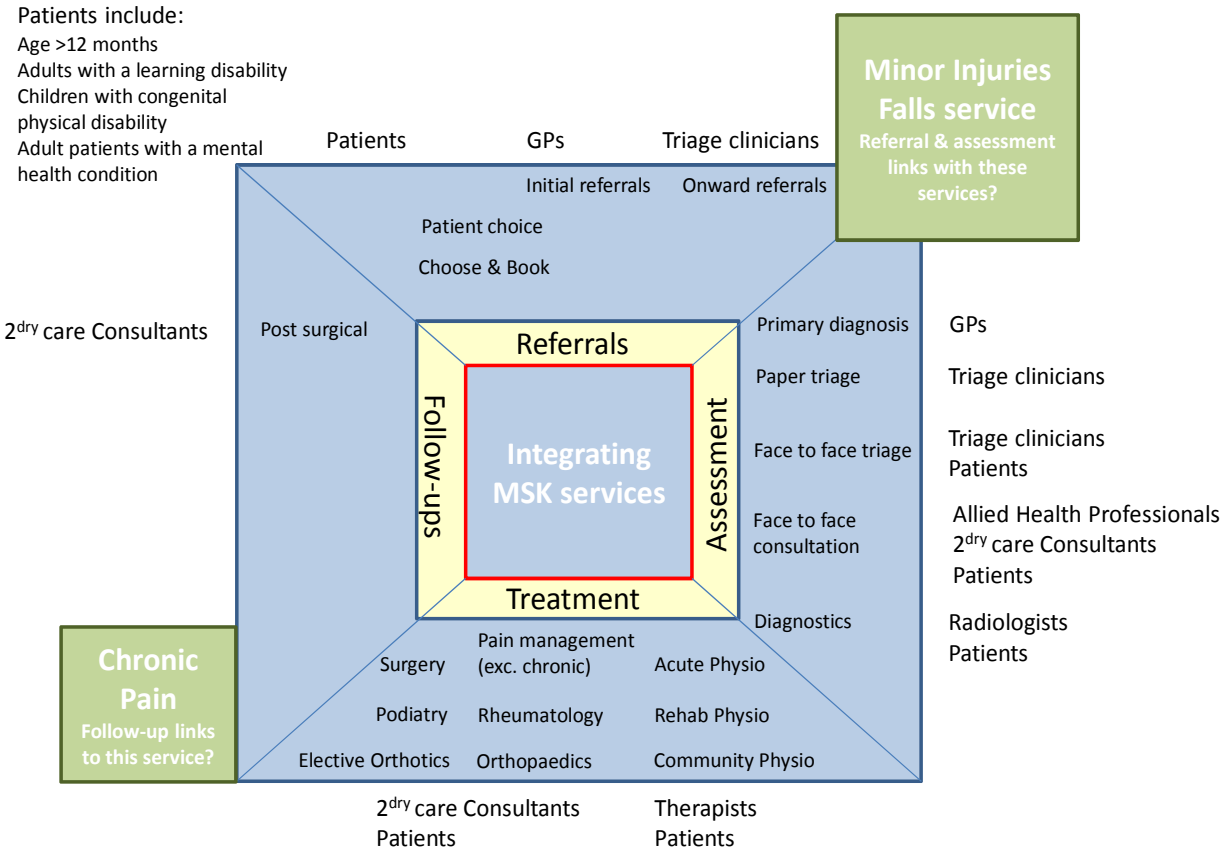
The scope of this project is still in draft and subject to change, but at this stage it is proposed that the future service will retain inclusion of all patients over the age of 12 months presenting with a Musculo-skeletal related condition: It will include a review of special requirements for adults with a learning disability, children with congenital physical disability and adult patients with a mental health condition. Integration of services will include:

- Orthopaedics (including orthopaedic surgery)
- Rheumatology
- Podiatry
- Acute Physiotherapy
- Rehab Physiotherapy
- Mental Health Physiotherapy

Referral processes will also be included within this review:

- Choose and Book (offering patient choice and booking process)
- How referrals are managed
- Access for patients entering the health system via other services e.g. Minor Injuries

Musculo-Skeletal Scoping Diagram



Explanatory Notes to diagram:
Large outer square shows services or elements of service that will be reviewed within the respective section of the pathway indicated by the inner square e.g. patient choice will be reviewed as part of the Referrals process.
Adjacent outer text shows key stakeholders connected with the respective services, or elements of service e.g. Radiologists and Patients are connected with Diagnostics

Project Approach:

This project will be managed in three phases:

1. Outline business case: Clinicians and patients/public will be engaged to inform the outline business case by considering the issues with the current services and developing improved service model options. Contracting/ procurement options will also be scoped.
2. Full business case: Appropriate stakeholder engagement with clinicians and patients/public will be undertaken to develop service model options and service specification. Decisions on contracting, or procurement, routes will also be made at this time.
3. Mobilisation: Contract agreements and transition arrangements.

