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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 16 July 2015 at 2.00 pm
County Hall, New Road, Oxford

Peter G. Clark
County Solicitor

July 2015

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

Membership

Chairman – Councillor Ian Hudspeth (Leader, Oxfordshire County Council)
Vice Chairman - Dr Joe McManners (Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Councillor Anna Badcock *(South Oxfordshire District Council)*	Vice Chairman, Health Improvement Partnership Board
Eddie Duller	Chair, Healthwatch Oxfordshire
Dr Matthew Gaw	Vice-Chairman, Children's Trust
Councillor Mrs Judith Heathcoat *(Oxfordshire County Council)*	Chairman, Older People's Joint Management Group
Councillor Hilary Hibbert-Biles *(Oxfordshire County Council)*	Cabinet Member for Public Health & Voluntary Sector
John Jackson	Director for Adult Social Services
Jim Leivers	Director for Children's Services
Dr Jonathan McWilliam	Director of Public Health
Dr Paul Park	Vice-Chairman, Older People's Joint Management Group
Rachel Pearce *(NHS England)*	Interim Director of Commissioning Operations (South Central)
Councillor Melinda Tilley *(Oxfordshire County Council)*	Chairman, Children's Trust
Councillor Ed Turner *(Oxford City Council)*	Chair, Health Improvement Partnership Board

In Attendance: Joanna Simons, Chief Executive, OCC
David Smith, Chief Executive, OCCG

Notes:•Date of next meeting: 5 November 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 Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting (Pages 1 - 12)

To approve the Note of Decisions of the meeting held on 5 March 2015 (**HBW5**) and to receive information arising from them.

6. Implications of the Chancellor's Budget

2:05
10 minutes

Persons responsible:	Clinical Chair, Oxfordshire Clinical Commissioning Group (OCCG), Director for Adult Social Care & Community Services
Persons giving report:	Chief Executive, OCCG and Director for Adult Social Care, Oxfordshire County Council (OCC)

David Smith, Chief Executive of OCCG and John Jackson (OCC) will comment on the implications of the 8 July Chancellor's Budget Statement.

7. Director of Public Health's Annual Report (Pages 13 - 84)

2.15
15 minutes

Person responsible:	Director of Public Health
Person giving report:	Director of Public Health

The Director of Public Health will present his Annual Report for 2014/15 (HWB7). It is an independent report for all organisations and individuals.

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 recommendations for future work.

The report covers the following areas:

Chapter 1: The Demographic Challenge
Chapter 2: Health, Houses and Roads
Chapter 3: Breaking the Cycle of Disadvantage
Chapter 4: Mental Health
Chapter 5: Lifestyle and Health: We are what we eat, drink, smoke and do
Chapter 6: Fighting Killer Diseases

The Oxfordshire Joint Health Overview & Scrutiny Committee discussed the report at their meeting on 2 July 2015 and its comments will be brought to this meeting and to Cabinet on 21 July 2015.

Action Required: to consider the report and to advise Cabinet of any comments accordingly.

8. Healthwatch Oxfordshire Report and Summary of Responses to Quality Accounts (Pages 85 - 90)

2.30
10 minutes

Board Member responsible: Chair, Healthwatch Oxfordshire
Person giving report: Chair, Healthwatch Oxfordshire

An update is attached at **HWB8** which also summarises the responses to, and the outcomes of the work undertaken by Healthwatch Oxfordshire. It also contains further comments they would like to pass on to the Board.

Action Required: to note the report.

9. Performance Report for 2014 - 15 - final report on last year's outcomes (Pages 91 - 114)

2.40
15 minutes

Persons Responsible: Director of Public Health, Director for Social Services and Director for Children's Services, Chief Executive, OCCG
Person coordinating reports: Director of Public Health

There will be a review of performance against all the outcomes for 2014-15 as set out in the Health & Wellbeing Strategy.

The review is attached at **HWB9** for consideration.

10. Revised Joint Health & Wellbeing Strategy and proposed Performance Framework for 2015-16 (Pages 115 - 146)

2.55
20 minutes

Person(s) responsible: All Partners
Person coordinating report: Director of Public Health

The revised Strategy and proposed framework for 2015-16 is attached at **HWB10.**

11. Primary Care - Implications for Services following award of funding from the Prime Minister's Challenge Fund (Pages 147 - 160)

3.15
10 minutes

Person responsible: Clinical Chair, OCCG
Persons giving report Clinical Chair and Chief Executive, OCCG

The implementation of plans to improve access to primary care is set out in the paper which is attached at **HWB11.**

12. Better Care Fund plans - Update (Pages 161 - 168)

3.25
10 minutes

Person(s) responsible: Director for Adult Social Services and Clinical Chair, OCCG
Person giving report: Director of Adult Social Services and Chief Executive, OCCG

There will be an update **(HWB12**) on the better Care Fund plans for implementation and what they will mean for services in Oxfordshire**.**

13. Oxfordshire Safeguarding Adults Board (OSAB) - Annual Report 2013/14 (Pages 169 - 196)

3.35
10 minutes

Person responsible: Independent Chair of the OSAB
Persons giving report: Vice Chairman of the OSAB & Deputy Director of Adult Social Services.

The OSAB is required to report annually on the work of the Board and of its partners, assessing the position of the partnership in relation to the safeguarding of adults at risk within Oxfordshire. Sula Wiltshire, Vice Chairman of the Safeguarding Adults Board and

Seona Douglas, Deputy Director for Adult Social Services, will present the report which outlines the work of the Board and its partners to safeguard adults at risk within Oxfordshire for the financial year 2013/14. It also covers the main national and local policy changes that happened in that period (**HWB13**).

Action Required: to note the report.

14. Reports from Sub-Groups (Pages 197 - 202)

3.45
10 minutes

Written reports on activities since the last full Board meeting in March **(HWB14)** from:

- Children's Trust
- Older People Joint Management Group
- Health Improvement Partnership Board

Action Required: to receive the reports.

15. The Children & Young People's Plan (Pages 203 - 234)

3.55
25 minutes

Person responsible:	Chairman of the Children's Trust Board
Persons giving report:	Chairman of the Children's Trust Board and Director of Children's Services

A presentation of the draft Plan **(HWB15)** will be given with the aid of some young people who have had an involvement with its production.

Action Required: to accept the report.

16. PAPERS FOR INFORMATION ONLY (Pages 235 - 236)

The following papers are attached for information:

- A summary of correspondence with the Chairman is attached for information **(HWB16).**

4.20 Close of Meeting

OXFORDSHIRE HEALTH & WELLBEING BOARD

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

Present:

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

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

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

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

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

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

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

added that the OCCG had put in a bid for £4.5m to the Prime Minister's Challenge Fund to address particular issues one of which was to address avoidable admissions to emergency care, and the outcome of the bid would be known by the end of March.

Councillor Biles commented that she would like to see the expansion of first aid units (EMU's) around the county, which would also serve to keep A & E only for acute cases. David Smith responded that the expansion of this model had already been included within the Better Care Fund range of initiatives.

Dr McWilliam highlighted the following in relation to the Public Health indicators:

8.2 and 8.3 - Health Checks - there was still not sufficient people picking up to their health checks. Notwithstanding that the service had been recognised nationally as good practice, Public Health Officers were working with GPs, looking at the service in detail to see how it may be improved;

8.4 'At least 3800 people will quit smoking for at least 4 weeks' – Dr McWilliam reported that the contract for this service had been re-let and would start in 1 April 2015;

8.5 and 8.6 – Opiate and non-opiate users successfully leaving treatment by the end of 2014/15 – A new contract would be put in place on 1 April 2015. A gradual improvement in getting people off opiates altogether was showing.

9.1 – 'Ensure that the obesity level in Year 6 children is held at no more than 15% and no district population should record more than 19%' – Oxfordshire was bucking the national trend, but there was a need to continue working on it.

11.1 – 11.4 – Immunisations – Dr McWilliam reported that the Health Improvement Partnership Board was working with the NHS England Area Team to ensure that they did not slip.

It was noted that the use of more detailed 'Report Cards' on individual outcomes had proved to be very successful at the Health Improvement Board and that this could be used by the Children's Trust.

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

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

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

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

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

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

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

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

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

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

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

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

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

..... in the Chair

Date of signing .....

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DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT VIII

Reporting on 2014/15
Produced June 2015

Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 8th Annual Report for Oxfordshire.

It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope that it is found to be interesting, but, more than that I hope it is found to be useful in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many - too numerous to name. I thank you all for your help, support and encouragement.

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
June 2015

The Thrust of This Report and Its Main Messages

This report presents a review of the population's health.

In conducting that review, I have come to two main conclusions. These are:

The overall state of health in Oxfordshire is fundamentally good. Work carried out over the last 8 years is paying dividends. This must be maintained.

And

To continue to improve we need to tackle the remaining and emerging health challenges in a more comprehensive way.

This report points to that way in 6 chapters, and together these form a **6 point plan** as follows:

1. Older People and Population change

This remains our number one challenge. All organisations need to transform services to meet the changing character of Oxfordshire's population to help people achieve a healthier old age.

2. Building better health through housing, roads and planning

The built environment if fundamentally connected to our quality of life and to our health. We need to work together to build consciously for health.

3. Breaking the Cycle of Disadvantage

This report reviews 15 aspects of disadvantage and finds we are improving in areas such as reducing teenage pregnancy and achieving better school results. However new sources of disadvantage continue to arise. All agencies plans need to specifically and persistently combat disadvantage.

4. Mental Health

Services have improved over the last seven years. This needs to continue through seeing physical and mental health as two sides of the same coin and designing new services accordingly.

5. Lifestyles: We are what we eat, drink, smoke and do

We need to widen the scope of our activity to prevent disease. There is scope to do more, particularly through the massive potential the NHS has to offer.

6. Fighting Killer Diseases

Constant vigilance is required. All organisations need to protect their specialist services which guard against diseases like TB and Ebola.

Why Now?

Now is the time to tackle these. Why? We have a strong and established Health and Wellbeing Board led by the County Council and the Clinical Commissioning Group. Public Health is well established in the County Council. The Clinical Commissioning Group, Public

Health England, NHS England and Healthwatch are now reorganised and stable. Our two main NHS trusts are now fully engaged in planning for the County. District Councils are active in the Health Improvement and Health and Wellbeing Boards. The Universities are well engaged in economic development. Plans are in the pipeline to improve our infrastructure and thus the economy with new road and rail links. We are working with the Voluntary Sector in a more constructive way. We are supported by active Scrutiny Committees which are doing their work with vigour.

In these tough fiscal times, it is still a time of opportunity. We must work together if we are to push forward. We really do have the ability to work together in a unique way in Oxfordshire to improve health and help the County thrive.

How will we do this?

This report contains suggestions and makes recommendations for how this might be taken forward. Many other individuals and organisations will have positive contributions to add. This is an ambitious agenda for an ambitious County.

I hope that promoting this debate finds support and that health and wellbeing truly becomes everyone's business.

Chapter 1: The Demographic Challenge

Main Messages in this Chapter

1. **The population is living longer, often with complex health needs and all services will have to change as a result.**
2. **Changes can already be seen in primary care, in improved dementia services and through the Care Act.**
3. **Loneliness is now recognised as an additional risk to health in old age.**
4. **NHS and Social Care services will need to keep on changing to adapt to the demographic challenge.**

We live in rapidly changing times, and the population's needs are changing too. What are the factors driving this change which have an impact on our health? I will concentrate in this chapter on the population change due to the ageing population. **This is the demographic challenge and it remains our most serious health issue.**

An Ageing Population

This is our greatest challenge. It is a well-documented fact that life expectancy continues to rise. A woman in Oxfordshire who reaches her 65th birthday can expect to live around 21 more years on average and reach 87. However, because this is the average, a great many will live far beyond this, into their 90s and 100s.

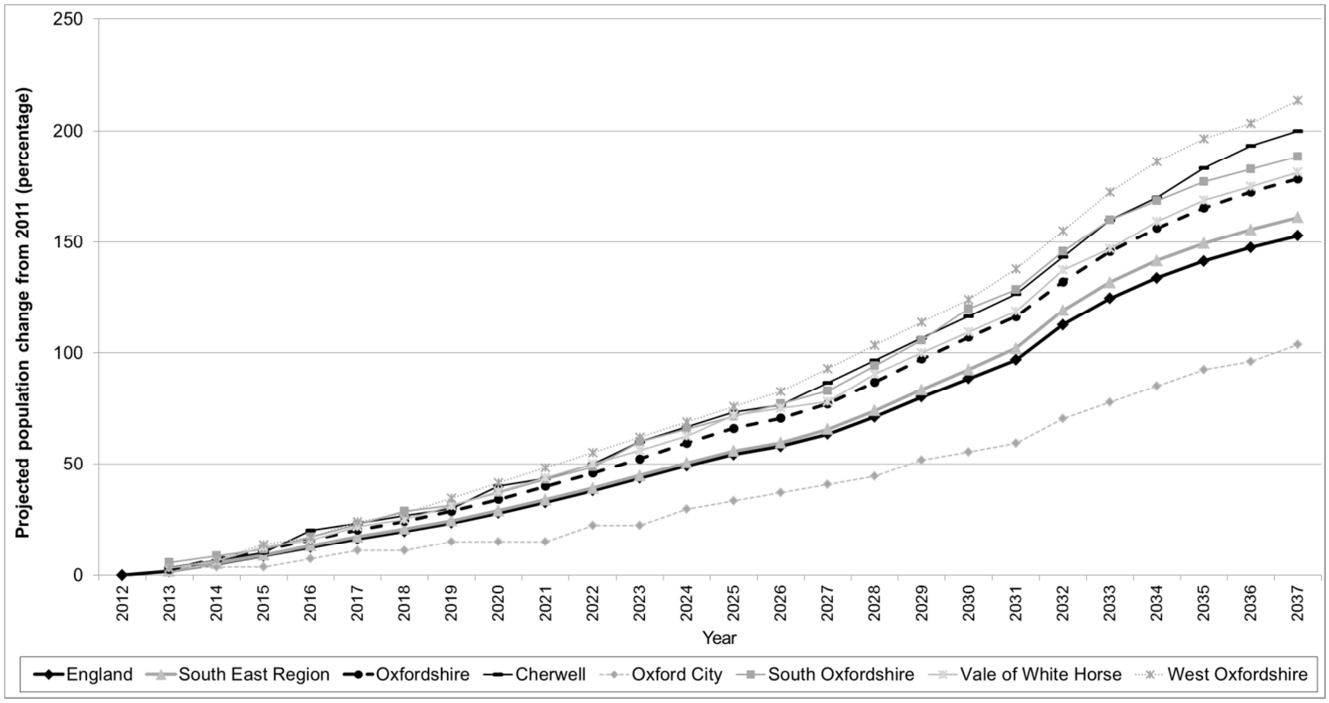
Longer life is of course a blessing, and a healthy, active, productive longer life is an even greater blessing. However, ageing inevitably brings change, and often declining health, some limitations and often loneliness. Learning to adjust to this is a life skill we urgently need to acquire.

The impact of an ageing population is now a daily reality for our health and social services. It manifests as increasing demand on GPs, pressure on hospital beds and social services and delayed transfers of care.

There is, however, some comfort here: a statistic called **'disability-free life expectancy'** which measures the years of healthy life we can, on average, expect. For the period 2009-2011 disability-free life expectancy at birth in Oxfordshire was 67.6 years for males and 69.3 years for females. Trends since 2006-2008 show that disability-free life expectancy is increasing for both sexes.

Disability-free life expectancy in Oxfordshire remains significantly above the national average. Male disability-free life expectancy has consistently been in the top 10% of the 150 upper tier local authorities in England since 2006-2008. Female life expectancy has been in the top 20%.

In terms of numbers, the pattern of ageing is not the same across the County. The chart below shows the projected percentage increase in the over 85s from 2012 to 2037 by District:



Source: Office for National Statistics

It can be seen that the percentage growth in the number of over 85s in the more rural parts of the County is higher than in the City. Growth is highest in West Oxfordshire. This means that demographic pressure is not even across the county and plans will need to reflect this. It is not a case of 'one size fits all'.

The pattern of diseases also changes as the population ages. Patterns of disease in older age are characterised by:

- chronic diseases such as diabetes
- heart problems, stroke and high blood pressure
- physical diseases accompanied by mental health problems such as depression
- physical diseases accompanied by mobility problems
- increasing numbers of people living with dementia.

This means that services need to change to respond, and we are seeing a re-shaping of GP services in response, through personal long-term care plans and care by teams of professionals sharing a single electronic record of care. There is also a move to longer GP appointments for people with multiple diseases and a recognition that dementia is a condition whose course can be improved through prevention, early detection and treatment.

Society as a whole has needed to respond to this change too as it is recognised that the tax-base will struggle to cope – hence we see increases in pensionable working age, increasing national insurance payments and squeezes on occupational pensions.

We have also seen radical change in the way social care is funded and what it covers. **The Care Act** has come into force and it strives to strike a 'fair deal' between people and their lifetime entitlement to social care, their personal wealth and the thresholds for State support. Crucially it has also recognised **the needs of carers** and has enshrined their entitlement to support. The plain fact is that without carers, our present health and social care system would be 'dead in the water' and so carers need to be cared for too.

In terms of health and social care funding, the trend is for these to become more closely aligned. **The Better Care Fund** is an example of this. The NHS continues to have its funding protected while Local Government funding is squeezed. This means that there will need to continue to be a flow of funds from NHS to social care in exchange for shared plans and integrated services.

We will now look at 3 crucial aspects in more detail:

- the exact size of the ageing population going forward
- the challenge posed by dementia
- the problem of loneliness and isolation.

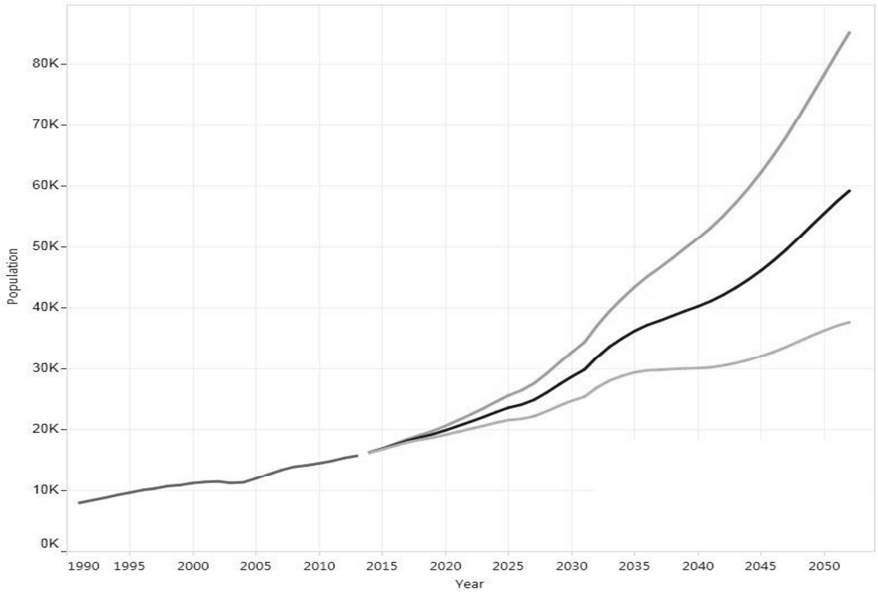
Just how big will the ageing population be?

The answer is uncertain. Any future projection is an educated guess and depends on:

- Life expectancy
- Housing growth
- Movement of people in and out of the County

The chart below shows just how different the population estimates might be, looking at the period 1990 to 2050 for those aged 85 and over. As we get further towards 2050, it becomes less a matter of science as we move into the realms of clairvoyance! Factors such as housing growth and their impact on where older people live are notoriously hard to predict.

Population projection for those aged 85+ in Oxfordshire showing 3 scenarios:



The top line, shows the maximum projected number (and it is truly shocking), the bottom line the minimum number and the middle line the most likely scenario. This gives us a range of growth to 2052 of between 22,000 and 70,000 people aged 85 plus, i.e. the difference between highest and lowest projections is around 48,000 people!

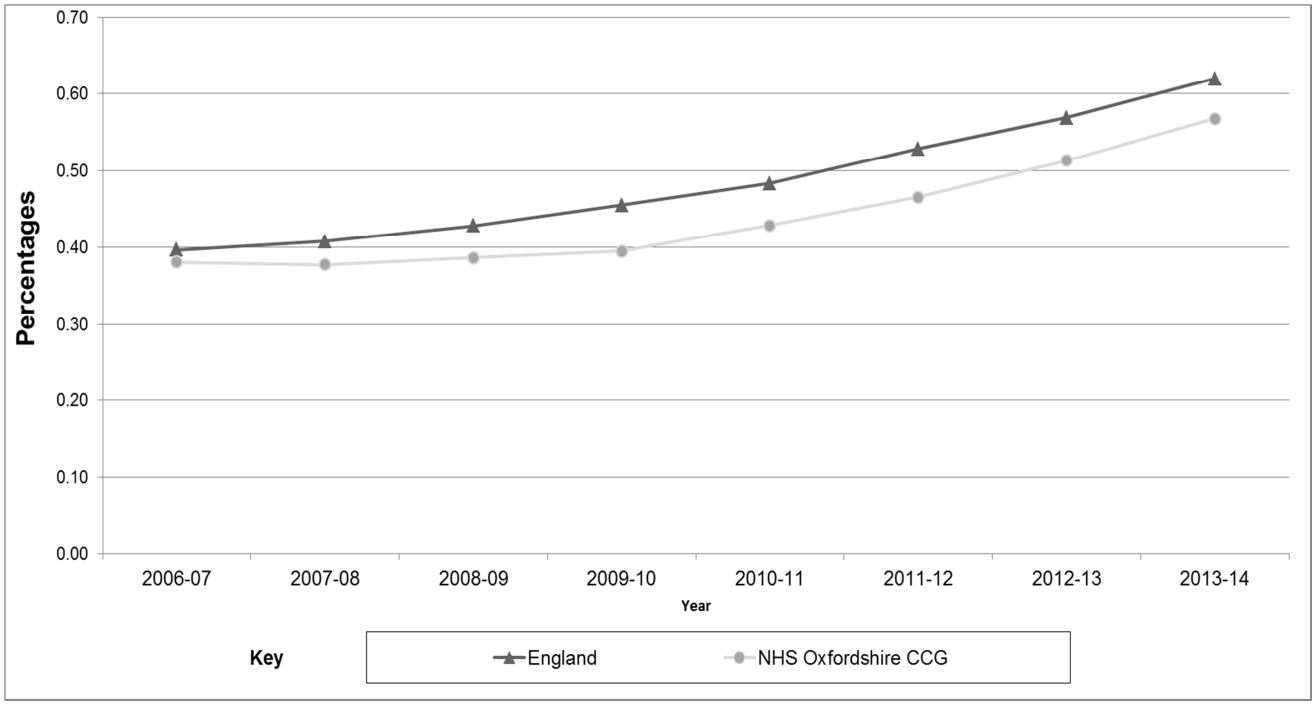
Of course, the projections closest to the present day are the most accurate, and this shows a growth in the ten years from 2013 to 2023 of between 4,900 and 7,700 people (31% increase to a 49% increase). The 'most likely' increase (the middle line) is 6,300 people aged over 85, an increase of 40%.

Looking at the figures for disability-free life expectancy shown above, it can be seen that we can expect many people at this age will have some disability and be in need of complex long term health and social care.

Dementia

The Government estimates that in the UK around 800,000 people are living with dementia and that this costs the economy around £23 billion every year.

The chart below shows the percentage of patients registered with local GPs in Oxfordshire Clinical Commissioning Group diagnosed with dementia from 2006/2007 to 2013/14:



The chart shows:

- A gradual rise in the number of cases known to GPs from 2,500 to 4,000.
- A gradually increasing trend.
- Oxfordshire is broadly in line with national trends.

We need to be careful with this measure. There will be many people with early dementia who are not yet known to general practice or people who are known, but are not recorded as such. The recorded cases may be only 50 % of the total. The upward trend shows in part the increasing awareness of dementia, and the benefits of recording and treating it early. We also need to remember that these patients will be some of the frailest in the County and will also suffer from other chronic diseases.

As a County we have a target for GPs to have recorded 67% of people with dementia by March 2016 using Government estimates of the likely 'true' number of cases in Oxfordshire.

Is Dementia a preventable disease?

The jury is still out. Dementia is really a family of diseases and some may be preventable. There is a growing consensus that a sensible lifestyle may prevent some cases of dementia, especially those resulting from disease of the heart and blood circulation. It is a complex topic, and until a definitive conclusion is reached it seems reasonable to follow the advice summarised by the NHS and leading dementia charities which recommend that the following may reduce one's chances of developing dementia:

- not smoking
- controlling high blood pressure
- reducing your cholesterol level
- controlling your blood glucose if you have diabetes
- exercising regularly
- achieving and maintaining a healthy weight
- eating a healthy, balanced diet with lots of fruit and vegetables and low amounts of saturated fat
- drinking alcohol within the recommended limits.

The list sounds familiar and is good news, as it is in line with general advice for a healthy life and is well covered by the NHS Health Check. It may provide some with the extra motivation they need to adopt a healthier lifestyle – not only will you feel better, and reduce risk of heart attack, stroke and cancer; you may well lower your risk of dementia too.

Health and Social Services and Dementia

Services have undergone significant improvements over the last 5 years.
Noteworthy improvements are:

- The CCG have appointed a GP to lead on improving dementia services and as a result we have a new primary care memory assessment service across 32 practices.
- The existing memory assessment service provided by Oxford University Hospitals Trust has been improved to reduce waiting times.
- Plans are underway to commission a countywide dementia support service to help patients and families throughout the disease, to help plan and navigate a path through services to make care less disjointed. This will be in place in early 2016. This includes younger patients with early onset dementia.
- Adult Social Care services are working on improving the quality and supply of the market for home care and residential care.

Dementia Friendly communities, organisations and individuals

This isn't all about statutory services. Everyone can help. The idea behind 'Dementia Friendliness' is to raise awareness of dementia in individuals and communities and organisations so that they can help and support people suffering from all stages of dementia. This can help at many levels, from a more understanding village shopkeeper to a better signposted city.

Oxfordshire has responded well to this and has worked with the Rural Community Council to establish 57 dementia friendly communities and to train staff to become 'dementia friends'.

Loneliness and older people

Since highlighting this issue two years ago, loneliness is now firmly established as a risk factor for poor health in old age. It occurs in both rural and urban communities, but older people living in greater isolation in more rural parts can be more at risk, especially if local facilities such as shops and post offices are scarce. Age UK have called loneliness the "hidden killer", because it is estimated to increase the risk of death in elderly people by about 10 per cent.

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

- Depression and suicide
- Cardiovascular disease and stroke
- Increased stress levels
- Decreased memory and learning
- Poor decision-making
- Alcoholism and drug abuse
- Faster progression of dementia

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

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

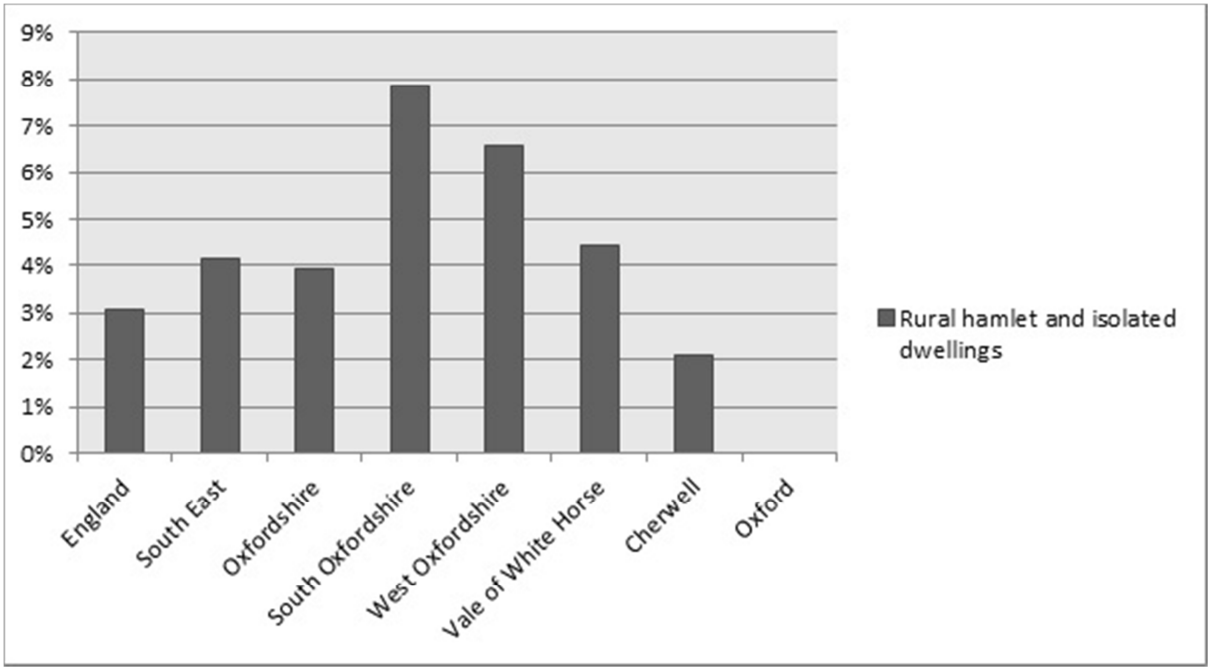
Area	One person households aged 65 and over in 2001	One person households aged 65 and over in 2011	One person households aged 65 and over in 2001 – As a percentage of all households	One person households aged 65 and over 2011- As a percentage of all households
Oxfordshire	31,140	29,852	13%	12%
Cherwell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

The data tells us that:

- Living alone in older age is a common finding. In 2011 there were 30,000 people over the age of 65 living alone **– that's about one in every 8 households across the County.**
- The percentage of older people living alone is about the same in rural and urban areas.
- The percentage has been fairly stable on average over the last 10 years at around 12% to 13%.

We can get a handle on isolation from the chart below:

Percentage of People living in a rural hamlet/isolated dwelling by Area



Source: ONS 2011 Census: Population Density

This shows that:

- The proportion of people living in isolated hamlets is around 1/3 higher in Oxfordshire than the England average (around 4% vs. 3%).
- The proportion varies from District to District with South Oxfordshire the highest (almost 8%) followed by West Oxfordshire (around 6.5%).

The data needs to be interpreted with caution – for example the many isolated hamlets in Cherwell will be masked by the much larger populations living in Banbury and Bicester. The data also includes all ages, not just the elderly, but as we have seen, many rural parts of the County have a greater number of older people, and so, isolated hamlets are likely to contain more elderly people. Every small community is different, but elderly people in these settings can be particularly vulnerable to loneliness.

The Impact on Social Care

Dementia, lack of an informal carer and loneliness all act as triggers for needing residential social care services. Tackling these problems early can therefore both increase quality of life and reduce the County's Social Care bill.

With regard to the ageing population, dementia and loneliness, what have we said before and what should we do?

Previous annual reports have recommended:

- The importance of joining up services and plans between health and social care.
- Using the Health and Wellbeing Board as a vehicle for change.
- Improving the sophistication of the use of the existing pooled budgets.
- Improving the lot of carers and making them a priority.
- Working more closely with voluntary organisations to help communities support themselves.
- Supporting volunteering to make it easy for people to volunteer.
- Making loneliness and isolation better understood causes of poor physical and mental health.
- The need to detect dementia early and improve services.
- Work all of the above factors into a single plan for Oxfordshire.

These recommendations all show improvement, but now need to be driven to a new level as this issue is such a high priority for the decades to come.

Recommendations re Population Change

1. Oxfordshire Clinical Commissioning Group and Oxfordshire County Council Adult Social Care Directorate should continue to plan explicitly for services for an increasing population of frail elderly people. Further integration of health and social care services should include this topic as a priority.

2. The Clinical Commissioning Group and NHS England should work with GP services to consider loneliness as a risk factor for disease and consider how affected individuals could be signposted to use local resources such as befriending services and lunch clubs.

3. The Oxfordshire Clinical Commissioning Group should continue to develop improved services for dementia as a priority.

4. Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospitals Trust and Oxford Health Foundation Trust and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide care new models of care closer to home, care focussed on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.

5. Oxfordshire Adult Social Care Directorate should continue to analyse carefully the implementation of the Care Act and feed this information into future service planning.

6. The Director of Public Health should continue to commission NHS Health Checks and ensure that the offering and uptake of these services achieved by local GPs is kept at high levels. Poorly performing practices should be helped to improve the way Health Checks are delivered.

7. Oxfordshire Healthwatch should consider paying particular attention to dementia services and care for carers as part of their forward planning.

8. The Oxfordshire Health Overview and Scrutiny Committee should consider scrutinising progress on these matters as part of its forward planning.

Chapter 2: Health, Houses and Roads

Main Messages in This Chapter:

1. **The built environment and the road network have a clear role to play in health and wellbeing, including stimulating the economy, providing jobs and prosperity, building communities that support health and helping to promote exercise.**
2. **Put together with well-designed green spaces, these will have a powerful, sustainable and long term impact on the health of Oxfordshire.**
3. **It is therefore time to place health considerations into a more prominent place when planning decisions are made.**
4. **We have made a good start on this and are in a good position to do more.**

This chapter is about the relationship between health and wellbeing and planning for the built environment and road and rail projects.

I'm pushing an open door here, as, during 2104/15, County Council planners have welcomed input from the Public Health team with open arms and this has helped to lever new funds into the County.

This gain has been made possible by Public Health being part of Local Government.
It helps that the link between health and planning is already enshrined in national planning practice guidance as follows:

"(Local Authorities should) *ensure that health and wellbeing, and health infrastructure are considered in Local and Neighbourhood Plans and in planning decision making*".

This chapter sets out some of the issues for the future as well as reporting on progress made.

Demography and Housing Numbers

According to current plans, the next couple of decades will see the number of houses in Oxfordshire increase dramatically. According to the Strategic Housing Market Assessment (SHMA) published in March 2014, **the current plans for housing growth (set at 2,887 new homes per year) need to be increased dramatically to between 4,678 and 5,328 new homes per year**, i.e. just about doubling the existing plans.

The report comes to this figure by taking current plans and adjusting them to take into account the need for affordable housing, the need to improve housing affordability and the need to support committed economic growth in line with Government expectations.

In summary the SHMA concluded:

"…..up to 93,560 – 106,560 additional homes are needed across Oxfordshire in the period 2011-2031 (between 4,678 – 5,328 homes per annum). "

Of course, this is all highly controversial and is the subject of much current debate about just how many houses there should be, where they should go and how they should be grouped and joined to the road network. However, whatever the result, it seems clear that there will be a significant increase in the population on the back of more house-building for all age groups in Oxfordshire in excess of current projections.

Other trends such as the tendency for more single people wanting to live alone make the picture more complex still.

My aim here is not to dispute the figures but to look at the implications for the health and wellbeing of Oxfordshire in its broadest sense.

More people and a growing economy means more houses, and more people means more travel on our road and rail systems, more need for schools and health services and a need to link the housing with workplaces and jobs.

The current systems to make all this happen are complex and confusing to say the least: a mixture of District and County Councils, developers, appeals, inspectors, businesses and the views of Town and Parish Councils and the views of many local people. New developments are rarely welcomed by locals, and the whole system is fraught with difficulties until an uneasy compromise is reached.

There is currently a disconnection between this planning and the future planning of GP and hospital services and it is a disconnection we should bridge.

I am not a housing expert, but looking at the data with common sense suggests that population change gives us a number of dilemmas:

- An increasing population means that more houses are needed.
- An ageing population means that a wider range of housing choices suitable for older people are needed.
- Loneliness and isolation in old age means that we need to find 'smarter' ways to design communities which will help older people be in contact with others.
- High house prices in Oxfordshire means that we need to build affordable places for the workers we need who attract lower salaries.
- The way populations and available land are distributed across District Council boundaries means that close cooperation between Districts and County is needed.
- Congestion on the roads means that we need to encourage workplaces that are strategically placed and which are near to where potential workers live. Broadband should help with this and will help reduce commutes through working at a distance.
- We need to consider facilities like GP surgeries along with schools and shops when designing new communities.
- We need to consider the impact on hospitals and community health services as a key element of community infrastructure.
- We need to design new communities with care to avoid creating areas where the cycle of disadvantage can thrive.

The link to Health and Wellbeing

But what has this got to do with health and wellbeing? The simple answer is - plenty!

There are strong links between housing and health. 150 years ago, the fledgling science of Public Health cut its teeth on issues of overcrowding, poor sanitation and disease-laden air and water which helped diseases like TB and cholera run rife.

Research shows that people's perception of the good life is tightly bound with their feelings about their homes and local communities, the quality of their commute, and the environmental change this implies. On top of that, 'growth' is linked to prosperity, income and satisfaction at work which all promote good physical and mental health. Good jobs help to lift communities out of disadvantage and help people stand on their own two feet.

For example, the 2012 Marmot review of Spatial Planning makes no bones about it and summarises the position as follows:

'The elements identified as having a significant impact on health, as well as relating to socio-economic status are:

- *Pollution*
- *Green and Open Space*
- *Transport*
- *Food*
- *Housing*
- *Community Participation and Social Isolation*

The link between disadvantage and the quality of the environment in its broadest sense was also made explicit:

'There is a social gradient in health: those living in the most deprived neighbourhoods die earlier and spend more time in ill health than those living in the least deprived neighbourhoods. Such health inequalities are determined by social inequalities, including environmental inequalities; there is a gradient in the distribution of environmental disadvantages: those living in the most deprived neighbourhood are more exposed to environmental conditions which negatively affect health.'

Spatial planning decisions are thought to have a direct influence upon:

- Heart disease
- Respiratory disease
- Mental health (acute and chronic effects)
- Obesity
- Physical injury
- Increased mortality and morbidity

There is also strong evidence to suggest that:

- Providing safe and easily accessible space increases physical activity levels
- Reducing traffic improves air quality
- Green spaces improve mental health

What practical things can we do to build improved health into developments?

A realistic list might be:

- Building health-promoting communities, i.e. those incorporating green spaces and those which encourage exercise, play and socialising. This needs to be part of planning for major new developments. A difficulty here is the creation of 'pepper pot developments' which scatter a few houses here and there. They add to existing communities piecemeal and make an overall plan difficult to achieve.
- Building in proper, purpose-built cycle paths into new road schemes where the terrain is suitable and the demand is high. This could reduce commutes by car and pays back handsomely in terms of preventing heart disease and improving mental wellbeing
- Build according to population need – in particular working with developers to build housing options which are attractive to older people as they age, enabling their larger houses to be freed up for younger families, and to build sufficient key-worker and affordable housing to make sure our hospitals, fire stations and schools are staffed.
- The need to make provision for these factors through developer contributions and the new Community Infrastructure Levy (which in effect 'tax' developers of housing so that essential roads, schools and amenities can be built). This currently does not include GP surgeries as a requirement. This issue is also difficult to handle if new houses are scattered pepper-pot style and again, this can lead to a mismatch between where houses are located and the services they need, which puts further pressure on the roads they need which supply them, which makes congestion still worse.
- All of this will rely on goodwill between Districts and involving the health service in the debate.

I don't want to be naïve or Pollyanna-ish about this. This is incredibly difficult, fraught and sensitive work, and Local Government Councillors and planners wrestle with these issues day in day out, but the stakes seem too high for our future wellbeing not to include health considerations more explicitly.

Recent Developments and Progress Made

Local Transport Plans and Active Transport

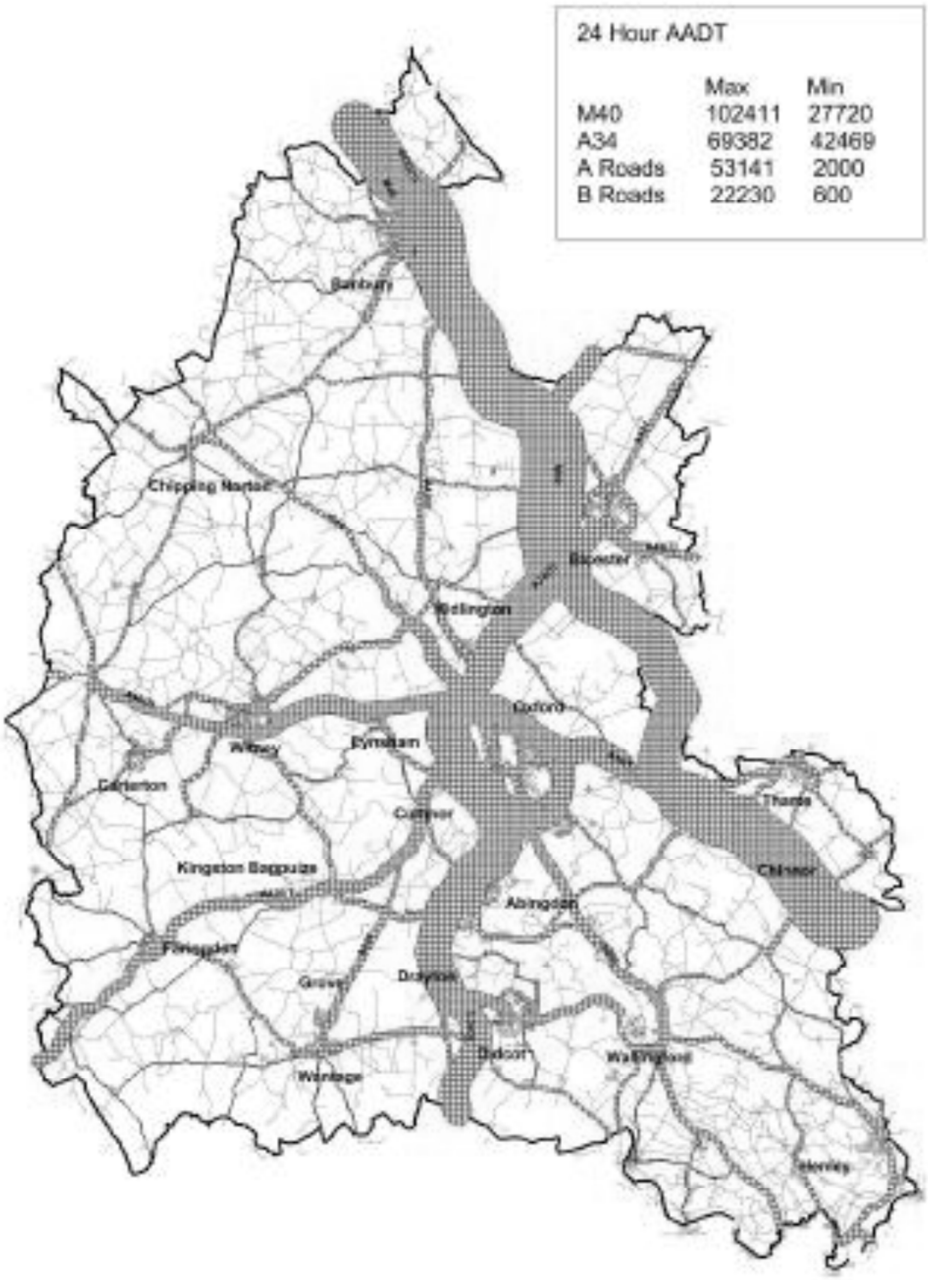
The County is currently completing its fourth Local Transport Plan (LTP4). This plan acts as a blueprint for developments to our road and rail networks, which in turn need to mesh into plans for housing and future workplaces. Its four objectives are:

- To support jobs and housing growth and economic vitality
- To support the transition to a low carbon (dioxide) future.
- To protect and, where possible, enhance Oxfordshire's environment and improve quality of life.
- To improve public health, safety and individual wellbeing.

It is great to see that to some extent, all of these goals are aligned with improving health and wellbeing, and the last explicitly so.

Creative solutions will be needed because, as in many other parts of the country, using Oxfordshire's roads is not always easy. **The map below shows the current road system by frequency of use**. The wider the road, the bigger the volume of traffic it carries. The current road network has real problem areas, some of which have implications for the national economy (and therefore national wellbeing) as well as the local economy.

The A34 is perhaps the most celebrated example. Instead of a North-South motorway connecting ports with the Midlands, we have a half-way-house dual carriageway which at times turns into a ring road and is prone to traffic jams when there is an incident (or a Black Friday shopping event!).



Annual average daily traffic flow bandwidth map – based on automated traffic counts throughout Oxfordshire. (Source: Oxfordshire County Council Transport Monitoring)

With roads and transport come concerns about air quality, which is a fiercely debated bone of contention.

Air Quality

This is a highly technical topic, but the current position on air pollution can be summarised as follows:

1. Outdoor air pollution has decreased markedly over the last 100 years and has continued to decrease over recent decades due to tighter laws and advances in technology. The age of coal burning, "pea-soupers", blackened buildings and leaded petrol is past.
2. However, burning fuel does produce pollutants such as Nitrogen Oxide, Nitrogen Dioxide, Nitrous Oxide and Sulphur Dioxide, which in turn react with the air to form further pollutants including ozone. 'Fine particles' are also produced.
3. These pollutants can cause adverse effects on health, both short term and long term. It may be the fine particles that have the most long term impact but these are hard to measure.
4. This impact is mostly a generic one, i.e. many people will be slightly affected. The impact is very difficult to measure credibly and statistics should be viewed with caution. On the whole levels in Oxfordshire are about the same as the England average.
5. In some ways this could be seen as a trade-off. We all want to have warm houses and to move around, and the cost is a slight impact on health. Of course, having warm houses also has a positive impact on health and so the final balance sheet is hard to tally.
6. Local situations cause local people considerable aggravation and thus, air quality as a health issue is frequently raised as one of a number of objections about a proposed development or to argue for a new development such as a by-pass.
7. The long term view is that air quality gradually continues to improve and that standards and legislation can gradually reduce pollutants. However, as a society, there is always likely to be a balance between the desire for faster travel, warmer homes and air conditioning etc. and a threat to air quality.
8. Greener options such as solar panels and electric cars are becoming gradually more accepted and more feasible and may be the way of the future.
9. This situation needs close monitoring as population numbers rise.

Broadband as Infrastructure Planning

We should also include the development of broadband here, as it allows the idea of 'workplace' to change.

The workplace for an increasing number has either shifted to home or is a flexible arrangement between home and office. Broadband also enables offices to be located in innovative developments such as converted barns up and down the County and makes working patterns much more flexible, taking some of the heat and stress out of the traditional rush hour. For example, this report is being typed at home on a warm Spring evening – unthinkable 10 years ago.

Broadband is also the lifeblood of the hi-tech industries that fuel the Oxfordshire economy and keep its 'knowledge spine' alive.

Oxfordshire has done well in introducing broadband and has leap-frogged the national queue. Of course coverage isn't perfect in some areas, but the overall picture is positive.

A Word about Cycling

I'm often surprised by how much negativity cycling (or cyclists) generate when I discuss the topic. It's a shame because cycling has real, tangible, strong and lasting health benefits.

For example the research shows that:

- Cycling for 60 minutes per week or more reduces cardiovascular mortality by 13% and cancer mortality by 7%.
- Switching from using a car to cycling to work results in an increase in life expectancy of between 3-14 months on average.
- The health benefits of switching to cycling as a form of travel to work result in savings of approximately £1,100 per year per person.
- It is estimated that an 8 fold increase in cycling nationally would result in £17bn in savings to the NHS over 20 years.

Much of the problem arises because we are obliged to mix bikes and cars, or bikes and pedestrians, and they mix together about as well as oil and water. Let's face it, it isn't easy to modify towns and villages laid out in medieval times to accommodate the ever-widening car, the juggernaut and the ever-so-vulnerable cyclist.

All that aside, on balance I would like to say a serious word in support of cycling and the need to encourage it where possible. It seems to me that the practical longer term answer lies in separating cyclists from other road users and building this into selected new transport schemes.

A strong dash of pragmatism will be needed too. Some places are pretty hilly even in Oxfordshire, and, where money is tight, schemes will need to be chosen with care starting with those where demand will be high. Cheaper and sensible solutions are likely to include using parts of footpaths where they are wide enough and promoting selected quieter streets as cycle routes.

Meanwhile we will have to do our best with improving the sticking-plaster solutions that painted-on cycle lanes provide.

The really great thing to bear in mind is that once a cycle path is in place, the pay-back in terms of health goes on increasing for decades.

Recommendations

1. Oxfordshire County Council's Environment and Economy Directorate should continue to embrace input from the Public Health team and this should develop further.

2. The NHS should become a consultee for local planning decisions and the Clinical Commissioning Group should be offered membership on key planning groups.

Planning and health infrastructure should be considered when developer contributions are considered.

3. Housing developments and housing developers should more closely reflect population need, with regard to housing options suitable for people as they age, and the needs of key workers should be given increased strategic consideration.

4. Cycling should be seriously encouraged in new road developments which are likely to attract high usage. Alternative cycle-only commuter routes using features such as rivers and canals should be considered.