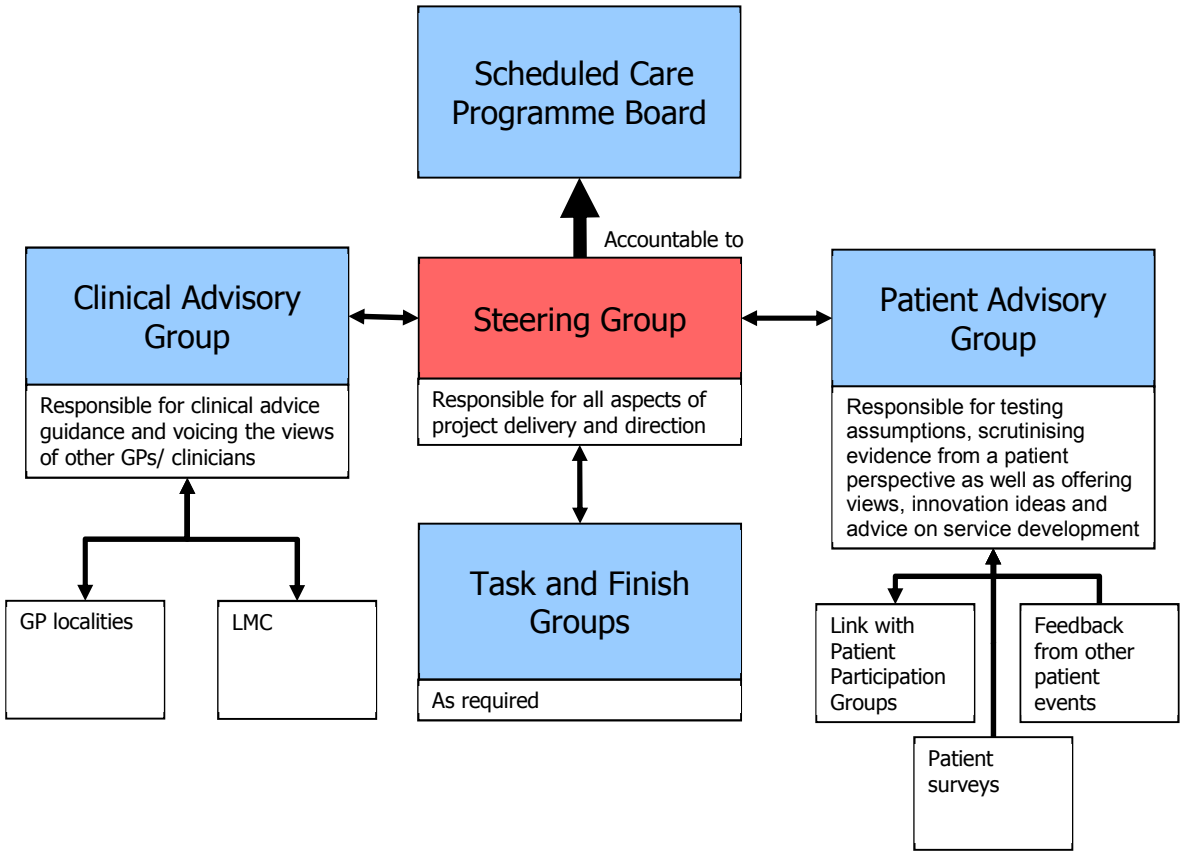
Engagement strategy in summary:
A full communications and engagement plan is being finalised within OCCG in accordance with the allocated project time-frames. See appendix A for draft summary of the engagement management plan.

An invitation has been extended to patients and GPs to participate in the development of this project via the CCG's locality Patient Participation Groups and GP locality Leads. Patients and carers with experience of using local Musculo-skeletal services and GPs with a special interest in Musculo-skeletal services are being approached directly.

Clinical Advisory Group:
This group will include the clinical lead, GPs representing their respective localities and other clinicians as appropriate.

Patient Advisory Group:
This group will include patients and carers with experience of local Musculo-skeletal services. Other patient/ public representation may be invited as appropriate e.g. Voluntary organisations.

Steering Group:
Will include representation from the Clinical Advisory Group and Patient Advisory Group, one patient (and deputy patient) and a member of the Local Medical Council (tbc).