Chapter 3: Breaking the Cycle of Disadvantage

Main Messages in This Chapter

1. **Inequalities due to disadvantage taken as a whole appear to have reduced over recent years.**
2. **This is due to persistent targeting of problems for a number of years. This is a good result but the problems have not gone away. Continued effort is needed.**
3. **However areas of disadvantage remain and new areas are emerging.**
4. **This is a serious concern and will require further persistent effort.**
5. **Persisting with work to break the cycle of disadvantage should remain a major priority**

I was recently asked whether inequalities due to disadvantage in the County were increasing or decreasing. This chapter attempts to answer that question.

It is particularly timely as the Health and Wellbeing Board supported the establishment of a Commission to look closely at this issue across the county. It is intended that this section will inform that process.

Overall, we have to remember that disadvantage is a many-headed hydra: it exists in many forms. New types of disadvantage appear all the time as society changes. The answer about whether the 'gap' is widening or not is, 'it depends which aspect of disadvantage you look at'. I provide here an overview of the main forms of inequality due to disadvantage and come to a judgement about whether they are increasing, decreasing or staying the same.

The good news is that we are making a positive impact on many forms of long term disadvantage which are reducing. It is however a mixed picture and we need to make concerted efforts to tackle those that remain or are emerging.

In this chapter I will consider 15 different indicators of disadvantage in turn and reach a conclusion about each.

1. Disadvantage in gender

The bare facts show that women can expect to live longer on average than men, but that men are catching up and narrowing the gap. This is because fewer men are now injured in the workplace due to improved health and safety standards and the decline in the more hazardous industries. Men have also begun to smoke less than previously, and smoking is still the biggest killer. The effect of two world wars used to increase the gap in life expectancy, but this effect is now diminishing as the population ages.

Women on the other hand have tended to take up smoking over the last 50 years, increasing their death toll – the number of younger women smoking is now about the same as in men. Drinking levels in women have also similarly increased. Women also suffer from the relatively common breast cancer which adds to the early death toll, although vastly improved treatment and survival rates mean that many more women now survive this condition.

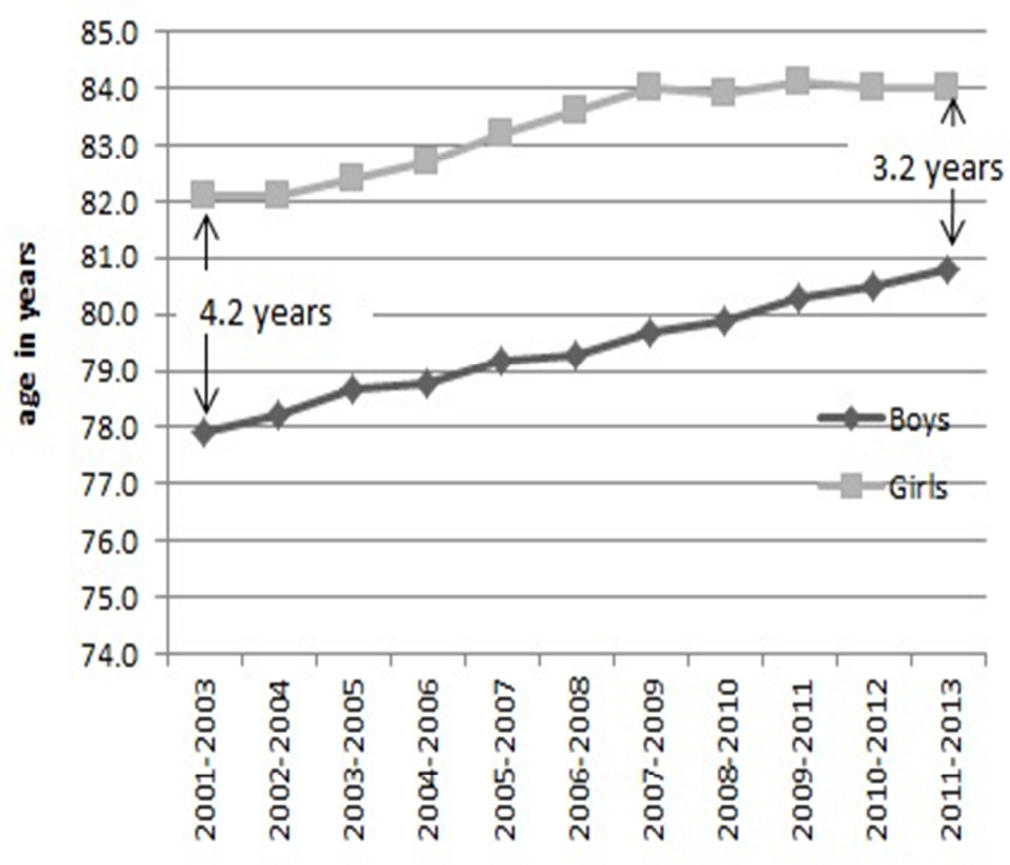
The situation can be summed up as follows:

- The male avoidable death rate fell from 408 deaths per 100,000 in 2001 to 278 deaths in 2013. The ***female rate dropped more slowly*** from 235 to 169 per 100,000.
- Coronary ***heart disease*** is still overall the most common ***single cause of avoidable death***, having ***fallen proportionately more for men than women***.
- Avoidable ***lung cancer*** deaths have also ***dropped for men but risen for women***: lung cancer is the biggest single avoidable killer.

The gap between male and female life expectancy at birth in Oxfordshire has reduced in recent years. The change is due to male life expectancy increasing at a faster rate.

The picture is shown below using a measure of life expectancy from birth.

Male and female life expectancy at birth in Oxfordshire



<u>Conclusion:</u> On the whole disadvantage due to gender inequalities are reducing, mainly because men's prospects have improved. Women need to be cautious with regard to smoking and drinking habits.

2. Inequalities in Health and Wellbeing and Age

I have discussed ageing more thoroughly in Chapter 1. This section deals briefly with the main points with regard to disadvantage.

While ageing is often a rewarding and fulfilling part of the life cycle, it is often accompanied by declining health and mobility and fewer material resources. As mentioned in the previous chapter, the main risk for diseases such as dementia is simply being older. We have also already noted the additional risks posed by loneliness in old age. Ageing is therefore a source of disadvantage. The question is, is it getting better or worse?

Chapter 1 also noted that the period of 'disease-free life expectancy' was also gradually increasing, and this can be seen as a reduction in the overall impact of ageing on health. The fact that dementia is now better detected and treated also reduces a further potential disadvantage.

Conclusion: ***Disadvantage is potentially present in the ageing process, but improvements in health care and its delivery and tackling issues such as loneliness and adopting healthier lifestyles may be reducing this cause of disadvantage as shown by longer 'disease free life expectancy'. Persistence will be required as the population continues to age.***

3. Carers and Disadvantage

We rely on carers of all ages to keep health and social care services functioning and we neglect them at our peril. As mentioned previously, the rights of carers to receive care themselves have recently been enshrined in the Care Act. I have underlined the importance of carers in many annual reports and the summary position last year was that Oxfordshire's performance was good overall. A new Carers' Strategy is currently being developed to enhance services further.

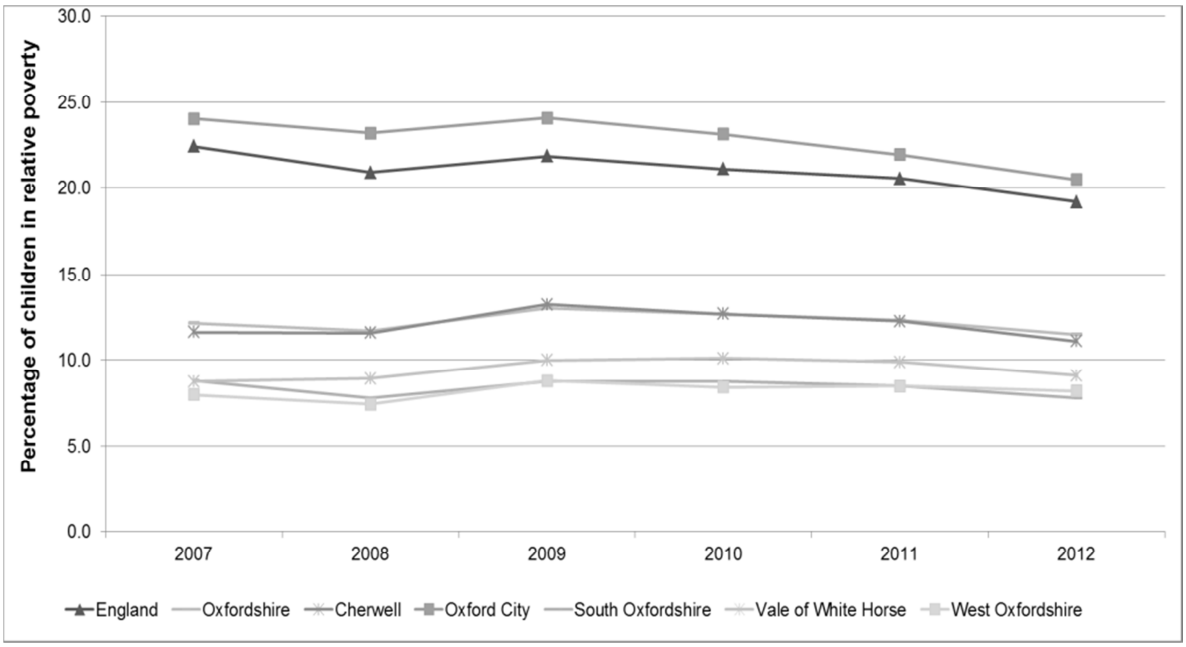
Being a carer can represent a serious disadvantage, and the impact on people's lives needs to be minimised.

Conclusion: ***There is still a way to go, but the recognition of the importance of carers of all ages and the development of services to help them means that on balance this cause of disadvantage is decreasing.***

4. Poverty

The following statistics shed light on the local picture. With regard to child poverty the chart below shows the current picture:

Child Poverty in Oxfordshire and Districts (2007-2012)



Source: Child Poverty Unit

Defining child poverty is difficult and controversial. It is a relative measure based on the average national income. The definition used is: "*children under 16 in families in receipt of out of work benefits OR who are in receipt of tax credits with an income of less than 60% of national median income.*"

The chart shows that child poverty overall in Oxfordshire is low compared to England and is fairly static at around 12%. The England figure is around 19%. This reflects Oxfordshire's overall prosperity and is broadly good news.

However, the City is a clear outlier here compared with the rest of the County, with slightly higher than the national average figure of around 21% in 2012. That is 1 in 5 children in the City were classed as living in poverty by this measure.

This is a significant source of disadvantage in the County and a serious cause for concern, although levels are falling across the board.

Smaller areas around the County in every District will also be affected, but the poverty will be masked by the overall prosperity of the District as a whole. This effect is shown in the table below which shows data from the most recent quarter available in 2013.

Here Banbury Ruscote, Abingdon Caldecott and Witney Central also feature while the majority of the wards are in the City.

Top 10 wards in Oxfordshire for child poverty in 2013:

	Percentage of children in Poverty
Abingdon Caldecott	21.33%
Banbury Ruscote	20.88%
Blackbird Leys	23.20%
Carfax	22.18%
Churchill	20.41%
Cowley Marsh	21.82%
Littlemore	19.01%
Northfield Brook	21.94%
Rose Hill and Iffley	22.05%
Witney Central	20.11%

Conclusion: ***This form of disadvantage overall is reducing. Higher rates tend to occur in persistent pockets of disadvantage. These are a cause for concern.***

5. Employment

Correlations have been found between being in good quality employment and better health. Conversely, unemployment is linked to poorer health.

In the financial year 2013/14 there were 355,000 economically active people in Oxfordshire. This was equivalent to 80.1% of people aged 16-64. The rate of economically active people was just higher than for the South East (79.9%) and higher than England (77.5%). It was higher among men (85.5%) than women (74.4%).

In Oxfordshire 77% of people aged 16-64 were in employment (65% were employees; 12% were self-employed). This proportion has remained fairly stable over the last five years, having peaked at around 80% in 2006. The proportion employed was higher in Oxfordshire than in the South East (75%) and England (72%).

In 2013/14, 3.4% of people aged 16-64 in Oxfordshire were unemployed. This figure represented a reduction from a nine-year high of 6.5% in 2012/13. The rate in Oxfordshire was lower than for the South East (5.4%) and considerably lower than for England as a whole (7.3%).

Employment rates were similar across different parts of the County.

In November 2014, 0.7% of people aged 16-64 in Oxfordshire claimed Job Seekers Allowance .This continued a declining trend since February 2013, when the claimant rate was 1.7%. The rate for Oxfordshire remains lower than for the South East (1.2%) and less than half that of Great Britain (2%).

Conclusion: ***Unemployment in Oxfordshire is generally very low and this source of disadvantage is decreasing.***

6. Housing and Homelessness

The Health Improvement Board, which has representation from all District Councils, keeps a close eye on levels of housing need , people on the edge of homelessness and rough sleeping. A great deal of close partnership working takes place to keep the figures as low as possible.
The main measures it looks at and recent trends are summarised in the table below:

Indicator	Number of households		
	2012/13	2013/14	2014/15
Homeless households in priority need	312	307	325
Total homeless Households	476	517	498
Households in temporary accommodation	216	197	192
Homelessness Prevention	1992	2298	2454
Rough Sleepers			70

Households in priority need are defined as follows:

Local housing authorities have a duty to secure accommodation for households who are in priority need under homelessness legislation. Categories of priority need are pregnancy, dependent children, vulnerable as a result of old age, mental illness or handicap, or physical disability or other special reason, homeless as a result of an emergency such as fire or flood, a child aged 16 or 17, vulnerable as a result of having been looked after, accommodated or fostered, as a result of serving in the armed forces or having been imprisoned or ceasing to occupy accommodation because of actual or threatened violence.

In an Oxfordshire context, District Councils are the Housing Authorities, but it is recognised that working in partnership is required for effective services – the Health Improvement Board oversees this.

The data shows that:

- There are fluctuations in the data from year to year as one would expect. Drilling down into the data shows that levels in the City are higher than for the other Districts.
- The number of households in priority need has been broadly static at just over 300 presentations per year. However if we look back a little further, there is an upward trend from 249 households in 2010/11 to 325 households in 2014/15.
- The total number of homeless households has been broadly static, fluctuating around the 500 mark.
- The number of households in temporary accommodation fluctuates at around 200 per year.
- There has been a gradual increase in the number of households prevented from becoming homeless through 'positive action', from 1992 to 2454. Positive action covers securing accommodation with a housing association or in the private rented

sector as well as a result of the provision of advice, support or other intervention. This is a good achievement.

- The estimated number of rough sleepers is around 70 at any one time. This is the first year when all Districts have counted rough sleeping in the same way so no conclusions about the trend can be drawn.

What are we doing about it - Joint Working in 2014/15

There have been a number of areas of joint working over the 2014/15 year, between the County Council, District Councils, and other statutory partners such as the Oxfordshire Clinical Commissioning Group. This has included:

- Considering the health needs of homeless families placed in temporary accommodation by using a Health Notification Protocol.
- Working together to commission services for young people to support those in housing need.
- Multi-agency work to ensure current services for homeless adults still provide what is most needed.
- Making a successful bid for Central Government funding to support offenders with housing need. This work was led by Cherwell District Council.
- Closer working between the District Council Housing Authorities, Social Care and health services following a Housing and Health event in the City. This work was particularly focussed on preventing delayed discharge from hospital.

Conclusion: ***Overall the balance of evidence shows that the number of households in difficulties in maintaining accommodation and in need of help is broadly static. This form of disadvantage remains a cause for concern.***

7. Education – School Results

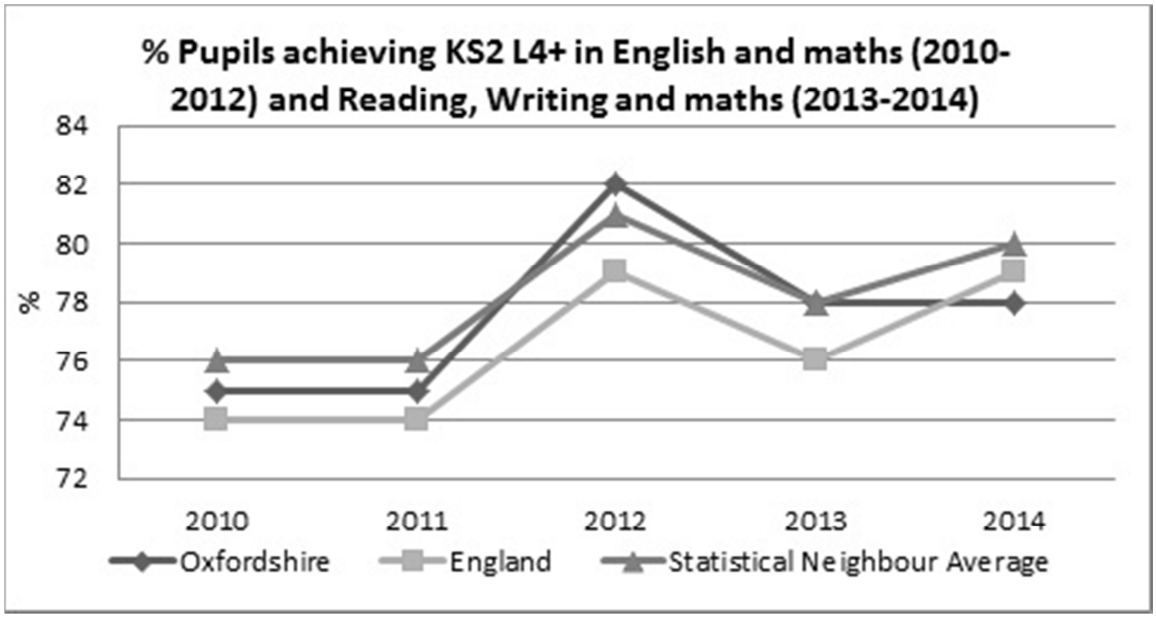
School results give a useful indicator of prospects for children. Poor results can reflect general disadvantage. The accuracy of the data means that these figures can be used to tease out underlying trends.

It has been noted in previous reports that this indicator is not simply about schools. It also reflects the general level of disadvantage among pupils in a local area which is due to many factors beyond the control of schools.

In this section we will look at the actual results at different key stages, focusing on results locality by locality. We will then look at the performance of different ethnic groups.

Results at Key Stage 2 (typically aged 11)

- Pupils are assessed at the end of Key Stage 2, which runs from Year 3 to Year 6. The key performance measure is the percentage of pupils achieving level 4 or above in reading, writing and maths.
- In 2014 78% of pupils in Oxfordshire achieved level 4 or above in reading, writing and maths. This represents a drop below the England average (79%) for the first time in a number of years. Oxfordshire now performs below the national and statistical neighbour averages and ranks 8th out of its statistical neighbour group (down from 5th in 2013).



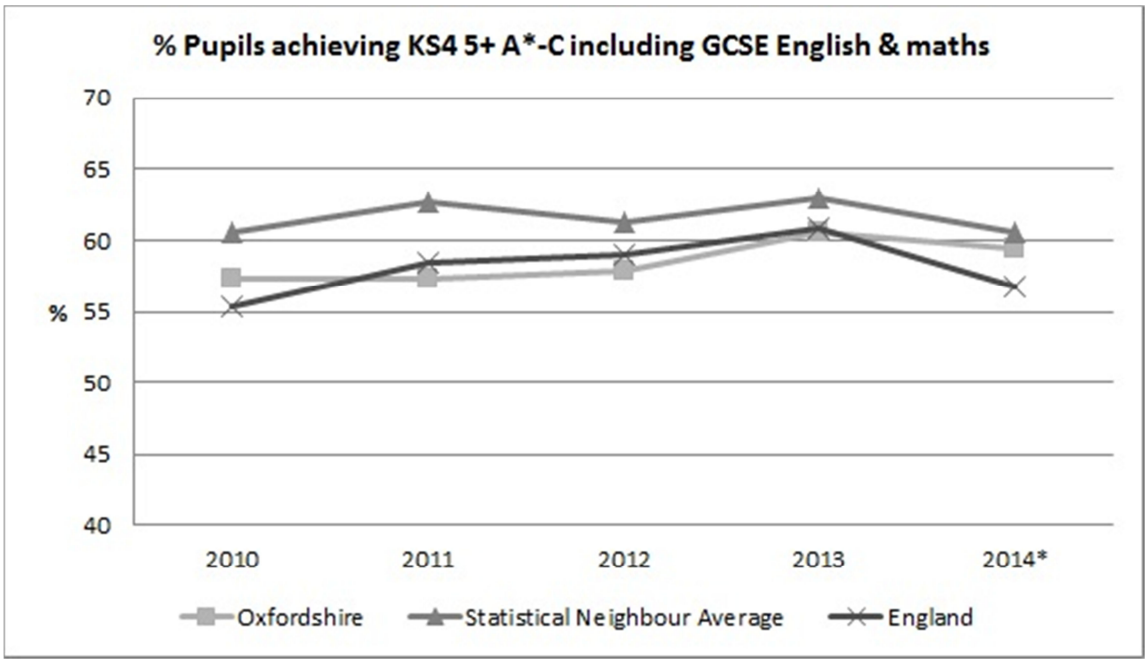
Source: Department for Education

- However, progress between Key Stage 1 and Key Stage 2 was higher across all subjects in Oxfordshire than the national average, with at least a 1% increase in each subject being reported in 2014.
- In 2014 pupils known to be eligible for free school meals in Oxfordshire were 23% less likely to achieve level 4 or above in reading, writing and maths than those who were ineligible. This attainment gap remains larger than the national average (18%).

Oxfordshire's statistical neighbours are: Bracknell Forest, Bath and NE Somerset, Buckinghamshire, Cambridgeshire, Gloucestershire, Hampshire, Hertfordshire, West Berkshire, West Sussex and Wiltshire

Results at Key Stage 4 (typically aged 15)

- The key performance measure at Key Stage 4 is the percentage of pupils achieving five or more A*-C grades at GCSE, including English and maths.
- In 2014, 59.4% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and maths. This was above the England average of 56.8% but just below the statistical neighbour average of 60.6%.
- This is a good result as previous reports have 'flagged' the previous poor performance compared with England as a major indicator of disadvantage.

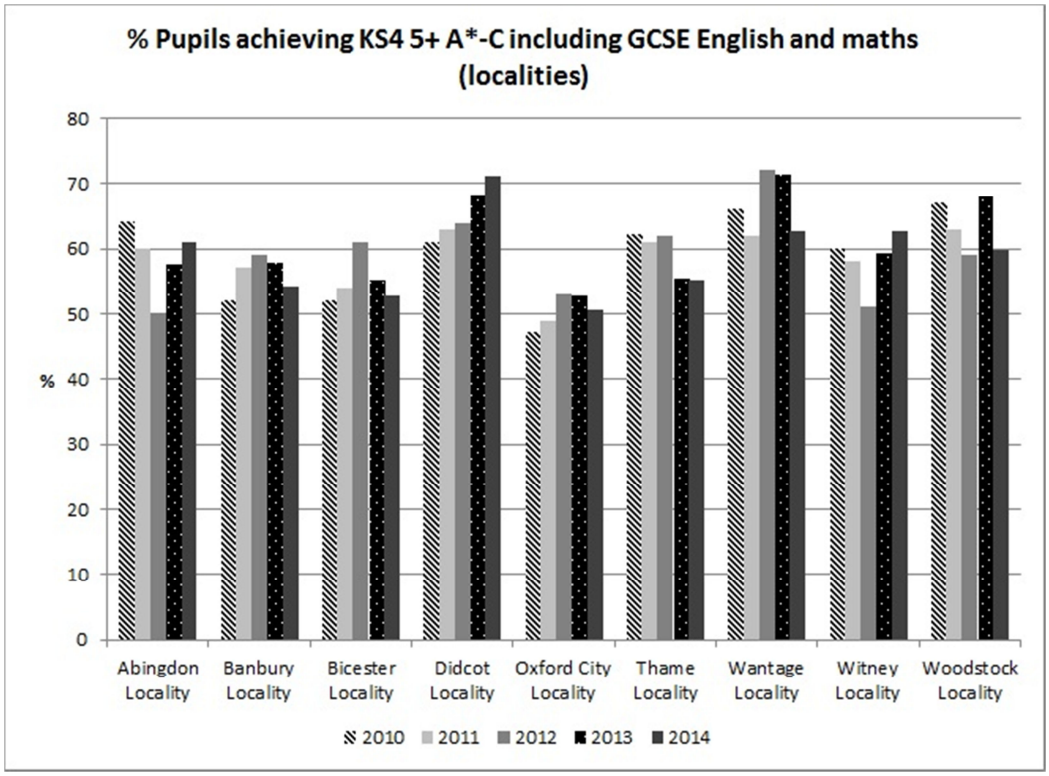


Source: Department for Education

- In 2014 the proportion of pupils at schools in Oxfordshire making the expected progress in English and mathematics was higher than the national average. This is a good result.
- Pupils known to be eligible for free school meals in Oxfordshire schools were 34% less likely to achieve five or more A*-C GCSE grades, including English and maths than those who were ineligible. This attainment gap remains larger than the national average (27%).
- The way in which performance is reported changed in 2014 and is now based on First Entry (i.e. the first time a pupil sits an exam), rather than Best Entry (which can include resits). For this reason previous years' results cannot be directly compared. The trend chart above should therefore be treated with caution.
- Across the County, GCSE performance in Oxford schools has moved out of the bottom quartile for the first time in a number of years. This is a good result and indicates a decrease in disadvantage.

Key Stage 4 results by Locality

Looking at school results at GCSE grouped by locality gives the following picture:



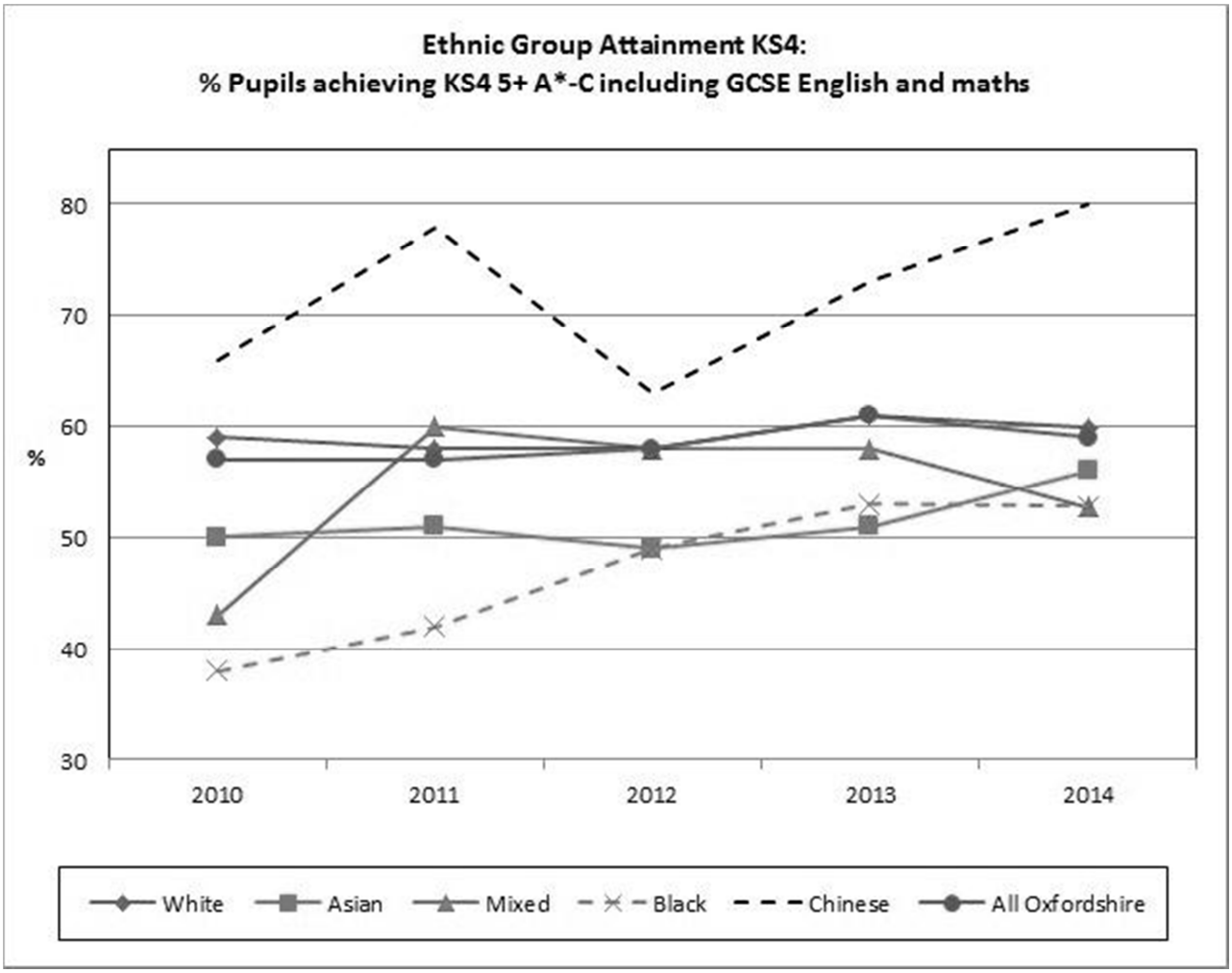
Source: Department for Education

It can be seen that:

- The Didcot locality has been gradually improving and now has average attainment at over 70%.
- Oxford City locality has improved since 2010, but has average attainment levels of around 50%.
- The gap between best and worst has remained broadly constant at around 20 percentage points.

Key Stage 4 results by ethnicity

- In 2014, 60% of White pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE, including English and Maths. This compares with 56% of Asian pupils, 53% of Black pupils and 53% of Mixed ethnicity pupils. ***Caution should be exercised due to the relatively small number of non-White pupils: in 2014 there were 302 Asian pupils, 258 Mixed ethnicity pupils; 125 Black pupils and 30 Chinese pupils. This means that results will fluctuate from year to year and is likely to account for some of the differences shown in the chart below.***



Source: Department for Education

The chart above shows that:

- Results for children from Black and Asian ethnic groups have improved steadily. This is a good result.
- The Chinese population's numbers are small, but perform above the average.
- Results for children of mixed ethnicity fell slightly last year.
- Overall these results show an improvement.

Conclusion: ***There has been recent improvement in this measure which has been a serious cause for concern in previous years. The gap has closed at key stages 4 and between key stages 1 and 2, but have widened at key stage 2. Children from minority ethnic groups are performing better on the whole. Children in receipt of free school meals and areas with the poorest results can be used to focus further effort.***

8. Ethnicity related Disadvantage

There has been an 'across the board' increase in the number of Oxfordshire residents from ethnic minority groups of 57% comparing 2001 and 2011, (46,000 more residents) the increase involving every District of the County.

Over a third of all city residents are from ethnic minority groups and over 10% of all Cherwell residents.

The picture continues to be fluid as populations from parts of the EU migrate in and out of the country.

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.

The position in schools, which shows improvement, was highlighted above – many schools are now teaching children whose first language is not English and the number of first languages spoken may be over 20 different languages.

In terms of disadvantage, ethnicity presents a number of challenges for example:

Health related disadvantage
Ill health does not affect all equally. For example people from the Asian sub-continent have a higher risk of developing diabetes, and are at risk of diabetes at lower Body Mass Index BMI than are 'white' ethnic minorities.

Language related disadvantage
Particularly among 1st generation migrants, language presents a challenge. It is more difficult to do as well at school or to secure a high paying job if fluency is poor.

Conclusion: ***Ethnicity may be a risk for disadvantage, but it isn't necessarily so. However, the increasing number of migrants does mean that the potential for disadvantage is widening.***

9. Teenage pregnancy

This is a success story in Oxfordshire. Rates have been falling steadily since 2001-2003 from just over 35 per 1000 15 to 17 year olds to around the current rate (2011-13) of 20 per 1000. This easily out-performs England's figures of around 42 per 1000 in 2001-2003 and 28 per 1000 in 2011-2013)

This achievement has been due to careful attention from all services, including sexual health services, schools, school health nurses and targeted services to improve access to contraception such as condoms and the morning after pill.

The five wards with the highest rates per 1,000 females aged 15-17 years in rank order are:

District	Ward
Oxford	Blackbird Leys
Oxford	St Mary's **
Oxford	Iffley Fields
Oxford	Barton and Sandhills
Oxford	Rose Hill and Iffley

** this ward now includes figures for Holywell ward

However, even in the wards with the highest rates, the numbers have fallen over the last decade. And this is overall a good result.

Teenage pregnancy is one of the persistent markers for social disadvantage. Recent improvements in the school health nursing service help to target teenage pregnancy with a holiday time, as well as term time, service in the City, access to the morning after pill in selected pharmacies across the county and contraceptive advice focussed on Banbury and the City. Also an outreach service of two trained sexual health staff goes out to help young people in the most difficult areas to give help and advice.

Continued targeting of the services mentioned above will be needed to continue to keep teenage pregnancy in decline.

***Conclusion:* This is a good result and is a decreasing cause of disadvantage.**

10. Safeguarding and Exploitation

Children who need to be safeguarded and protected from exploitation are by definition disadvantaged.

Improvements made to services over recent have been thoroughly scrutinised by the Oxfordshire Safeguarding Children Board (OSCB), by external review, and by the Council's Performance Scrutiny Committee. The results show the substantial gains made in understanding these issues in Oxfordshire and the work done by all organisations to improve matters. This has been extensively covered elsewhere, but in summary, Oxfordshire has faced up to this issue and improved the local situation.

***Conclusion:* This issue is now well understood and the determined approach in Oxfordshire acts to reduce this cause of disadvantage.**

11. Female Genital Mutilation

Female genital mutilation (FGM) (also referred to as female circumcision) is defined by the World Health Organisation (WHO) as "*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons*".

There are no health benefits to FGM. Immediate effects include severe pain, shock, bleeding and infection. Long term physical effects include chronic infection, difficulties passing urine, kidney failure and damage to the reproductive system including infertility. There may be long term psychological and mental health effects, including depression and anxiety.

FGM is illegal in the UK – both the practice itself and assisting in it.

As well as a legal issue, FGM is an inequality issue. It is linked to cultural practice and behaviours which cross religious, ethnic and language boundaries. No accurate figures of the numbers of women affected in Oxfordshire exist, though there is now regular reporting

of the number of women who have been affected by FGM and who are seen years later in local hospitals, often when they are pregnant.

Much is being done to raise the profile of this practice as a safeguarding issue. The Oxfordshire Safeguarding Children Board has been operating at the forefront of this work. The Oxfordshire FGM strategy is addressing the needs of women who have undergone FGM by providing specialist health services for them. The strategy also includes longer term prevention initiatives.

The role of public health is focussed on prevention, working with communities to help them to raise awareness and start talking about FGM. By this means the community members themselves will start to change expectations.

So far the FGM strategy group has:

- Established a network of trained professionals who work across different agencies to provide the best services for affected women.
- Secured funding for the "Rose Clinic" where specialist help is available for women through pregnancy and childbirth.
- Supported a group of young people who are raising the issue of FGM in local secondary schools. They have already run several workshops and a successful poster competition.
- Worked with a local voluntary group who are developing a website to highlight the stories of those affected.
- A very successful conference was also held with the Department of Health where the development of the work in Oxfordshire was described and celebrated.

The next steps in this work are to:

- Press on for the long term in parallel with enforcement agencies to ensure that children are protected.
- Work with survivors of FGM to help them undertake action research in their own communities and bring about change from within.
- Ensure that professionals are trained and aware, so that a range of organisations can work together to recognise risk, support those affected and prevent FGM in the next generation.

Conclusion: ***This is an example of disadvantage which has come to the fore in recent years. Sound and solid action is being taken, but at present it remains as an area of potential disadvantage.***

12. Inequalities in mental health and mental health services

The chapter on mental health and wellbeing gives a fuller account of this topic. In summary, over the last 5 years there has been a gradual improvement in the way mental health services are viewed, commissioned and provided. There have been 5 'drivers' behind this:

- The move to see mental health problems as common, and to improve basic services to help people combat anxiety and depression.

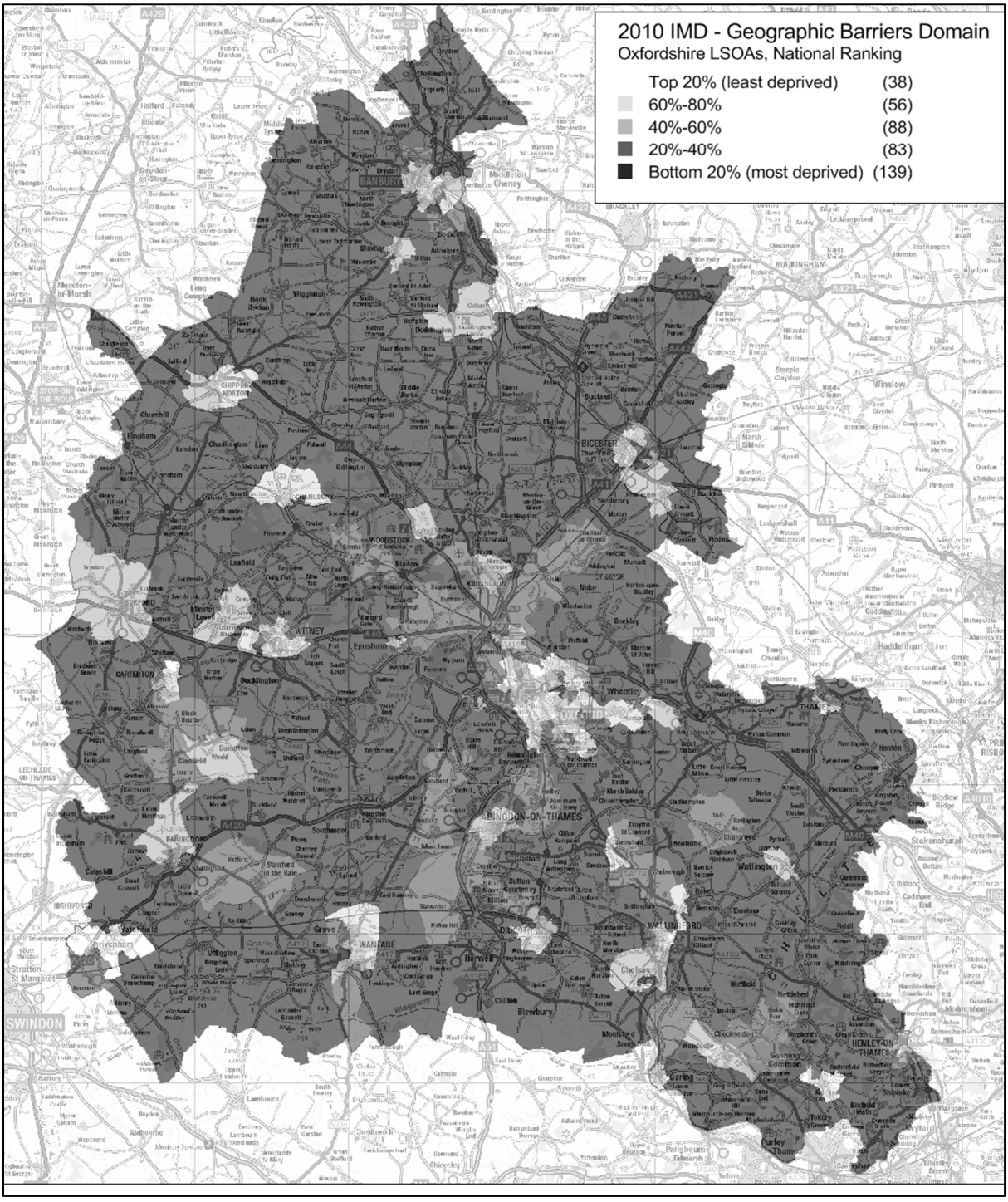
- The move to discuss mental health problems alongside physical health problems and thus reduce stigma.
- The concept of 'parity of esteem' enshrined in the NHS five year plan which seeks to 'level the playing field' and give equal weight to mental and physical health issues and services. This includes acknowledging that mental and physical health problems are not separate, but form a continuum in each individual, and this needs proper attention to achieve recovery.
- The good work done in dementia awareness and dementia services described elsewhere in this report.
- A much improved partnership between the statutory agencies and the voluntary sector.

Conclusion: ***There is a way to go, but this inequality is gradually reducing. See the next chapter for more detail.***

13. Disadvantage in Access to Services: A Rural County

Oxfordshire is a rural County. Services tend to be located in population centres to give access to the greatest number and so, from that point of view, there will always be a disadvantage in living off the beaten track. The most celebrated example of this is the long-running struggle of the Health Overview and Scrutiny Committee to improve rural call-out times for ambulances.

The map below summarises a mixture of data about access (which includes distance to GP, food shops, primary school or Post Office) and shows it as areas on the map. It can easily be seen that the more rural areas have poorer access to services. This can be particularly disadvantageous to older people and compounds the problem of loneliness and isolation:



The darker the area on the map, the poorer access to amenities will be compared to other places in Oxfordshire.

<u>Conclusion:</u> This form of inequality is 'hard-wired' into the fabric of Oxfordshire. As such it neither increases or decreases, but it is a feature of this County which needs to be borne in mind when planning services.

14. Inequalities from place to place

Much of the information mentioned about disadvantage described above can be gathered together and mapped. The measure used is called the index of multiple deprivation (IMD). The IMD measures relative levels of 'social deprivation' across England. It combines a number of indicators into a single score for each small area of the country.

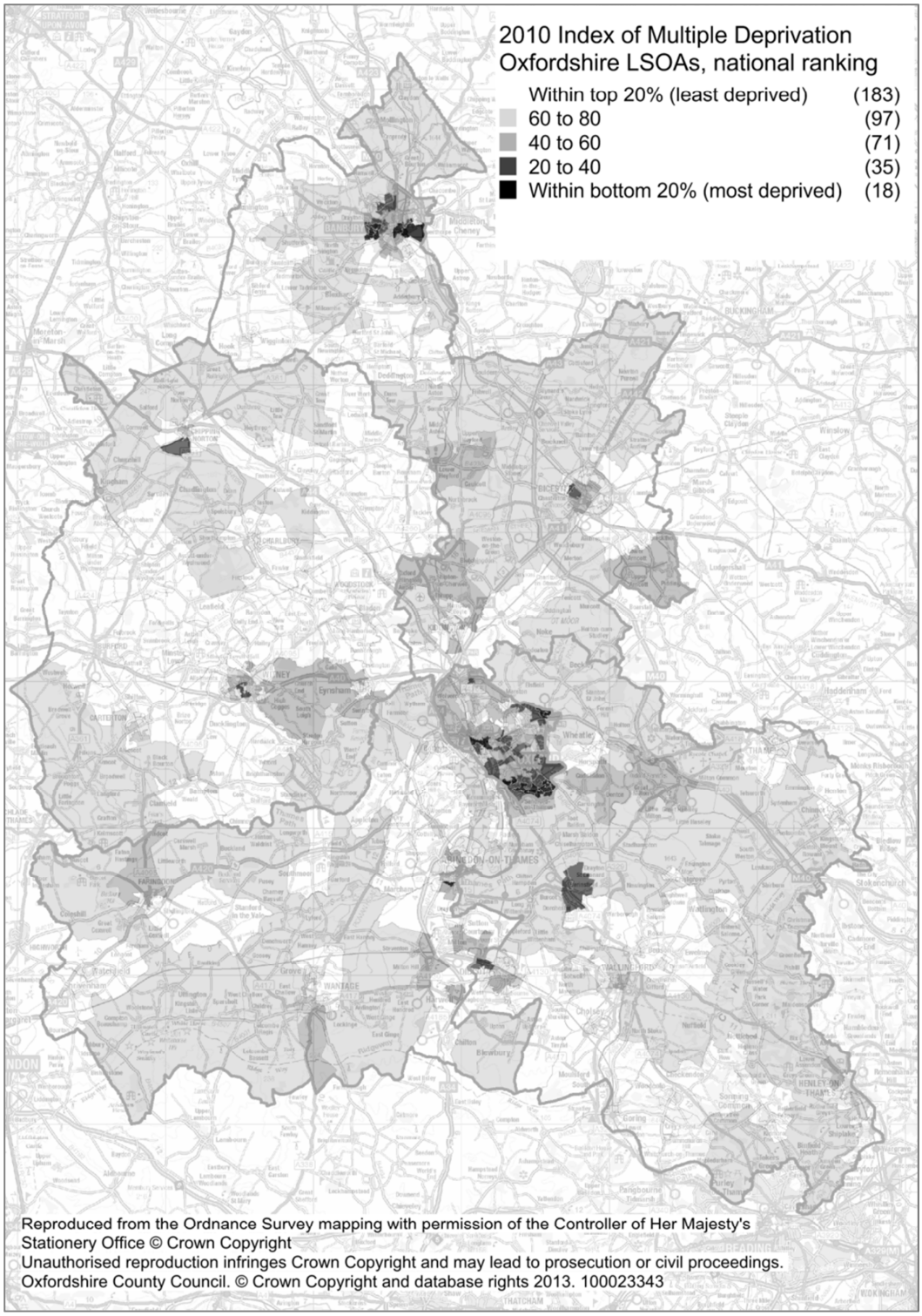
Overall, Oxfordshire is an affluent and prosperous county. According to the 2010 IMD, Oxfordshire ranked as the twelfth least disadvantaged upper tier local authority out of 152 in England. 102 of Oxfordshire's 404 small areas in 2010 ranked among the 10% least disadvantaged nationally; 183 ranked among the 20% least deprived.

In population terms, around a quarter of the County's population is estimated to live in areas that were ranked among the 10% least deprived areas in England. Over two fifths live in areas ranked among the 20% least deprived.

However, the flip side of that is that one of Oxfordshire's small areas ranked among the 10% most disadvantaged in England, (Northfield Brook) and 17 areas are ranked among the 20% most disadvantaged. Relatively disadvantaged areas in the County include parts of South East Oxford, Abingdon, and Banbury.

The small areas in the 20% most disadvantaged are; Northfield Brook, Rose Hill and Iffley, Blackbird Leys, Barton and Sandhills, Banbury Ruscote, Banbury Grimsbury and Castle, Littlemore, Holywell, and Abingdon Caldecott. In population terms, just under 5% of the county's population is estimated to live in areas that were ranked among the 20% most deprived nationally.

These areas are shaded as the darkest on the map in below. 'Social deprivation' is consistently linked to poorer health and wellbeing.



<u>Conclusion:</u> This measure compares one area in the County with all others as a snapshot and so can't be used to measure a trend in disadvantage, i.e. it doesn't say whether disadvantage is growing or declining, but it can tell us about the disadvantage 'hard-wired' into the fabric of the County. However, because of the useful combination of statistics, this remains a valuable way of identifying and targeting areas of disadvantage.

15. Disadvantage in families who are most in need: Thriving Families

Phase 1 of the Thriving Families Programme in Oxfordshire

The national Troubled Families programme was launched in 2011. The Oxfordshire Programme, known as the "Thriving Families Programme", was set the task of identifying 810 families who had 2 or 3 of the following "family problems".

1. Children not attending school.
2. Adults out of work.
3. Families involved in anti-social behaviour or youth crime.

It is also aimed at making long-term savings by reducing the financial burden these issues place on society. The County Council has consistently supported this programme as a priority.

The Results of Phase 1

Over the 3 years from April 2012 the programme in Oxfordshire identified 810 families and demonstrated improvement for them all. This is a very good result.

Of the **810 families** identified:

- **743 families** saw significant improvement in school attendance, to at least 85% attendance over the school year.
- **607 families** entered continuous employment or engaged in work related activities (Apprenticeships, Work Experience, Volunteering, Permitted Work, Work Choice, Non-Mandatory Training Courses) for at least 13 weeks.
- **443 families** previously engaged in anti-social behaviour or youth crime did not commit further offences for at least 6 months.

The features of phase 2 of the programme

The delivery of 100% performance in phase 1 of the programme has led to very strong working relationships with the Troubled Families Unit in the Department for Communities and Local Government. Oxfordshire became an early implementer of phase 2 of the programme in September 2014 ahead of the national roll out in April 2015.