Timeframe:
Please see appendix B for draft high level project plan

Stake holder	Key issues, concerns, perspective	How will we engage them?	When will we engage them?	Who is responsible?
Local GPs Locality Leads	How will the change affect GP practice's and patient experience?	Clear concise communications	June 2014	Clinical Lead Project Lead Communications Lead
Patients (with experience of using existing services)	Will a service with a redesigned pathway improve patient experience? Will patients get a more restricted service? Will this address or create inequalities?	Invitation to sit on Patient Advisory Group – links with PPGs. Patient survey at targeted service areas Workshops to inform the patient pathway and service specification	July 2014 (inform options in business case) Sept – Oct 2014 (co-design following business case approval) Jan – Mar 2015 (?) Public engagement	Project Lead Communications lead
Health Overview and Scrutiny Committee	Will a service with redesigned pathway improve patient experience? Will patients get a more restricted service? Will this address or create inequalities?	Presentation	Prior to submission of business case	Project Lead
Local Medical Council	How will this affect member GPs?	Communications to GPs and LM. Also a presentation	May/ June 2014	Clinical Lead Project Lead
Healthwatch	Will redesigned pathway improve patient experience? Will patients get a more restricted service? Will this address or create inequalities?	Invitation to join Patient Advisory Group. Explore whether Healthwatch can help support work on getting patient opinion	June/ July 2014 September/ October 2014	Project Lead Communications Lead
Providers: Oxford University Hospital Oxford Healthcare Nuffield (NOC) Other providers	What will this mean for each organisation? Different levels of involvement in services will require different levels of engagement. Will this affect contracts, volumes of activity, costs and introduce changes in clinical practice?	Preliminary early discussion and on-going communication to update Provide information for current state analysis Possible engagement on redesign but dependant on contracting/ procurement route	June 2014 June 2014 September/ October 2014	Project Lead

Public Health (OCC)	How will this meet the healthcare needs of the local population? What preventative measures can be promoted?	Preliminary early discussion Involvement in current state analysis – needs of the local population Involvement in future state analysis (advising on patient education/ prevention, required outcomes	June 2014 July 2014 September/ October 2014	
Local MPs and Councillors	How will this affect patients within their constituency?	Written briefing	Imminently at start of project and when appropriate thereafter	Project Lead Communications Lead
Social Care	Will this change provide an opportunity for more integrated working?	Communication updates via Dir of Adult Social Care and carer routes.	At appropriate intervals	Project Lead Communications Lead
Clinical Commissioning Group	How will this improve patient experience? How will this increase value for money?	Senior Leaders on project board. Staff informed via internal channels.	Throughout	Project Lead Communications Lead

Integrating MSK Project number 50			May				June				July				August				September				October				November				December			
Ref		Precedences	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4
1	Interpret project brief				19th																													
2	Define and agree project scope (Programme Team)	1			19th				19th																									
3	Establish Steering Group	2						13th	19th																									
4	Draft Communications Strategy (Programme Team)	1				26th			19th																									
5	Finalise Communications Strategy	4								26th																								
6	Draft project plan	2 (lag 2 weeks)					6th																											
7	Finalise project plan (Programme Team)	6							19th																									
8	Current State analysis	1			19th						4th																							
9	Preparation for workshops	2 (start-start lag 3 weeks)							16th	27th																								
10	Future state analysis (service model options)	8, 12 (finish-finish)										7th			8th																			
11	Contracts analysis (Contracting options)	2							19th						8th																			
12	Draft outline business case	2 (start-start lag 2 weeks)					6th								8th																			
13	Data analysis	2 (start-start lag 2 weeks)					3rd			26th																								
14	Prepare finance case	15									4th				8th																			
15	Write PID	2 (start-start lag 2 weeks)					6th			26th																								
16	Finalise outline business case (steering group)	12, 13, 14													8th		15th																	
17	Submit outline business case	16															18th																	
18	Outline business case approval	17																26th				25th												
19	Develop/ revise service model (existing or new)	18																29th					3rd											
20	Draft new or revise service specification	19																					3rd		14th									
21	Develop contracting route/ procurement plan	18																29th					3rd											
22	Draft full business case	19,21																				26th		10th										
23	Steering Group finalise Business Case and PID	22																							13th	21st								
24	Submit full business case	23																								21st								
25	Full business case approval	24																								28th	Will require Chairs action by Gov Body							
	Activity from this point forward to be determined following business case approval																																	
	Clinical Execs meeting					27th				24th				22nd				26th				23rd				28th				25th				
	Governing body meeting in public					29th								31st								25th								27th				

Draft HOSC Forward Plan – Proposed Items

Below is a list of forward plan items that have been suggested by HOSC members during previous meetings and discussions held to identify priorities for the year ahead.

18th September

- Action Plan to address CQC Inspection (OUH)
- Horton Hospital Strategy (CCG, OUH)
- Outcomes based Contracting (CCG, OH OUH)
- Community Hospitals (CCG, OH)
- Eligibility criteria for Patient Transport services in Oxfordshire (CCG)
- Healthwatch

20th November

- Delayed Transfers of Care (annual performance from OCCG, OUH, OCC, OH)
- Healthwatch

Items to be scheduled:

Health Strategy

- Pooled Budgets (CCG, OCC)
- NHS England commissioning:
    - Primary care
    - Specialist services
- Oxford Health Foundation Trust Strategy

Performance

- Urgent Care Pathway (CCG, OH)
- Community Hospitals (OH)
- Review of Public Health as part of the local authority (PH)
- Emergency Services in Oxfordshire (Emergency Multi-disciplinary Units)
- Review of the new arrangements for Emergency Abdominal Surgery
- Rapid Nurse Assessment System (OUH,SCAS)
- Sexual Health Contract Performance(PH)

Topics

- Health of Ethnic Minorities (CCG)
- District Nursing and Health Visitors (OH)
- Public Health contracts (PH)
- Public Heath obesity strategy (PH)

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