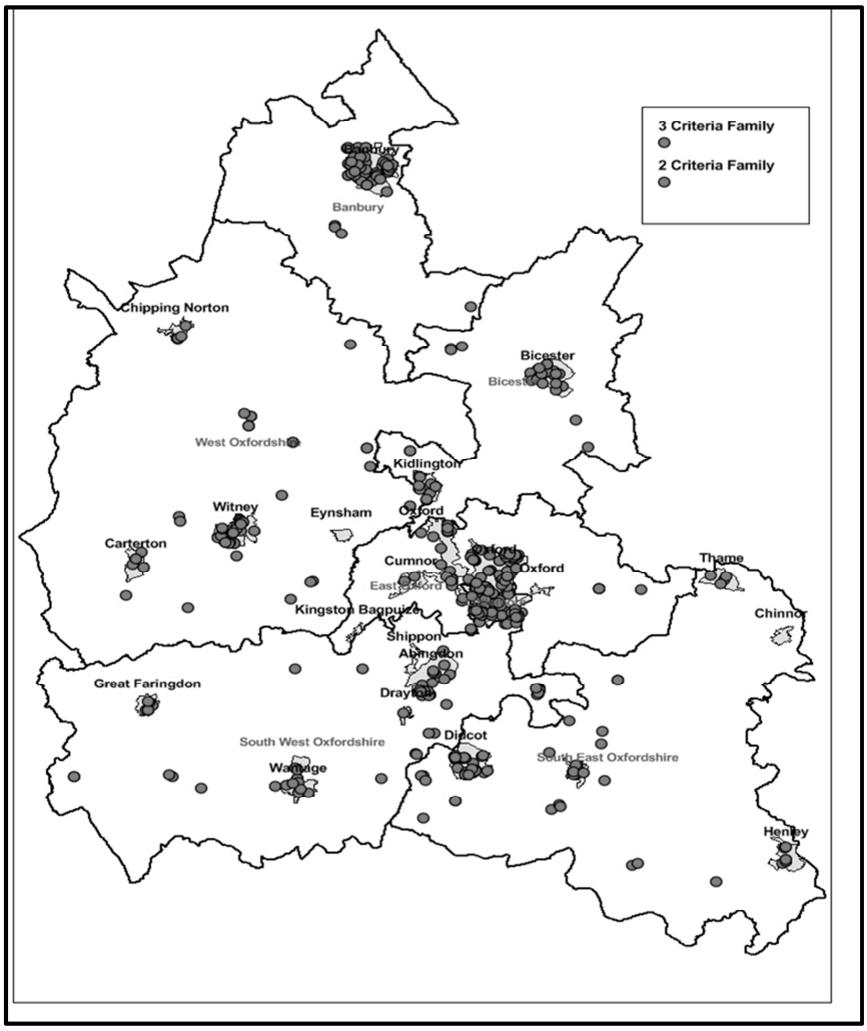
In phase 2 of the programme Oxfordshire have been asked to identify and work with 2,890 families over 5 years from 2015 to 2020 – an ambitious programme.

Results will be sought for 6 family problems rather than just the 3 used in phase one. The issues that have been added are:

- Children on child protection plans or Children in Need plans for neglect.
- Domestic abuse.
- Health issues including substance misuse.

A map of the locations of families identified in phase 1 is shown below. The great thing about the Thriving Families programme is that it achieves coverage of every corner of the

County, which are NOT masked by surrounding better off areas. This means that areas like West Oxfordshire, South Oxfordshire and Vale receive services too where they are most needed.



The Council is also at the forefront nationally in finding new and practical ways to engage the NHS in the initiative through local GPs.

<u>Conclusion:</u> Because the 'Thriving Families' programme is reaching out to all parts of the County, urban and rural, and because it achieves demonstrable results, it is likely that this represents a decrease in disadvantage

What have we said previously about Disadvantage in Oxfordshire

Previous annual reports have highlighted and called for action on many of these topics, including:

- Teenage pregnancy
- Educational achievement
- Breaking the Cycle of Deprivation in families who need help the most
- Dementia
- Mental health

Many of these topics have also been of concern to the County's scrutiny committees. It is good to see that progress is now being made in all of these areas. The key is now to retain and improve on this position and tackle the newly emerging areas.

Other topics previously reported on such as ethnicity still require attention.

Summary of Breaking the Cycle of Disadvantage

At the beginning of this chapter the question was posed, 'Are inequalities due to disadvantage increasing or decreasing in Oxfordshire.'

The table below summarises the information reviewed:

Decreasing Inequalities	Inequalities 'Hard Wired into the fabric of Oxfordshire	Static / Increasing/newly recognised Inequalities
Inequalities in men's health	Geographical inequalities: inequality by place	Ethnicity
Disease free life expectancy	Social isolation and rural access to services	Women and lifestyles
Dementia detection and care		Loneliness in older people
Children in Poverty		FGM
Unemployment		Homelessness
Educational attainment		
Teenage Pregnancy		
Mental Health Services		
Families in Greatest Need		
Breastfeeding (see lifestyles chapter)		
Caring for Carers		

Reducing Disadvantage

Overall there is evidence of reducing disadvantage in a number of important areas in Oxfordshire which have been causing concern for some time. Good examples are school results, teenage pregnancy, helping families who need it most, and mental health services. Why is this? There are probably 3 reasons:

- Persistent policies applied over time which are paying off, e.g. teenage pregnancy and improved school results.
- National policy priorities targeted at areas of inequality with earmarked funding, e.g. dementia services, mental health services and the Thriving Families programme.
- General improvements in healthy lifestyles, e.g. the gradual improvement in men's health.

This points to a formula for success in tackling disadvantage which has 4 components:

1. **Identify,**
2. **Target,**
3. **Fund,**
4. **Persist.**

All of these are likely to be assisted by the relative economic prosperity of Oxfordshire and its high levels of employment.

Stubborn Causes of Disadvantage

Some causes of disadvantage are less likely to diminish however because they are currently 'hard-wired' into the fabric of Oxfordshire. These are the persistent geographical areas in which disadvantage persists, particularly in areas of the City and Banbury, and there are persistent inequalities of access which are a result of the rural nature of much of Oxfordshire. These contribute to isolation and loneliness in older people.

These causes of disadvantage are likely to be stubborn to combat and require a more strategic long term approach.

Increasing Disadvantage

The data shows that there are also areas where disadvantage is worsening and these need to be addressed:

- Our services need to accommodate a more ethnically diverse population.
- Those in the greatest need require help to stay in settled accommodation - this is a basic prerequisite for thriving.
- We need to maintain the good progress we have made to eradicate Female Genital Mutilation.
- Women need to consider their smoking and drinking levels with care so as not to cause the diseases of the future.

If targeting is the key who should we target?

The characteristics suggested by the evidence follow. They apply equally to all areas, urban or rural. They are:

- Loneliness and isolation in older people
- Local areas with low educational attainment
- Children in receipt of free school meals / in areas of high poverty levels
- Families identified by the thriving families programme
- Families and individuals on the brink of homelessness
- Women with regard to lifestyle factors such as smoking and drinking
- Areas in the bottom 20% of multiple disadvantage for England
- Mental health problems as an additional factor alongside other physical health problems

How should we target them?

People sometimes shy away from targeting because they think 'their' area will lose resources.
This isn't necessarily the case and making a difference needn't cost more. Practical targeting is less about big free-standing initiatives and more about 'tweaking' the hundreds of initiatives and services we already have to be more sensitive to the groups described above.

Tackling Disadvantage is in everyone's interest

Ill health, disability and early death are tragic. They are also expensive for state-funded services. They also sap the economy and the workforce and lead to unhappiness in old age. It is in everyone's interest to tackle disadvantage and to promote good health for all, and it can be done right across the County as Oxfordshire's proud record with the Thriving Families programme has shown.

Recommendations

Short term recommendations:

1. The Health and Wellbeing Board should carry out its plans to sponsor a more detailed review of disadvantage, and should use the analysis in this report as a source of information. This analysis should inform the Joint Health and Wellbeing Strategy, Local Authority plans the Clinical Commissioning Group's 5 year plan and the work of the NHS and County Council Systems Leadership Group and Transformation Board.

2. All agencies should maintain current programmes which are successfully reducing disadvantage. These include:

   - Teenage pregnancy
   - The Thriving Families programme
   - Work with schools to improve school results
   - The promotion of breastfeeding
   - Improved dementia services
   - Improved mental health services

3. All agencies should target the causes of disadvantage which are static or increasing. Specifically:

   - The Health Improvement Board should continue its efforts to prevent homelessness through partnership working
   - GPs and the Public Health team should target NHS Health Checks to improve take up by ethnic groups and manual workers
   - Partnership work to eradicate FGM should continue

4. Contract specifications for services being renewed should carefully consider how to target areas in the bottom 20% IMD and areas of high child poverty so as to give a

good service across the county and a specific service to meet the needs of these areas.

5. NHS Trusts and General Practice should consider how to give additional help to those in the target groups listed above when they come for help for any condition. This consideration should be built into the Health and Wellbeing Board's planned work on disadvantage and specific recommendations should be made.

Longer term recommendations:

6. See the recommendations in chapter 2 regarding housing and the design of communities so as to combat isolation, loneliness and to break the cycle of disadvantage in specific areas.

7. The Local Enterprise Partnership, Local Government, Local Employers and Oxford University should continue to work together to secure central government funding to provide the infrastructure to favour continued economic prosperity and high levels of employment.

8. The Health Overview and Scrutiny Committee should consider scrutinising the extent to which reducing disadvantage and inequality are built into the plans of the Clinical Commissioning Group, General Practice and NHS Trusts.

9. Healthwatch should be invited to consider monitoring the inequalities identified in this chapter as part of its on-going work programme.

Chapter 4: Mental Health

Main Message of This Chapter:

Mental Health services have gradually improved over the last seven years. Current plans aim to push this further.

The last six annual reports have called for improvements in mental health services. They were then considered a 'Cinderella service'. Since then we have seen steady improvement and it seems fair to say that Cinderella has now received an invitation to the health ball.

Why is this?

The chapter on inequalities summarised 5 'drivers' which have helped to gradually improve mental health services. To re-cap, these are:

- the move to see mental health problems as common, affecting one in four of us and to improve basic services to help people combat anxiety and depression
- the move to discuss mental health problems alongside the physical and thus reduce stigma
- the concept of 'parity of esteem' enshrined in the NHS five year plan which seeks to 'level the playing field' and give equal weight to mental and physical health issues and services. This includes acknowledging that mental and physical health problems are not separate but form a continuity in each individual, and this needs proper attention to achieve recovery
- the good work done in dementia awareness and dementia services described elsewhere
- a much improved partnership between the statutory agencies and the voluntary sector.

The 'NHS 5 year Forward View' sums up the issue and the ambition well:

> *"Mental illness is the single largest cause of disability in the UK and* ***each year about one in four people suffer from a mental health problem.*** *The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked - people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease. Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together.*).

This chapter details some of the recent initiatives taken locally.

- With regard to improving access to therapies, there are now 9,100 Oxfordshire residents in treatment every year with 50% moving towards recovery.
- A criticism of the current system is the length of time it takes to be seen. In response, waiting time standards for access to psychological therapies (counselling,

and help from clinical psychologists and the like) will be in place from April 2016 and the services are working on achieving these.

- This will include a 2 week wait target for intervening earlier in cases of serious mental illnesses such as schizophrenia and bi-polar disorder (formerly known as manic depression).
- An effective 'psychiatric liaison service' between physical and mental health professionals is being designed and will be in place by 2020. This will ensure that people being treated for physical disorders which have a mental health component (e.g. in hospital) will be treated as a whole person. This is beginning with:

    - A 24/7 liaison service in Accident and Emergency.
    - A psychological medicine service in inpatients in the John Radcliffe Hospital and Horton Hospital– focussing on patients with depression, delirium and dementia.
    - A more active service in outpatient clinics.
    - Assessment of the mental health needs of frequent service users to make more appropriate use of services.
    - Planned improvements for services for eating disorders in children.

Another interesting development is Outcome-Based Commissioning (OBC in the jargon, more accurately known as outcome based contracting). This combines agreeing contracts with service providers for achieving defined results instead of just counting the number of treatments given. An example of what would be counted includes whether or not the individual is back in work. It is designed to empower service providers to work together for the long term so that they redesign services so as to achieve real results.

While it sounds good in theory, it is complex to achieve in practice. We are on the brink of putting in place an outcomes-based contract for mental health in Oxfordshire with a value of £35M each year for 5 years initially. The funding comes from pooled NHS and County Council Social Care budgets. The 'preferred providers' for the contract have put together an exciting consortium of partners involving the Oxford Health Foundation Trust and 5 local voluntary sector partners including MIND and Restore. The outcomes set will aim to achieve concrete improvements of improved mental and physical health, improved support for carers, more patients in employment and improved 'social functioning' (e.g. improved personal relationships and better integration into 'society').
Work is also in progress to improve the Child and Adolescent Mental Health Service to improve the transition from children's to adults' services.

Recommendations

1. The Clinical Commissioning Group, Oxfordshire Adult Social Services, Oxford University Hospitals Trust and the associated Voluntary Agencies should ensure that outcome-based contracting really does improve outcomes.

2. The Oxfordshire Health Overview and Scrutiny Committee should consider continuing to monitor these proposals as part of its forward plan.

3. Oxfordshire Healthwatch should consider continuing to closely monitor the quality of mental health services from the perspective of the service user.

Chapter 5: Lifestyles and Health: We are what we eat, drink, smoke and do.

Main Messages In This Chapter:

1. **Our lifestyles have a massive impact on our health and there are many things we can each do to improve it. This is good news.**
2. **Obesity is an epidemic which has not yet reached its peak. Action is needed at all levels, individual, local and national. This is the major pressing lifestyle issue.**
3. **Smoking is on the decline: we need to target groups where rates are highest, in this case, manual workers.**
4. **Tooth decay is gradually declining but inequalities persist. Oxfordshire's new prevention service will help.**
5. **Drug addiction services are improving.**
6. **Legal Highs present an important risk, particularly to younger people. Oxfordshire is active in combatting the threat. Proposed legislation will help.**
7. **Drinking levels have fallen slightly, but the disease and misery caused by alcohol addiction remain.**
8. **Breast feeding has real health benefits. Local breast feeding rates are good. We need to keep this up.**
9. **Our local NHS Health Checks are performing well. We need to work with GPs to improve further still.**

There is an old saying, 'You are what you eat'. But we are also what we smoke and drink and do. This chapter will look at important 'lifestyle choices' to paint the current picture.

Obesity, diet and physical activity

Rising levels of obesity present a major challenge to our health. This is as true today as it was 8 years ago when the importance of the topic was first raised. Next to quitting smoking, staying reasonably slim is probably the best thing you can do for your health.

There is an epidemic of obesity in this country and Oxfordshire is no exception. Nearly one in four people in the UK is obese – being obese reduces life expectancy by an average of nine years. Obesity makes its impact in many ways. It affects general mobility leading to problems with joints and causes long-term diseases such as diabetes, stroke and heart disease, as well as affecting self-esteem.

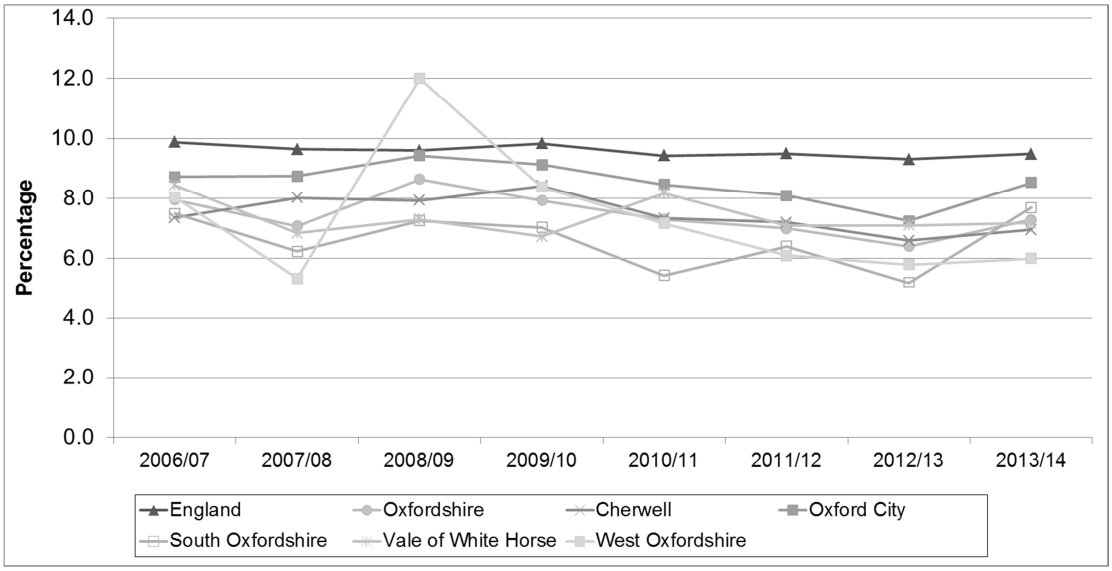
In 2014, Public Health England calculated that NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £50 billion per year.

Obesity does not affect all equally; it is more common in children in areas of disadvantage, in women and in manual workers. It is therefore another aspect of inequality. For example, obesity levels amongst women in unskilled roles are nearly twice that of women in professional roles.

If obesity continues to increase, the knock-on effect on NHS and Local Authority budgets in terms of increasing levels of diabetes, heart disease, stroke, cancer and limited mobility will break the bank.

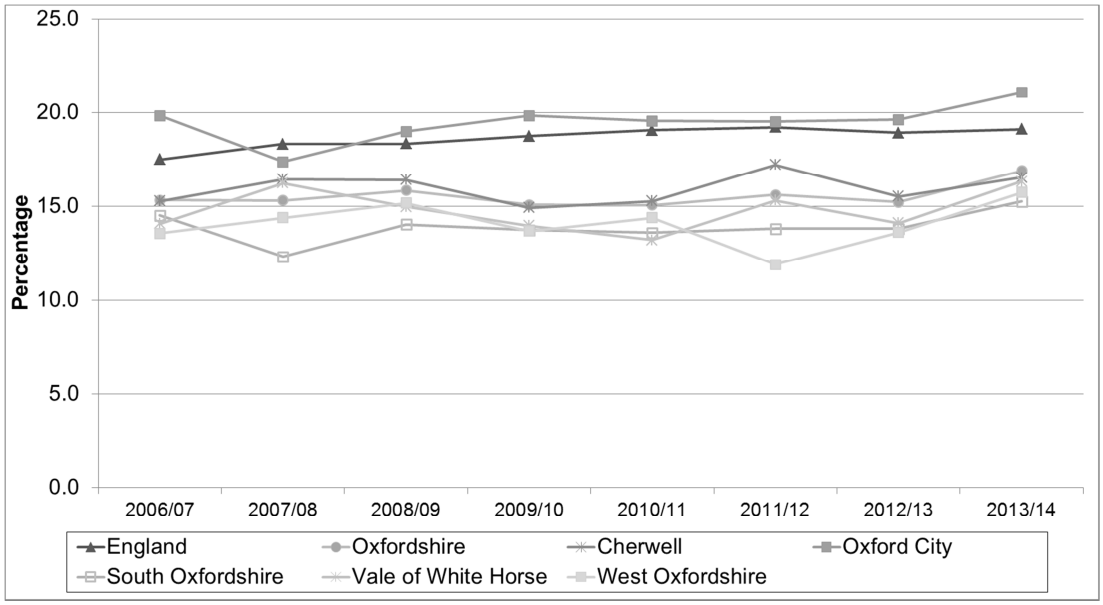
Obesity itself is the tip of the iceberg. **The average adult in this country is now classed as overweight**.

The chart below shows the picture for reception year children. Around 7% of Oxfordshire's children are already classed as obese. This is a dangerous situation as obesity in early life tends to carry through into adulthood.



Source: National Child Measurement Programme (NCMP)

There is some comfort for Oxfordshire in the figures. All Districts, except for Oxford City, have significantly lower levels of obesity than the England average (10%), at around 6% to 8%. Oxford City's figure is almost 9% and this is another inequality. By the time year 6 is reached, we see the following picture:



Source: National Child Measurement Programme (NCMP)

The position has become worse; the County average is around 17%, with all Districts except for the City at around 16%. These figures are again significantly better than the national average which stands at around 19%, but Oxford City's figure is greater than the national average at 21% - a significant inequality.

A similar picture is seen in adults and the figures are shocking. In England around 64% of adults are overweight or obese – that's more than 6 out of every 10 adults. The figure for Oxfordshire is better at around 55%, but that means that over half the adult population is overweight or obese. By the time the current cohort of schoolchildren reach adulthood the figures will be even worse.

What can we do about it? Public Health England Director Kevin Fenton summarises the issue well:

'There is no silver bullet to reducing obesity; it is a complex issue that requires action at individual, family, local and national levels. We can all play our part in this by eating a healthy balanced diet and being more active.'

In short we need a blend of individual, local and national action. It is said that every epidemic has its peak. It happened with the HIV epidemic, it is happening with the epidemic of smoking, but when we turn to obesity, it doesn't look like we have reached the peak yet despite best efforts. Why? The reason is simple: the factors pushing us into obesity are stronger than those promoting a healthy weight. What sort of factors am I talking about? A straightforward list follows:

- Modern lifestyles make it easy for busy people to reach for fast food or takeaways, and while the quality of these is improving, they rely too heavily on fat and are often packed with calories. They tend to push fruit and veg out of the diet.
- We like to use modern gadgets, from cars to computers to TV remote controls. This means we simply don't move about as much, even to change the TV channel, and so we don't burn the extra calories. Over months and years this all adds up.
- Children seem to losing the culture of active play for reasons of safety and maybe because a lot of interaction now takes place on-line.
- Obesity may be becoming the new norm – when 50% or more of adults are overweight, carrying extra pounds starts to look like 'business as usual'.
- The increase in alcohol consumption over recent decades has also contributed. Beer, wine and spirits are essentially high calorie fuel and can tip the balance into overweight.

But there is a further catch. Tacking obesity is like turning the titanic. Anything we do to combat obesity takes time to have an impact. A new tool was launched recently to calculate savings from obesity programmes. Payback on investment is very real, but a programme may take 6 or 7 years to break even. After that the savings made accumulate quickly.

The message is that we need to plan for the long term and avoid stop-start interventions. Organisational change and endless re-structuring of services are the great enemy here. It

is very hard to maintain momentum and funding when organisations continually chop and change.

The solution doesn't lie in preaching and nannying. It's about swinging the pendulum back a bit. We need to make it easier to move around a bit more and change our eating patterns towards the healthy.

It isn't all doom and gloom. There are signs that the rise in obesity is slowing nationally and the prize is worth the effort. Time will tell if we have reached the high tide mark.

On an individual level things are brighter too. A reduction in 10% of body weight (no matter what the starting point) gives the following benefits, even if you do not return into a normal weight category:

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

So, if you are say 15 stone, it's still worth it to lose around a stone and a half. This sounds like a good deal, though those who have tried will tell you it is easier to say than to do and even harder to maintain. The way to do it seems to be to plan for the long term, be a bit more active and eat a bit better.

What have we said previously?

Previous annual reports have called for local action in a number of areas and all of these are being taken forward. They include:

- Bringing together all organisations to pool their efforts within single healthy weight strategy.
- Establishing a successful NHS Health Checks programme.
- Promoting breastfeeding which counteracts obesity.
- Supporting national campaigns such as 5 a day.
- Encouraging play at school through initiatives like working with London Welsh to promote tag rugby and healthy eating.
- Setting up a new 'lifestyles clinic' in the John Radcliffe to which clinicians can refer people for health advice as well as treating their illnesses.
- Targeting young people, e.g. by promoting the 'sugar swaps' campaign which tells young people about just how much sugar food contains and helping them choose healthier drinks and fruit.
- Writing to parents when their children are weighed and measured at school to let them know what the situation is.
- More than doubling the number of School Health Nurses in secondary schools to help schools work on better 'Health at School' policies.
- Working with local GPs to commission services to help weight loss, e.g. through referral vouchers to organisations like Weight Watchers and setting up services to help children lose weight with support from their families.
- Supporting the Oxfordshire Sports Partnership

- Working with the County Council team on long term transport and road planning to include purpose built cycle paths when feasible.
- Beginning to work with District Councils to connect their work on leisure centres and green spaces.
- Working through stop – smoking services to help people not put on weight after they kick the habit.

What do we need to do next?

Essentially, we have to keep pressing on, promoting a healthy weight and building long term infrastructure **now** so that when the tide eventually turns we are ready to capitalise on it. This means we need to keep up what we are doing now but also intensify our work with schools, transport planners and District Councils to put together an improved long term plan.

This plan also needs to focus on disadvantage, putting a little more emphasis on parents and schools in areas where levels of obesity are highest. We need to plan for the long term and not be tempted by 'stop-start' short term plans, short term funding and one-off initiatives.

We need to talk to the NHS, including GPs, to take obesity more seriously and consider investing in a long term NHS funded obesity prevention programme to complement the work of Local Government as this will save the health service money in the long run.

Recommendations with regard to Obesity

1. The Health Improvement Board should review its healthy weight strategy and make recommendations for a range of services, including schools, health visitors, school health nurses, hospitals, general practitioners and highway planners. The key role of District Councils should be emphasised with regard to green spaces, leisure centres, play areas and the licensing of premises.

2. The Clinical Commissioning Group should work with the new General Practice Federations and should consider commissioning innovative ways of preventing obesity using NHS funding as this will prevent health care expenditure in the long run.

3. The Health Overview and Scrutiny Committee should consider scrutinising the District Council role in the fight against obesity as part of its forward work-plan.

Smoking tobacco

For the population overall, smoking is still the biggest risk to health and early death, as it causes many different cancers, chronic lung disease, heart disease and stroke.

The death toll can be seen by looking at deaths attributable to smoking. It is estimated that there are over 2000 deaths in Oxfordshire in a three year period attributable to smoking in the over 35s.

Admittedly Oxfordshire's figure is lower than England's, at around 230 deaths per 100,000 deaths in over 35's in a three year period compared with around 290 deaths per 100,000 for England, but the City's figure is significantly higher and closer to the England figure at around 270 deaths per 100,000.

The good news is that the health message has gained ground over the last 20 years and the overall prevalence of smoking continues to fall nationally, from around 21% of adults in 2010 to around 15% currently.

However the figures mask an important aspect of disadvantage. Around 30% of 'routine and manual workers' smoke in both England and in Oxfordshire – that's double the average.

Considering smoking in children, the figures show smoking levels falling from around 12% throughout the 80s and 90's to around 4% for girls and boys currently with girls smoking fractionally more.

Girls are more likely than boys to have tried smoking (23% of girls, 20% of boys) between ages of 11 and 15 years.

Stop-smoking services

During the last year there has been a decline in the number of people taking up stop smoking services and Oxfordshire's figures have been the lowest in years too. It isn't clear why this is. Some say it's that there aren't as many smokers 'out there', but it may be something to do with people taking up e- cigarettes as an alternative to quitting. It is still too early to say whether these pose a threat to health.

However, we haven't let the grass grow under our feet and the County Council has just let a new and improved contract for stop-smoking services, which we hope will help to turn the corner – time will tell.

How Should We Move Forward?

All organisations should do their bit.

This includes:

- Brief Advice given by GPs and Hospital Doctors and all front line NHS staff.
- Referral systems within hospitals like the innovative Oxford University Hospital Trust's health promotion clinic.
- GPs should take the opportunity to promote NHS health checks and increase the number of people taking up invitations. Brief advice to give up smoking should be given emphatically as part of all consultations.
- Midwives and health visitors and school health nurses should consider how best to take an active role.
- The Health Improvement Board should coordinate this activity.

Recommendations re Smoking

1. The Health Improvement Board should consider reviewing the actions of all the agencies listed above in order to help more people never to start smoking or to quit.

2. The Clinical Commissioning Group and General Practice should consider how to emphatically promote the brief intervention to 'stop smoking' as a consistent part of all consultations.

Tooth Decay

Tooth decay has been falling over the last half century, largely due to better brushing with fluoride toothpastes and more awareness of oral health in general. Also in the past decade more people have been accessing dental services.

The current picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions. However, looking at the national data, we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of disadvantage 'hard-wired' into the structure of the County.

The most recent national figures (2012) show that approximately 1 in 4 of 5 year old children have active decay in their teeth with an average three decayed teeth in these children. The major sources of the sugar which causes decay in children are found in soft drinks and cereals.

The Picture in Adults

Tooth decay has fallen in adults in England from 46% having active decay in their teeth in 1998 to 28% in 2009. The main sources of sugar in adults' diets come from cereals, soft drinks, jams and sweets.

Older adults are now keeping their own teeth into old age as the norm. The proportion of 65 to 75 year olds with their own teeth increased from just 26% in 1979 to 84% in 2009 - a significant change. As the population ages it will be important that the NHS keeps pace with this change, particularly as the number of people needing more complex dental work rises steadily with age.

What are we doing and what should we do next?

Since the NHS reorganisation, the responsibility for oral health is split 3 ways. The NHS and Public Health England have a responsibility for dentists and more specialised surgery, while Local Government has an emphasis on prevention.

The County Council let an improved contract for prevention in 2014/15 which aims to prevent oral health problems as follows.

Oral health promotion interventions aimed at children

The service will contribute to improving the oral health of children by providing the following child focused services:

- Running an accreditation scheme for preschool settings
- Training a wide range of professionals who work with children about the importance of oral health and the causes of oral diseases
- Working to include oral health promotion into targeted home visits by health and social care workers.
- Providing oral health information and advice for 0-5's, tailored to areas where there is a higher risk of poor oral health.
- Promoting supervised tooth brushing schemes in early years' settings and primary schools based in areas where children are at higher risk of poor oral health.
- Promoting oral health in the primary and secondary school curricula.
- Working with the School Health Nurses to promote a 'whole-school' approach to oral health in education, such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting, oral health information for parents, carers and children, including details on how to access local dental services.

Oral health promotion interventions aimed at adults

The service will improve the oral health of the adult population by implementing the following actions:

- Delivering targeted services for adults at higher risk of poor oral health, including peer (lay) support groups.
- Training professionals who work with adults from disadvantaged populations and those who do not attend the dentist regularly, about the importance and promotion of oral health.
- Providing information about what services are available to the public and how to access them.
- Working with partners to promote oral health and oral health services in residential care homes.

Recommendation for Tooth Decay

1. The Director of Public Health should monitor the new contract for oral health promotion and ensure that it targets disadvantage.

Drug Abuse

There has been a sea-change in national policy about drug abuse.

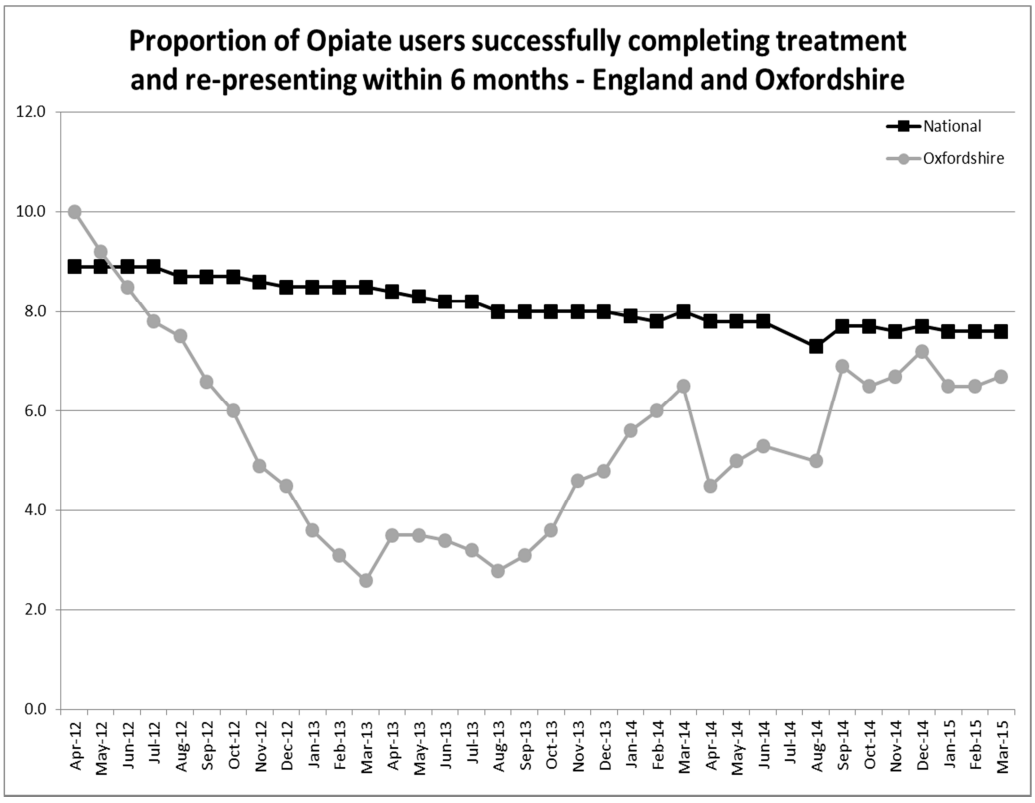
Under the old policy of minimising harm by maintaining narcotics addicts on methadone, Oxfordshire performed well. However, national policy changed a few years ago and is now

focussed on getting people off drugs altogether. Oxfordshire's services weren't designed to cope with this and performance declined dramatically.

The County Council took over responsibility for these services in April 2013 at a critical moment when performance was at a low, and since then has worked hard to re-vamp services to meet the new requirements. This culminated in a new and improved contract being let in April 2015 as well as new education services for secondary schools. We have worked closely with experts from Public Health England to improve the services. The results since then show that services are steadily improving and we are slowly climbing the national league table in terms of performance.

This doesn't mean to say that there is a crisis of drug taking in Oxfordshire, the overall prevalence is generally low, but it does mean that our services needed an overhaul if we to get more people off drugs altogether.

The chart below shows the picture for getting people off opiates such as heroin and methadone. The same picture and trends are also true for non-opiate drug abuse such as cocaine and amphetamines.



The chart shows the decline in performance mentioned above and the recent improvement in the figures which are now close to national averages.

Legal Highs (officially called New Psychoactive Substances)

I reported on this emerging threat to health last year. These are chemicals which are manufactured in labs which have are said to give you a 'high' and which are not strictly illegal. They are available on-line and in a few shops and are attractive to young people. The problem is that they can have a devastating effect on health and are largely unregulated. Deaths due to 'Legal Highs' rose nationally from 29 in 2011 to 60 in 2013.

Legal highs are manufactured to mimic other (illegal) drugs. The main effects of almost all 'psychoactive' drugs, including 'legal highs', can be described using three main categories:

- stimulants
- 'downers' or sedatives
- psychedelics or hallucinogens.

For example there is a growing market for synthetic cannabinoids – chemicals which are sprayed onto inert plant material and smoked. The effects mimic those of cannabis but the strength may be much higher, and they may also cause panic, paranoia and mental health problems.

These chemicals can be manufactured and put on the market very quickly and the number of new ones created is rising all the time. Because the market is difficult to regulate, it is difficult to know what substances or mixtures of substances they contain. This is a dangerous situation. There is a Europe-wide early warning system in place which helps to keep pace with the new drugs and keep track of them. This data shows that in 2008, 13 new substances were marketed and this rose steadily to 81 in 2013.

Recently the government made 5 of these drugs illegal, this helps, but it is swimming against the tide. The intention of the new Government to make all of these substances illegal in the year ahead will be helpful. The ban on 5 substances came into force in April 2015 and was on the recommendation of the Advisory Council on the Misuse of Drugs The Council said that one of the five legal highs, ethylphenidate, had been available over the internet in Britain for four years. Users inject it and it is widely marketed as a "research chemical" or as a component of branded products such as Gogaine, Nopaine, Burst and Banshee Dust. This chemical is one of the most commonly encountered legal highs in Britain and is taken as an alternative to cocaine.

What are we doing about it and what shall we do next?

We have been quick to take up this challenge in Oxfordshire and have prioritised work to disrupt the supply and demand of legal highs through our Alcohol and Drugs Partnership. We have:

- Convened a summit which gave a range of agencies the chance to talk about the work that was already going on and discuss what more was needed.

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- Researched which local shops supply these substances and worked to ensure that the supply is drying up.
- Sent information out to young people as the term "legal Highs" may imply "safe" to those who are not well informed. Campaigns at music festivals, through social media, information through schools and colleges and signposting to helpful websites are good routes to get information out.
- Reviewed the training available for front line professionals in schools, youth settings and health services and where the gaps are. For example, people working with homeless people need to know more as use of legal highs is a growing concern.

Recommendations re Drug Abuse and Legal Highs

1. The Directorate of Public Health should continue to lead a partnership of the many agencies involved to continually improve the performance of services for opiate, and non-opiate addiction. Services in primary care should be now be reviewed and updated as a next step.

2. The Directorate of Public Health should continue to lead a partnership to meet the emerging challenge of legal highs as new information becomes available.

3. The Community Safety Partnership, Health Improvement Board and Performance Scrutiny Committee should continue to monitor progress on these topics as a priority.

Alcohol

Previous reports have highlighted the health problems of drinking alcohol excessively.

To summarise, these are:

- Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression.
- In the UK in 2012-13, there were just over 1 million hospital admissions related to alcohol consumption.
- In 2012 there were 8,367 alcohol-related deaths in the UK.
- Males accounted for approximately 65% of all alcohol-related deaths in the UK in 2012.
- Alcohol now costs the NHS £3.5bn per year; equal to £120 for every tax payer.
- The alcohol-related mortality rate of men in the most disadvantaged socio-economic class is 3.5 times higher than for men in the least disadvantaged class, while for women the figure is 5.7 times higher. This is a serious inequality.
- In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease.

- Liver disease is the only major cause of mortality and morbidity which is on the increase in England whilst decreasing in other European Countries.
- Deaths from liver disease have reached record levels, rising by 20% in a decade.
- The number of older people between the ages of 60 and 74 admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 150% in the past ten years, while the figure for 15-59 years old has increased by 94%.

Young People and Alcohol

Some good news: drinking alcohol among young people appears to be reducing:

- Since 2003 there has been a downward trend in the proportion of young people who say that they have ever had an alcohol drink.
- Data on alcohol consumption show a decline in risky drinking behaviour.
- The proportion of girls who have ever had an alcoholic drink (39%) is the same as boys.
- Self reports of drinking within the last week are the same for girls and boys.
- The volume of alcohol consumed by girls that drink is similar to that of boys
- The proportion of young adults aged 16-24 that are teetotal has increased in the last decade.

Drinking in adults

Drinking trends are reducing slightly:

- Alcohol consumption in both men and women aged 16-44 has reduced between 2005 and 2013.
- Consumption of alcohol in adults aged 45 and over has remained relatively unchanged between 2005- and 2013.
- There has been a decline in the proportion of adults binge drinking at least once a week, mostly in the 16-44s.
- Trends in alcohol consumption have been more pronounced in men than women, with a larger drop in binge drinking amongst younger men and a larger increase in teetotalism in younger men.

In summary, the picture seems to be:

1. Women's and men's drinking levels are now more on a par.
2. There has been a recent welcome decline in drinking levels among young people and younger adults
3. Diseases - which are partly caused by the drinking patterns of previous decades – are still rising.

What are we doing about it and what should we do next?

The expert view in this controversial subject is that alcohol consumption can best be tackled at national level by controlling the minimum price for a unit of alcohol and controlling marketing.

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Local action taken can be summarised as follows:

The Alcohol and Drugs Partnership has prioritised reducing the harm caused by drinking too much alcohol in a Strategy published in 2014-15. Work done recently includes:

- Campaigns targeting young people who may be likely to binge drink, especially in the "party season" around Christmas.
- Promotion of Dry January – a chance to abstain from alcohol for a month and develop strategies for drinking less throughout the year.
- Pharmacy campaigns to enable people to think about how much they drink and to take some action. This work has included training pharmacists to be able to offer brief advice on drinking patterns so they can raise the questions more confidently.
- Helping adults to recognise unsafe levels of drinking as part of the NHS Health Check.
- Continuation of the work being done in the Emergency Department of the Oxford University Hospitals to follow up individuals who have been injured as a result of drinking too much and offer them advice and support.
- Supporting Street Pastor teams across the County as they give practical help as part of the Nightsafe initiatives in the City and market towns.
- Establishing new, streamlined referral routes to treatment services which include the use of a specially designed questionnaire so that GPs can discuss results with patients and make a direct referral for specialist help.

This work has to be maintained, and the focus needs to continue to shift from reactive work with binge drinkers to proactive work targeting those who are drinking regularly but at levels above the daily recommended maximum intake.

Recommendation re Alcohol

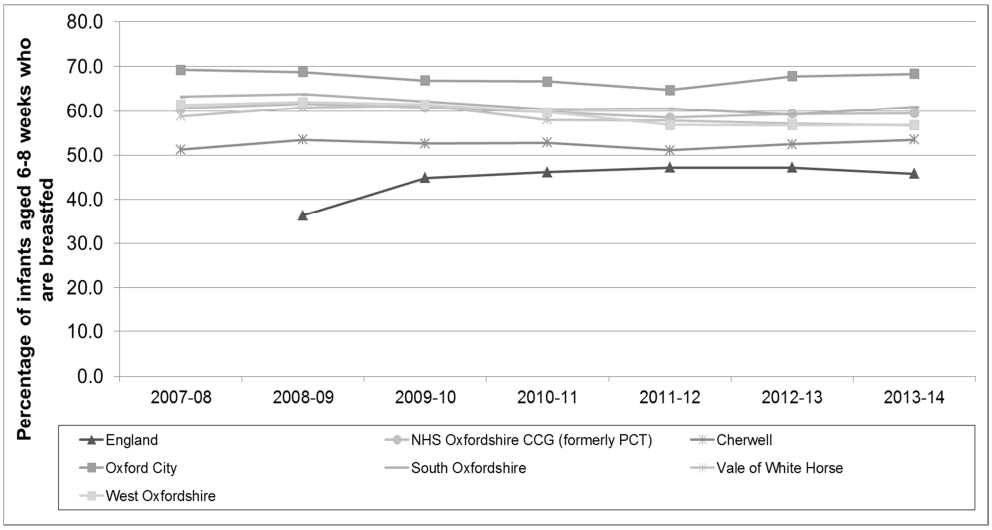
1. Continue to work across agencies to given relevant information and advice to people at risk of alcohol related harm, either through binge drinking on "high days and holidays" or by habitually drinking at harmful levels.

Breast Feeding

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire at 6 weeks is high (60%) compared with national levels (46%). This is a good result. Breast milk is a complete, balanced food and breastfeeding helps to prevent obesity in later life.

We have to remember however that despite best efforts, it is not possible for all mothers to maintain breastfeeding and we need to take care not to stigmatise those in this situation.

However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children. The chart below shows the current picture In 2013/14:



The chart shows that:

- Oxfordshire performs much better than the national average.
- The City overall does particularly well on this measure.
- Cherwell historically performs consistently poorly compared with other Districts.
- The Districts with the lowest rates are gradually 'catching up' and so this indicates a reduction in disadvantage.

What Have We Said Before and What Should We Do About It

This has been a County priority for some years, supported by Health and Wellbeing Board targets.

We have taken steps to promote breastfeeding over the years from targeting poorly performing general practices to promoting breastfeeding as a 'cool' thing to do through the 'Be A Star' campaign.

Looking forward, we need to keep pressing on to try to buck the national trend further. The move of Health Visiting to the County Council will provide a useful opportunity for this when we specify the service in 2017.

Recommendation re Breast Feeding

1. The current range of work should continue and should target areas of disadvantage.

NHS Health Checks

I reported fully on the NHS Health Checks Programme (commissioned by the County Council) in last year's report. This section comprises a briefing on what the Programme is and reports on progress.

The NHS Health Check is a national risk assessment and prevention programme required by statute. It is commissioned currently from local GPs.

NHS 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. It also includes the offer of information on dementia to people aged 60 and above.

The Programme requires us to invite all eligible individuals aged 40-74 years old for the check every five years (191,372 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 66% of those invited for NHS Health Checks to turn up for their Checks. If we achieve 66%, 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

What We Said Before and What We Are Doing About It

Last year we said that we would promote NHS Health Checks to raise awareness, quality assure the way GPs were delivering the Checks so as to increase uptake, and begin to look at alternative ways of deliver the Checks if we were dissatisfied with the approach from general practice.

During the last year we have carried out these tasks to good effect. GPs are responding well and we have worked hard to monitor services and spread good practice.

We have also successfully promoted the Checks in a number of ways, including reaching out to (primarily males) via events at the Kassam Stadium. The Kassam management and Oxford United and London Welsh RUFC have been a fantastic help in this and deserve our thanks.

The result is that the Oxfordshire service is currently one of the top performing Local Authorities in the region, achieving an uptake rate of 53.3% uptake in 2014/15 compared to 45.9% the previous year. As a result, we also delivered 2000 more Checks than in the previous year.

We need now to continue this approach and strive to improve performance further.

Recommendation re Health Checks

1. The Public Health Directorate should:

- Continue to work with GPs to improve the uptake of the offer of a free NHS Health Check.
- Identify and engage with high risk groups to take up the offer of a free NHS Health Check.
- Launch a new results booklet for service users in GP practices. This provides a record for people of their Health Check results and also advice on local public health services.

Chapter 6: Fighting Killer Diseases

Main Messages For This Chapter:

1. **We need to make sure our specialist services for fighting major outbreaks of disease such as Ebola stay strong and resilient.**
2. **Infectious diseases do not go away. They simply change and return in new guises. Constant vigilance is needed to stay ahead of the curve. Good teamwork across organisations is essential.**
3. **Local Government has a key role to play in the fight against killer diseases.**

Part 1. Epidemics: Ebola, Flu Pandemics and HIV

No Room For Complacency

Day to day we take our good health for granted and this can lead to dangerous complacency. It is easy to forget the importance of planning for hard times when the going is good.

Recent decades have shown that in reality we live on a knife-edge, and unpredicted and unexpected disaster can strike at any time. **The right response isn't fear and panic, it is systematic and calm planning and organising ourselves NOW so that we can fight back when the need arises.**

In recent times we have seen what new diseases could do through the emergence of HIV, virulent strains of flu and, most recently, Ebola. These crises have been managed because we constantly learn lessons and improve so that the UK response is good.

So far we have been pretty lucky in the UK. The flu pandemic proved to be milder than it might have been, and Ebola seems to be largely contained within West Africa where the effects have been devastating. The UK has played a major role in this containment effort. The military and Public Health England staff have done sterling work.

The need to keep emergency planning and response as a high priority

This means we need to constantly prioritise the work we do in the background day in, day out, to prepare for the worst while hoping for the best.

This is what emergency planning does, and Public Health has a key role to play.

Directors of Public Health work closely with Public Health England and the NHS across the Thames Valley to make sure that our response is up to the mark. Oxfordshire County Council has the lead role for all Councils in the Thames Valley for making sure this is done.

Relationships are good and we compare favourably with other regions.

How Do We Keep This Work Going?

Success depends on several key elements:

- Maintaining a well-qualified and well trained cadre of Public Health specialists in Local Government.
- Constantly building and maintaining long standing relationships with opposite numbers in Public Health England and the NHS,
- Mainstreaming our plans by working with the Police, the military and many other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Continually learning, planning and practising our plans.

Recommendation re Epidemics, Ebola, Flu Pandemics and HIV

1. The County Council, all Local Government organisations and the NHS should ensure that they maintain this specialist function as a priority and ensure that emergency planning continues to receive the resources it requires.

The remainder of this chapter reviews the most serious infectious diseases affecting the population of Oxfordshire and reviews recent progress.

Part 2. Infectious and Communicable Diseases

Health Care Associated Infections (HCAIs)

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 up to 2012/13 in response to the direct measures taken by hospital and community services to combat it. Last year saw a small upturn in numbers. This needs to be monitored closely.

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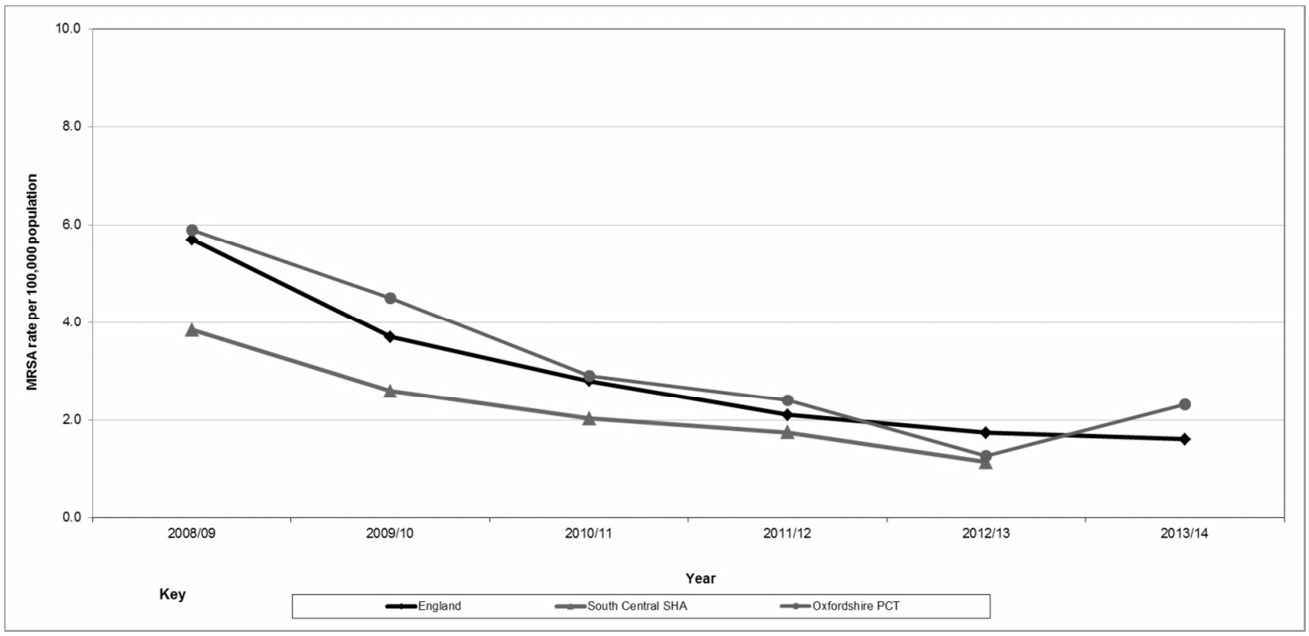


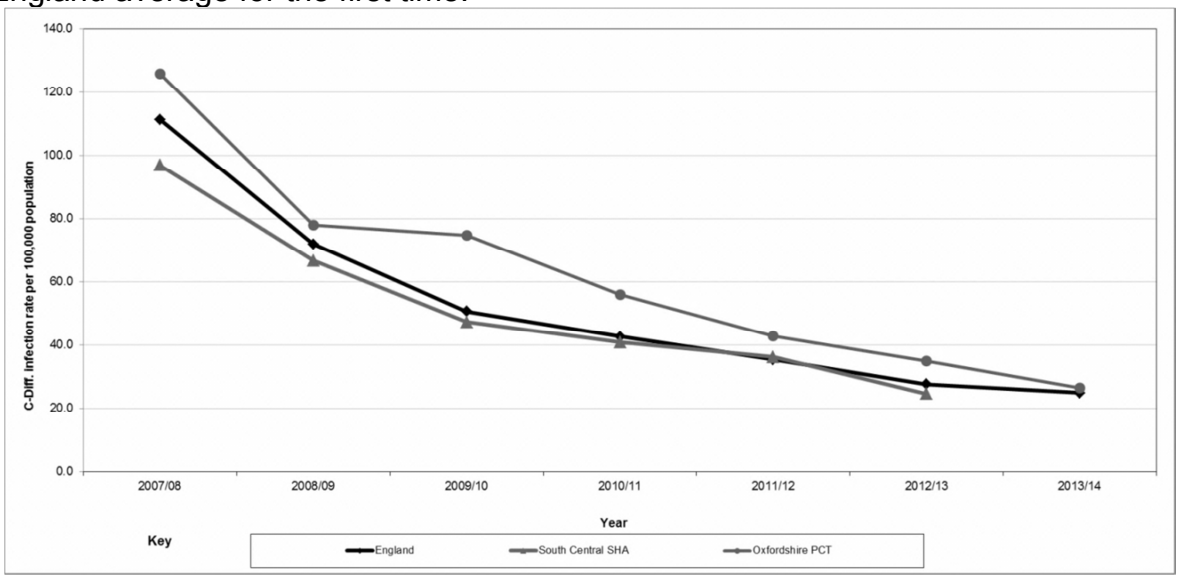
Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2013/14) England, South Central SHA and Oxfordshire

The recent slight increase reaffirms the continued vigilance that is required by all hospital and community services to address this increase.

Clostridium difficile (C.diff)

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

Last year saw good progress in combatting this disease, reaching parity with the England average for the first time.

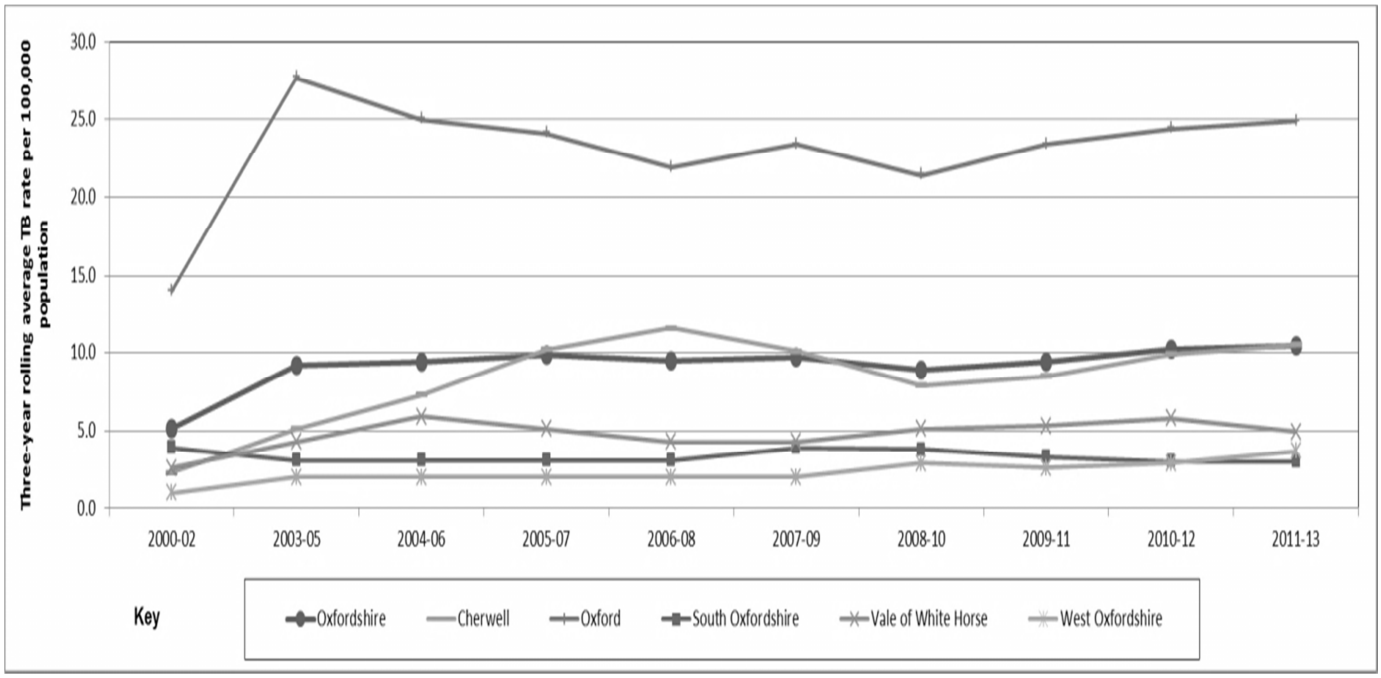


Clostridium difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2012/13) England, South Central SHA and Oxfordshire PCT

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 very low. These are shown below. In terms of numbers of cases, the average figure per District remains below 10. Because numbers are small, a modest outbreak of TB has a big effect on the overall figures. A three-year average is given which, at district level, still remains below 10



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

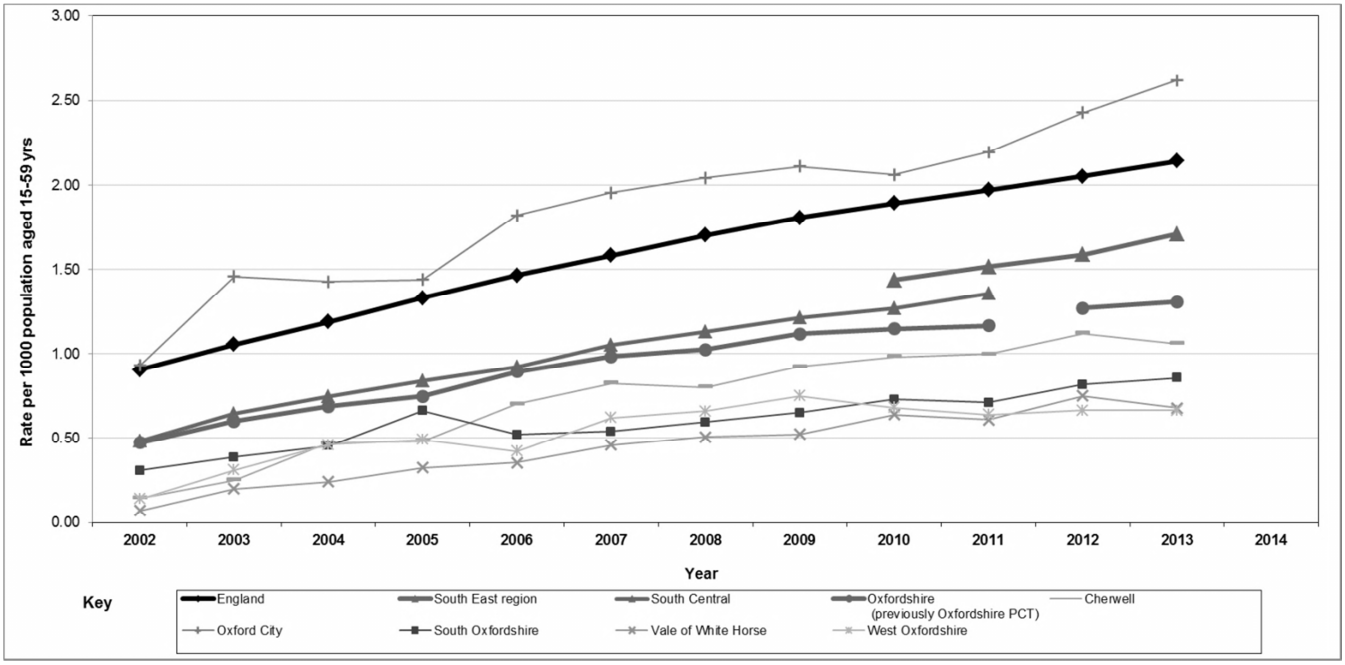
The levels of TB in the UK have been relatively stable over the past seven years. However, despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK is higher compared to most Western European countries.

The rate of TB in Oxfordshire is lower than National and Thames Valley levels. In the UK the majority of cases occur in urban areas amongst young adults, those coming 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 and Cherwell compared to other districts in the County. Given the importance of TB as a public health issue, it is one of the key priorities for Public Health England who are working to support local services to address TB in Oxfordshire.

Sexually transmitted infections

HIV & AIDS

Whilst HIV does not raise the public alarm it used to, it still remains a significant disease both nationally and locally. HIV is now a long term condition so we would expect there to be more people living with HIV long term. 2013 data shows that there are 524 people diagnosed with the infection living in Oxfordshire. 279 out of 524 live in Oxford City. This gradual increase is shown in the chart below.



Prevalence of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 yrs 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 four 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 community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford 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.

- Through offering a test in sexual health clinics when people attend with other diseases.

- Through prevention and awareness. Educating the local population about safe sexual practices and regular testing in high risk groups. The current contract for services ends on 31 March 2016. The Public Health Directorate are commissioning prevention and awareness services that will meet the changing needs of the local population.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments. HIV cannot be cured but the progression of the disease can be slowed down considerably, symptoms can be 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 has now slightly improved on 2012 data.

The different types of STI each show a mixed picture which is generally good with County averages below the national average. This is shown in the chart below. Looking at each disease in turn gives the following picture:

- Gonorrhoea – levels are below the national average for Oxfordshire as a whole and all Districts except in Oxford City where rates are high. A detailed piece of work is in progress to find out why this is. The reason may be connected with a more sensitive test for the disease which has been introduced. The situation needs close monitoring.
- 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 the 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.

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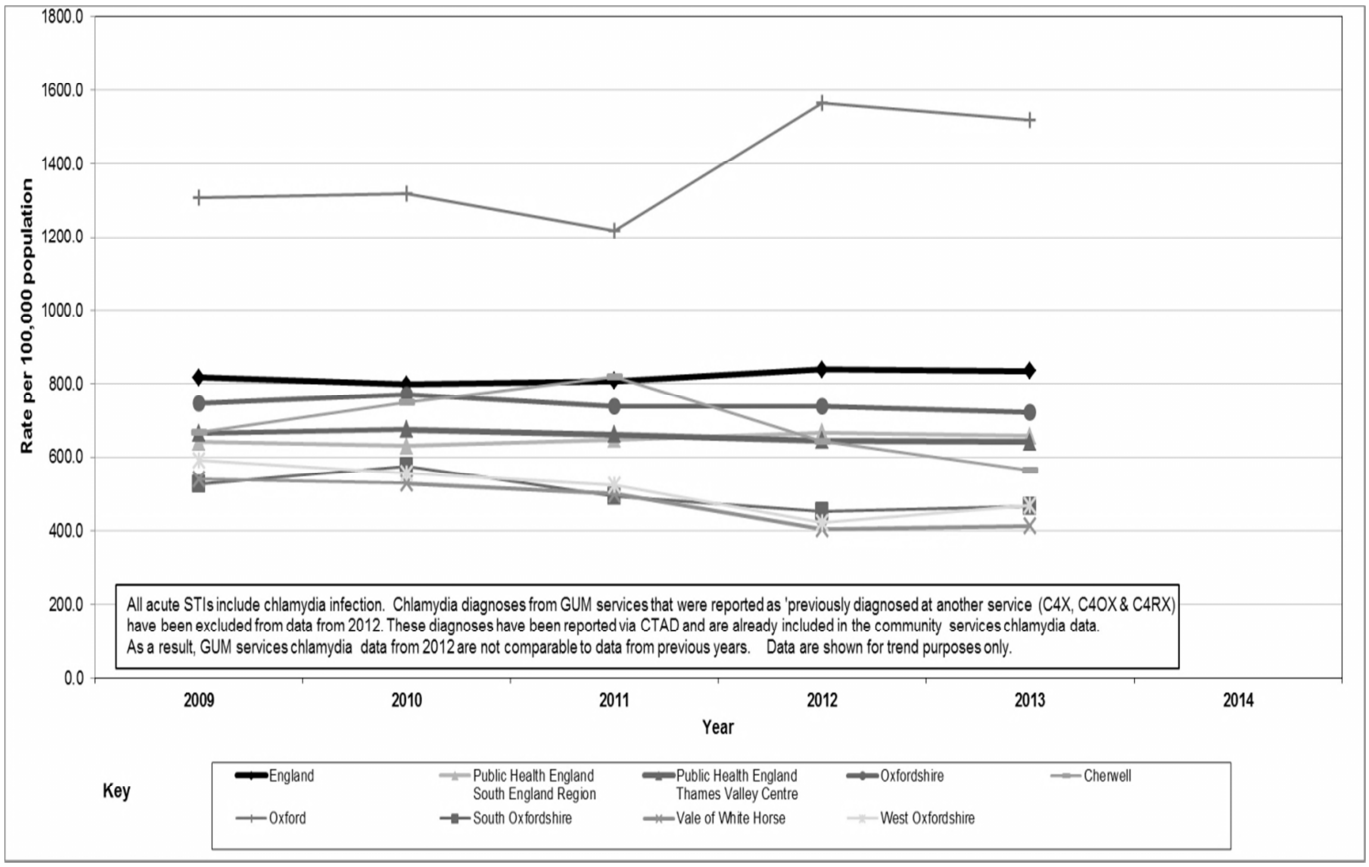
The chart below shows the overall position.



A new sexual health service began in 2014 which brought together STI and contraception services. A report on the first year of operation has shown improvements in public access coupled with better access to the 'morning after pill'. Safeguarding has also been strengthened.

In line with best practice a partnership of local stakeholders was established in February 2015. This group will work together to identify and address priorities locally to make further service improvements.

Recommendations

1. The Director of Public Health, the NHS and Public Health England should remain vigilant, spot the early signs of rising disease levels and continue to take action.

2. The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.

3. The new Sexual Health Partnership should steer multiagency action to combat sexually transmitted infection.

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Healthwatch Oxfordshire

Summary of responses made by Healthwatch Oxfordshire to the 2015/16 Quality Accounts.

1 Introduction

1.1 This report summarises the responses made by Healthwatch Oxfordshire to the Quality Accounts produced by providers in Oxfordshire for 2015/16. These responses are based on information gathered by Healthwatch Oxfordshire through:

a) It's outreach programme
b) Unsolicited feedback from the public
c) Monitoring of published quality and performance information
d) Issues raised with us in the course of our project work
e) Feedback from the OCCG Locality Forums
f) Feedback from other voluntary organisations.

1.2 **The report provides the Board with an overview, from the Healthwatch perspective, of the quality issues that need to be addressed in the local health economy in the year ahead.**

2 Background

2.1 Healthwatch has established a good relationship with all the major s delivering services in the County, and they have all been open to working with us on patients' behalf. We were glad to see this relationship recognised in the Quality Accounts, and to see the ongoing commitment across the system to working with us. We look forward to continuing to both support and challenge the Trusts in the year ahead, in the interest of helping them improve services for local people.

2.2 This paper, and Healthwatch's formal responses to the Quality Accounts, are also informed by the work led by Healthwatch with Directors of Quality and Patient Experience leads in all major commissioners and providers, to agree joint priorities for quality improvement work in Oxfordshire in 2015/16 – based on analysis of those organisations user feedback data.

2.3 These priorities are reflected in the updated Health and Wellbeing Strategy, and Healthwatch has encouraged providers to reflect them in their Quality Accounts.

2.4 The priorities which all parties committed to through this process are to make improvements in:

a) Joining up people's care, when it is being delivered by a range of health and/or social care providers.
b) Communication between different organisations within the system about patients.

c) Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
d) Carer involvement in care planning and care delivery.
e) Better treatment of patients with physical and mental health needs, and recognising and addressing the psychological component of all healthcare.
f) Continuing to build a culture in which staff, carers and patients feel able to raise concerns or complaints without fear of retribution.
g) Supporting delivery of public education about how to use the NHS wisely, and self-care programmes that might help reduce demand.

2.5 In addition individual organisations agreed to make improvement in the following areas :

a) OHFT pledged to continue to work to make patient care safer through reducing harm through falls, patients going missing ,aggression and violence and avoidable pressure ulcers and through the prevention of suicide
b) OUHT says it will continue to try and provide high quality, individualised care while meeting NHS Constitution pledges on A&E waiting times, cancer treatment times and 18 week referral to treatment targets
c) OCC says it will address the timeliness of social care assessments and access to care packages and re-ablement services
d) SCAS says it will work to improve ambulance rural response times
e) OCCG and NHSE says it will work to address the issues of access to GPs and GP retention and recruitment.

3 Healthwatch response to OUHT Quality Account

3.1 The issues raised about OUHT with Healthwatch Oxfordshire in 2014/15 have primarily related to:

a) The Trust's ongoing failure to meet NHS Constitution pledges on:

- The A&E four hour wait.
- 18 week referral to treatment time targets.
- 62 cancer treatment time targets.
- Patients being offered a binding date within 28 days following operations cancelled for non-clinical reasons.
- Making patients' transition as smooth as possible between services.
- Putting patients and their carers at the heart of decision making about care that affects them.
- Failures and delays in patients receiving copies of correspondence about their care.

b) The Trust's ongoing failure to work successfully with its partners to resolve the poor performance on hospital discharge.

c) Poor communication at all stages of the patient pathway between clinicians, between organisations and with patients – particularly but by no means exclusively with those patients who have specific access needs such as a need for translation or interpretation services.

3.2 Healthwatch Oxfordshire welcomes the fact that the Quality Account references the joint priorities agreed jointly with other providers and commissioners.

3.3 We also welcome the commitments made in the 2015/16 Quality Account to:

- Improve clinical handover in the hospital and interface with GPs.
- Improve discharge co-ordination and sharing of discharge information.
- Improve communication with patients and carers.
- To enhance the quality and timeliness of assessments for the frailest patients.
- Make pathways clearer.
- Assess and support the MH needs of patients.
- Reduce A&E attendances and avoidable admissions.

3.4 Healthwatch Oxfordshire was however extremely disappointed to learn that many of the Trust's longstanding failures to meet NHS Constitution pledges were not successfully addressed through the delivery of the 14/15 Quality Account priorities. We would also like to have seen a much clearer focus and much higher priority on improving performance against these basic NHS Constitution pledges in the Quality Account for 2015/16.

4 Healthwatch response to OHFT Quality Account

4.1 The issues raised about OHFT with Healthwatch Oxfordshire in 2014/15 primarily related to:

a) Access to community based mental health services and psychological therapies for people of all ages.
b) Delayed discharges from hospital.
c) Poor communication issues
d) Concerns relating to the capacity of the district nursing service.
e) The impact of recruitment and retention problems on effective service delivery.

4.2 Whilst the shared quality priorities described in para 2.4 were not explicitly referenced in the 2015/16 Quality Account, which was disappointing, Healthwatch Oxfordshire welcomes the commitments the Trust has made to:

- Address recruitment, retention and staff wellbeing issues Improve floor to board communication
- Improve processes to ensure staff can raise concerns and monitor action taken
- Evaluate integration of physical and mental health pathways
- Improve the management of patients' long term physical health conditions
- Extend the CAMHS in reach service in schools
- Improve information sharing with GPs
- Implement and evaluate the triangle of care, in order to improve patient and carer involvement in care planning and communication between the Trust, its patients and their carers.

4.3 We were also pleased to see in the review of 2014/15 that the Trust was:

- Developing partnership based approaches to delivery of services with local 3rd sector organisations and OUHT, in order to improve outcomes for Mental Health patients and older adults.
- Adopting a framework for assessing and improving patient experience.
- Implementing integrated physical and mental health pathways for older people.

4.4 Whilst we understand that some of the 2014/15 priorities will be rolled forward, we were disappointed not to see a greater emphasis on improving integrated working with OUHT and social services in the 2015/16 priorities in order to reduce delayed discharges and issues associated with transfer of care between organisations.

4.5 We would also have welcomed a significantly enhanced focus on improving access to community based mental health services and psychological therapies.

4.6 Finally we would like to have seen the focus on supporting staff to raise concerns to have been extend to include patients and carers and a much more explicit commitment to reporting on the action taken as a result of implementation of the new framework for assessing and improving patient experience.

5 Healthwatch response to SCAS Quality Account

5.1 The issues raised about SCAS with Healthwatch Oxfordshire in 2014/15 have primarily related to:

a) Rural ambulance response times.
b) Patients' experience of the PTS services.

5.2 Although we were pleased to see the emphasis in the Quality Account on improving the Patient Transport Service, and the recognition of the need to meet response times, we would have liked to have seen a clearer strategy for improving ambulance response times in rural areas in particular.

5.3 We have been delighted at the Trusts' active involvement in the multi agency Quality and Patient Experience leads meeting, and were pleased to see that this helped them deliver their patient experience targets for 2014/15. We regret, however, that ongoing participation in this group is not referenced as part of the Trust's strategy for delivering improvements in Patient Experience in the year ahead, and that the priorities agreed by that partnership are not overtly addressed in the Quality Account for 2015/16.

6 Healthwatch response to Southern Health FT Quality Account

6.1 The issues raised about SHFT with Healthwatch Oxfordshire in 2014/15 have primarily related to:

a) The problems associated with the transition between children's and adult services;
b) The failure to provide information and support to enable families to make informed choices about which services to use;

c) The need to develop 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;
d) The importance of services and commissioners working with families to seek solutions rather than perceiving families as part of the problem.

6.2 In addition, the avoidable death that occurred in the Trust's Oxfordshire premises in July 2013 raised awareness locally of the importance of families getting the right information, advice and support in order to understand how to safeguard and protect their loved ones.

6.3 We welcome the overall strategy and priorities set out in the Quality Account, but we would like to see evaluation of the care planning indicator address family and peer support, as well as patient engagement. Additionally we regret that we could not identify any clear focus in the Quality Account on improving transition between children and adult services.

7 Other Trust's

Healthwatch was invited to comment on the Great Western Hospital Quality Account, but declined to do so as it did not have sufficient information to warrant making a response.

8 ACTION REQUIRED BY THE BOARD

The Health and Wellbeing Board is asked to endorse Healthwatch's overview of the quality issues facing the local healthcare system as set out in this paper and to notify Healthwatch of any additional feedback it would like Healthwatch to give providers on behalf of the Board.

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Updated: 7th July 2015

Health & Wellbeing Board
16 July 2015

Performance Report

End of year performance

1. A table showing the agreed measures under each priority in the Joint Health and Wellbeing Strategy, expected performance and current performance is attached as appendix A.

2. There are 67 indicators included in the strategy with the majority reported on a quarterly basis. A number have annual targets, with a mixture being reported at the end of the academic year or the end of the financial year.

3. End of year data (Q4) is available for the majority of indicators, however data is still not available for 8 indicators. In many cases this is due to the delay in publishing data nationally.

4. End of year performance can be summarised as follows:

   28 indicators are Green
   14 indicators are Amber (defined as within 5% of target)
   12 indicators are Red
   8 indicators are awaiting data
   5 indicators have data but are for monitoring purposes only and hence not RAG rated. This includes 3 indicators that were to be developed around the Better Care Fund but these measures have not yet been developed nationally.

5. Current performance is generally positive, with 45% (of indicators with targets) meeting the end of year target. Appropriate action is being taken where performance is not currently meeting expected levels. This has been summarised in the notes column of the appendix.

6. Notable indicators that were rated as Green include:
   - Indicators 2.1 and 2.2. The number of eligible 2 year olds taking up free early education (2112) was much higher than the target of 1800. This follows significant work by the Early Years workers and children's centres in promoting this funding. In addition 86% of Looked After Children eligible for the 2 year old funding took up the free childcare, this is above the target of 80%.
   - Indicator 4.9 - at the end of March only 3.6% of young people were not in education, employment or training (NEET), below the ambitious target of 5%.
   - Indicator 10.2 - 87% of people receiving housing related support departed services to take up independent living against a target of 75%. (Indicator 10.2)
   - Indicator 8.2 - 21% of people aged 40-74 who are eligible for health checks once every 5 years, were invited to attend during the year against a target of 15%. This indicator was green throughout the year.

7. Of the 12 indicators that are rated as Red:
   a. 2 are in Priority 2 – Narrowing the gap for our most disadvantaged and vulnerable groups
      - Indicator 2.3 - persistent absence rates of looked after children (those looked after for at least a year). This increased from 4.7% (7 children) in 2012/13 to 5.3% (8 children) in 2013/14.
      - Indicator 2.8 The free school meal gap (the difference in attainment between pupils known to be eligible for free school meals and their peers) has widened slightly at both key stage 2 and key stage 4.The gap in Oxfordshire remains noticeably wider in Oxfordshire than that nationally.

   b. 1 is in Priority 4 – Raising achievement for all children and young people
      - 4.7 Only 8% of Oxfordshire pupils at school action plus achieved 5 GCSEs at grades A*-C including in English and in maths. This is a decrease from 2013 and significantly below the national figure of 21%.

   c. 1 is in Priority 5 – Living and working well
      - Indicator 5.2 – Excess under 75 mortality in adults with serious mental health illness increased to 412.0 from a baseline of 350.3

   d. 3 are in Priority 6 – Support older people to live independently with dignity whilst reducing the need for care and support
      - Indicator 6.1 – The number of days a patient is delayed in hospital increased to 4420 against a target of 2908 per month.
      - Indicator 6.2 – The number of avoidable emergency admission to hospital for older people increased to 16,492 against a target of 15,849
      - Indicator 6.6 – The number of people referred to reablement from their own home was at 764 compared to a target of 1875.

   e. 4 are in Priority 8 – Preventing early death and improving quality of life in later years
      - Indicator 8.3 - 53% of people aged 40-74 invited for an NHS Health Checks attended, against a target of 66%
      - Indicator 8.4 - A target was set for 3800 people to quit smoking for at least 4 weeks but the final figure was only half of this (1955).
      - Indicator 8.5 - 6.7% of opiate users successfully left treatment by the end of 14/15, roughly in line with the previous year (6.5%) and below the target of 8.6%.
      - Indicator 8.6 - 20.2% of non-opiate users successfully left treatment by the end of 14/15. This was an increase on 2013/14 performance (15.5%) but noticeably below the target of 38.2%. (Indicator 8.6).

   f. 2 are in Priority 9 – Preventing chronic disease through tackling obesity
      - Indicator 9.1 – The obesity level of Year 6 children increased from 14.9% to 16.9%.
      - Indicator 9.2 - Annual data from the Active People survey shows the proportion of people who are NOT physically active for at least 30 minutes a week increased from 22.2% to 23%.

Alison Wallis
Performance & Information Manager, Joint Commissioning July 2015

Oxfordshire Health and Wellbeing Board
Performance Report

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
Priority 1: All children have a healthy start in life and stay healthy into adulthood											
1.1 CCG	Increase percentage of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy from 90% to 92% by end March 2015.	**Expected** 90.5% **Actual** 95.8%	G	**Expected** 91% **Actual**		**Expected** 91.5% **Actual**		**Expected** 92% **Actual**			Updated. Q1 14/15 data has only just been made available by NHS England. National rate – 96.1%
1.2 CCG	Reduce the rate of emergency admissions to hospital with infections, for under 18's, maintaining low rates through 2014-15 (baseline 152.2 per 10,000 Mar13/14)	**Expected** 173.1 **Actual** not available		**Expected** 168.7 **Actual** not available		**Expected** 164.3 **Actual** not available		**Expected** 159.8 **Actual** not available			
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups											
2.1 OCC	Increase the take up of free early education for eligible 2 year olds in 2014/15 to 1800 (from 1036 in 13/14)	**Expected** 350 **Actual** 392	G	**Expected** 1020 **Actual** 1398	G	**Expected** 1275 **Actual** 1539	G	**Expected** 1800 **Actual** **2112**	G	Funding is targeted at areas of deprivation	
2.2	Maintain the take up of free early education for 2 year-old Looked After children to 80% (currently at 80% in 13/14)	**Expected** 80%	A	**Expected** 80%	A	**Expected** 80%	G	**Expected** 80%	G	Not applicable	

OCC		**Actual** 78%		**Actual** 78%		**Actual** 96%		**Actual** **86%**			
2.3 OCC	Maintain the current low level of persistent absence from school for looked after children. The target for 2013-14 academic year is 3.3%			**Expected** 3.3% **Actual** **5.3%**	R						
2.4 OCC	Maintain the number of looked after children permanently excluded from school at zero (13/14)			**Expected** Zero **Actual** Zero	G						
2.5 OCC	Decrease the rate of persistent absence from school of children in need from school from 19.8% (baseline 12/13 academic year)							**Expected** **<19.8%** **Actual** **15.0%**	G		Rate is lower than last academic year. Nationally the figure is 13.8%
2.6 OCC	Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (over a school year) and work to reduce this number in future years							Expected Baseline established Actual **4.3%**	G		
2.7	Identify, track and measure the outcomes of all 810 families in Oxfordshire meeting the national Troubled Families criteria			**Expected** a) 90% b) 80%	G			**Expected** a) 90% b) 80%	G		Q4 data updated

OCC	a) working with 90% of identified families b) turning around 80% of identified families			**Actual** a) 100% b) 90%				**Actual** a) 100% b) 100%			
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 a) KS2: 23% points; b) KS4 26% points (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)					**Expected** In line with national KS2: (19%pts in 12/13); KS4 (27%pts in 12/13)	**R**				KS2 the Free School; Meal gap has widened to 23%points, nationally it has remained at 19%pts
Page 98						**Actual** KS2 – 23%pts KS4 – 34%pts					
Priority 3: Keeping all children and young people safe											
3.1	Establish a baseline in order to reduce the assessed level of risk of high risk Domestic Abuse victims managed through Multi-Agency Risk Assessment Conferences (MARAC).							**Expected** Baseline established			Overall baseline for year – 80%.
		Actual 82%		**Actual** 84%		**Actual** **80%**		**Actual** **72%**			
3.2	Every child considered likely to be at risk of Child Sexual Exploitation (identified using the	**Expected** 100%	**G**	**Expected** 100%	**G**	**Expected** 100%	**G**	**Expected** 100%			

OCC	CSE screening tool) will have a multi-agency plan in place	**Actual** 100%		**Actual** 100%		**Actual** **100%**		**Actual**			
3.3	Reduce prevalence of Child Sexual Exploitation in Oxfordshire through quarterly reporting on victims and perpetrators to the Child Sexual Exploitation sub group of the Oxfordshire Safeguarding Children's Board	**Expected** Prevalence reported and action taken as appropriate	**G**	**Expected** Prevalence reported and action taken as appropriate	**G**	**Expected** Prevalence reported and action taken as appropriate	**G**	**Expected** Prevalence reported and action taken as appropriate	**G**		
Page 96		**Actual** Prevalence reported and action taken as appropriate		**Actual** Prevalence reported and action taken as appropriate		**Actual** Prevalence reported and action taken as appropriate		**Actual** Prevalence reported and action taken as appropriate			
3.4	Monitor the number of children who go missing from home and the proportion who go missing 3 or more times within a 12 month period	**Expected** No target		**Expected** No target		**Expected** No target		**Expected** No target			
OCC		**Actual** 25/179		**Actual** 56/356		**Actual** 90/527		**Actual** **132/694**			
3.5	Increase the proportion of quality assurance audits undertaken and reviewed through the Oxfordshire Safeguarding Children Board that show a positive overall impact from a baseline of over 76% (13/14)							**Expected** >76%	**G**		
OCC								**Actual** **87.5%**			

Priority 4: Raising achievement for all children and young people											
4.1	Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 85% (baseline 83% 13/14)	**Expected** 83.5%		**Expected** 84.0%		**Expected** 84.5%		**Expected** 85%		Varies between Oxford City – 78% And Vale of WH – 91%	
occ		**Actual** 82.1%	**A**	**Actual** 84.5%	**G**	**Actual** 84.7%	**G**	**Actual** **87.8%**	**G**		
4.2	84% of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2012/13 (baseline 81% 12/13 academic year)			**Expected** 84%							
occ				**Actual** **82%**	**A**						
4.3	80% of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (baseline 78% 12/13 academic year)			**Expected** 80%							
occ				**Actual** **77%**	**A**						
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			**Expected**	change of						Change of definition within the academic year means that the published figure (based

OCC	(baseline 61% 12/13 academic year)			**Actual 58.6%**							on pupils first entry results) cannot be directly compared to last year and to target (based on best results). However in 2014 Oxfordshire's results were significantly above the national average (56.1%)
4.5 a	a) At least 72% of young people will make the expected 3 levels of progress between key stages 2-4 in English (baseline 70% 12/13 academic year)			**Expected 72%**	**G**						
OCC				**Actual 74%**							
4.5	b) At least 73% of young people will make the expected 3 levels of progress between key stages 2 and 3 in maths. (baseline 71% 12/13 academic year)			**Expected 73%**	**A**						
OCC				**Actual 71%**							
4.6	Increase the proportion of pupils attending good or outstanding: a) primary schools to 86% at the end of 14/15 academic year (baseline 82% 13/14 academic year)	**Expected** Primary: 75% Secondary: 87%	**A**	**Expected** Primary: 75% Secondary: 87%	**A**	**Expected** Primary: 86% Secondary: 85%	**A**	**Expected** Primary: 86% Secondary: 85%	**A**		Indicator for 2013/14 academic year was for proportion of pupils attending good/ outstanding schools. For 2014/15 (Q3 onwards) this has

OCC	b) secondary schools to 85% at the end of 14/15 academic year (baseline 82% 13/14)	**Actual** Primary 78% Secondary 85%		**Actual** Primary: 79% Secondary: 85%		**Actual** Primary: 81% Secondary: 82%		**Actual** Primary: **84%** Secondary: **86%**			changed to proportion of schools that are good/ outstanding
4.7	Of those pupils at School Action Plus, increase the proportion achieving 5 GCSEs at A* - C including English and Maths to 17% (baseline 10%12/13 academic year)					**Expected** 17%	**R**				
OCC						**Actual** **8%**					
4.8 a	To reduce the persistent absence rates in primary schools to 2.8% (baseline 3.2% 12/13 academic year)			**Expected** Primary: 2.8%	**G**						Data updated with validated figures
				Actual **1.9%**							
4.8 b	To reduce the persistent absence rates in secondary schools to 6.7% (baseline 7.4% 12/13 academic year)			**Expected** **6.7%**	**G**						
OCC				**Actual** **6.4%**							
4.9	Continue to reduce the number of young people not in education, employment or training to below 5% (baseline 4.7% - 937 young people, 2013/14)	**Expected** <7%	**G**	**Expected** <7%	**G**	**Expected** <5%	**G**	**Expected** <5%	**G**	West Oxfordshire hub area – 2.9% Banbury and Littlemore hub areas – 5.3%	. This equates to 657 young people.
OCC		**Actual** 5.4%		**Actual** 6.0%		**Actual** **3.7%**		**Actual** **3.6%**			

4.10 OCC	Continue to reduce the proportion of young people whose NEET status is not known, to less than 5% (March 15) (Baseline 11% March 14)	**Expected** <10% **Actual** 5.4%	G	**Expected** <64% **Actual** 47.6%	G	**Expected** <20% **Actual** **7.5%**	G	**Expected** <5% **Actual** **5.2%**	A	S W Oxon hub area – 4.1% Banbury and Bicester hub areas – 6.4%	
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											
5.1	1800 people to receive information and advice about areas of support as part of community information networks	**Expected** 450 **Actual**		**Expected** 900 **Actual** 1284	G	**Expected** 1350 **Actual** Not yet available	G	**Expected** 1800 **Actual** 25,650	G		Contract runs from 1st November. The target for the first year of the contract (1st Nov 2013 – 31st Oct 2014) was 6,800.
5.2 CCG	Excess under 75 mortality in adults with serious mental health illness (PHOF 4.9 from outcomes framework) Baseline 350.3 in 2011/12 (England average 337.4).							**Expected** < 350.3 **Actual** 412.0	R		Figure is for 2012/13 and represents an increase. National data is 347.2. This figure is historical and does not reflect impact of in-year activity. This measure forms part of the outcomes based contract and will be measured from 2017-18 when that contract should have impacted on the physical health issues that drive this measure. In the meantime measures have been introduced into the outcomes based contract to reduce smoking and obesity prevalence amongst people with severe mental illness.

5.3 OCC	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			**Expected** >50% **Actual** 61%	G						Good levels of recovery achieved by local providers.
5.4 CCG	At least 60% of people with learning disabilities will have an annual physical health check by their GP (baseline 45.7% 2013/14)							**Expected** 60% **Actual** nya			Figure remains provisional as data not yet received from all practices.
5.5	Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)	**Expected** Less than 951.4 per 100,000 **Actual** na		**Expected** Less than 951.4 per 100,000 **Actual** 1010.8	R	**Expected** Less than 951.4 per 100,000 **Actual** 966.1	R	**Expected** Less than 951.4 per 100,000 **Actual** **964.6**	A		Although performance across the year has not improved on last year, it has improved each quarter and is considerably better than the national rate of 1112.
5.6 CCG	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.(2012/13 baseline 565.4 per 100,000 population)	**Expected** 565.4 per 100,000 **Actual** na		**Expected** 565.4 per 100,000 **Actual** 534.7	G	**Expected** 565.4 per 100,000 **Actual** 538.7	G	**Expected** 565.4 per 100,000 **Actual** **536.4**	G		
5.7	Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14							**Expected** >9.9%	G		This represents the % of people with severe mental illness in paid employment from amongst the population of patients

CCG								**Actual** **16%**			supported by Oxford Health NHSFT. Employment rates remain a priority for OCCG in outcomes based contracting, and will also form the basis of OCCG performance around mental health for the NHS Quality Premium for 2015/16.
Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support											
6.1	Reduce the number of days that a patient is delayed in hospital by 38% from an average of 4688 per month in 2012/13 to 2908 per month in 2014/15 (baseline 14.8 days in acute hospitals)	**Expected** 2908		**Expected** 2908		**Expected** 2908		**Expected** 2908 per month		.	A system wide DTOC plan has been adopted across commissioners and all providers and there are targets to halve DTOC from the January 2015 level and reduce days delayed owing to DTOC within the Better Care Fund. These plans are being reviewed at July 2015 to assess for maximum impact.
Page 302		**Actual** 3603	R	**Actual** 3922	R	**Actual** 4116	R	**Actual** **4420**	R		
6.2	Reduce the number of avoidable emergency admissions to hospital for older people (aged 65+) per 100,000 population from a baseline of 15,849 in 13/14	**Expected**		**Expected** <15,849		**Expected** <15,849		**Expected** <15,849			Non-elective admissions were up by 2.8% for 2014-15 financial year. A majority of these are attributable to frail older patients with multi-morbidities. There are system wide initiatives to increase the number of people treated in the community including the Better Care Fund. A long term conditions strategy is being developed, and whilst there is an improvement in admissions for ambulatory sensitive our work on ambulatory emergency care incorporated in the Better Care Fund should drive further improvement.
CCG		**Actual**		**Actual** 16,161	R	**Actual** 16,685	R	**Actual** **16,492**	R		

6.3 OCC	Reduce the number of permanent admissions of older people (aged 65+) to residential and nursing care homes from 582 in 2012/13 to 546 in 2014/15	**Expected** 136 **Actual** 172	A	**Expected** 275 **Actual** 324	A	**Expected** 410 **Actual** 445	A	**Expected** 546 **Actual** **598**	A		10% above target. 3% above benchmark (12/13 data in line with Better care Fund). 4% reduction on last year
6.4 OCC	Increase the proportion of older people with an ongoing care package supported to live at home from 60.0% in April 2014 to 61.9% in April 2015	**Expected** 60.0% **Actual** 61.4%	A	**Expected** 60.7% **Actual** 62.0%	G	**Expected** 61.3% **Actual** 61.9%	G	**Expected** 61.9% **Actual** **62.7%**	G		
6.5 CCG	60% of the expected population (5134 out of 8557) with dementia will have a recorded diagnosis (baseline 44.2% or 3929 people	**Expected** 48.2% **Actual** na		**Expected** 52.2% **Actual** 47.4%	No clear data	**Expected** 56.6% **Actual** 53.4%	A	**Expected** 60.0% **Actual** **57.8**	A		Oxfordshire did not quite meet the local target of 60% for 2014-15 in spite of a considerable investment of time and resources from the CCG and local GPs. In 2015/16 we are required to achieve the national target of 67%. A change in the way that Oxfordshire's prevalence is calculated (reduced levels of vascular dementia) means that the figure of <60% on 31/3/15 becomes >60% on 1/4/15. The current procurement of a new Dementia Support Service will encourage engagement with this KPI from primary care during 2015/16.
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	**Expected** 469	R	**Expected** 938	R	**Expected** 1406	R	**Expected** 1875	R		The issue remains low levels of community based referrals (with referrals from hospital above the expected contract level)..

OCC	from a baseline of 881 in 2013/14	**Actual** 196		**Actual** 391		**Actual** 570		**Actual** **764**			
6.7	Increase 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 from a baseline of 71.7% in April 2013							**Expected** 80%			Data not available until end of July 2015
OCC								**Actual**			
6.8	Maintain the number of organisations providing social care in Oxfordshire that meet the standard of treating people with respect and involving them in their care at above 95%	**Expected** 95%	G	**Expected** 95%	G	**Expected** 95%	G	**Expected** 95%	G		
OCC		**Actual** 95%		**Actual** 96%		**Actual** 96%		**Actual** **96%**			
6.9	Target to be developed around the Better Care Fund national patient/ service user experience measure							**Expected**			Measure not yet developed nationally
OCC								**Actual**			
6.10	Ensure an additional 523 Extra Care Housing places by the end of Mar 2015, bringing the total number of places to 768 by the end of March 2015			**Expected**		**Expected**		**Expected** 768			714 units delivered. One scheme for 54 flats in Kidlington will not complete building works until May.
OCC				**Actual** 512	G	**Actual** 512	G	**Actual** **714**	A		
6.11	Increase the proportion of people approaching the end of life who receive consistent care that is coordinated effectively							**Expected** Target tbc			Work is still underway to achieve a useful local dataset to inform this indicator. National End of Life Intelligence data that is

CCG	across all relevant settings leading to patients dying in their preferred place of care. Baseline and targets to be determined							**Actual**			rolling annual data and latest is 13/14 Q4 to 14/15 Q3 which gives an Oxfordshire figure of 48.3% deaths in usual place of residence vs an England figure of 45.1%.
Priority 7: Working together to improve quality and value for money in the Health and Social Care System											
7.1	A measure to be developed relating to how the County Council and the 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							**Expected**			Measure not developed nationally
Page 107								**Actual**			
	A national measure of patient/ service user experience to be developed in line with the Better Care Fund							**Expected** To be developed			Measure not developed nationally
								Actual			
7.3	Increase the number of carers known and supported by adult social care by 10% to 17,000 (baseline 15,474 Apr 2014)	**Expected** 15,855	A	**Expected** 16,235	A	**Expected** 16,615	A	**Expected** 17,000	A		
OCC		**Actual** 15,723		**Actual** 15,843		**Actual** 16,039		**Actual** **16,265**			
7.4	At least 880 carers breaks jointly funded and accessed via GPs (currently 880 at Apr 2014)	**Expected** 220	G	**Expected** 440	G	**Expected** 660	G	**Expected** 880	G		

CCC		**Actual** 459		**Actual** 747		**Actual** 880		**Actual** **1,027**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 8: Preventing early death and improving quality of life in later years											
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60%	R	**Expected** 60%	A	**Expected** 60%	A	**Expected** 60%			Indicator was previously separated into 60-69 and 70-74 age groups, however from Q2 these are no longer reported separately. Q3 data updated
NHS England		**Actual**		**Actual** **57.3%**		**Actual** **57.0%**		**Actual** **nya**			
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75%	G	**Expected** 7.5%	G	**Expected** 11.25%	G	**Expected** 15%	G	Q4 - All CCG localities achieved the 15% target. Only Oxford City (17.9%) did not achieve the aspired 20% (It must be noted that Oxford City performance increased from 13.4% in 2013/14 to 17.9% in 2014/15).	
Page 107		**Actual** 5.4%		**Actual** 11.6%		**Actual** 16.9%		**Actual** **21.2%**			
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	**Expected** 46%	R	**Expected** 50%	R	**Expected** 58%	R	**Expected** 66%	R	Q4 - No CCG locality achieved the 66% target. 4 of the 6 achieved	The rate of 53.3% for the year means that Oxfordshire ranks above the averages across

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
OCC	50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Actual** 41.5%		**Actual** 43.1%		**Actual** 48.3%		**Actual** **53.3%**		the 50% aim. (North East, North, West, South West). Oxford City (48.4%) and South East (48.8%) did not. Additionally, all localities improved on their previous year's uptake %).	Thames Valley (48.9%), South of England (47.7%) and Nationally (48.8%).
8.4	At least 3800 people will quit smoking for at least 4 weeks (Baseline 3622 in 13/14) Baseline women smoking in pregnancy (%) – 9% (Q4 1314)	**Expected** 868	R	**Expected** 1672	R	**Expected** 2574	R	**Expected** 3800	R		Women smoking in pregnancy – 8%
		Actual 626		**Actual** 1133		**Actual** 1633		**Actual** **1955**			
8.5	8.6% of opiate users successfully leaving treatment by the end of 14/15 (baseline 6.5% 2013/14)	**Expected** 7.0%	G	**Expected** 7.5%	R	**Expected** 8.0%	R	**Expected** 8.6%	R		The number of non-opiates users successfully completing treatment is below the set target. Through the introduction of the Public Health Outcome Framework the performance measure has changed from counting drug users safely
OCC		**Actual** 7.1%		**Actual** 6.9%		**Actual** 7.2%		**Actual** **6.7%**			
8.6	38.2% of non-opiate users successfully leaving treatment by the end of 14/15 (baseline	**Expected** **21.2%**	R	**Expected** **26.9%**	R	**Expected** **32.6%**	R	**Expected** **38.2%**	R		

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
CCC	15.5% 2013/14)	**Actual** 14.5%		**Actual** 17.7%		**Actual** 17.7%		**Actual** **20.2%**			supported in services to counting those who successfully complete treatment. Current performance is being addressed with a comprehensive recovery plan with Public Health England support to develop and implement system wide action plans. In addition, a new Integrated Drug and Alcohol Treatment Service has been commissioned and commenced delivery on 1 April 2015.
Priority 9: Preventing chronic disease through tackling obesity											
9.1 CCC	Ensure that the obesity level in Year 6 children is held at no more than 15% and no district population should record more than 19% (Baseline 15.2% in 2013)			**Expected** 14.9% or less **Actual** **16.9%**	**R**					Oxford City – 21% Is the only locality above 19%. South Oxfordshire has the lowest obesity level – 15.2%	
9.2	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire							**Expected** **21.2%**	**R**	Report from the Active People Survey 2014-15	

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
District council	22.2% against 28.5% nationally, 2013-14 Active People Survey)							**Actual** **23%**			
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%	**Expected** 63%		**Expected** 63%		**Expected** 63%		**Expected** 63%			
NHS England & CCG		**Actual** 60.3%	**A**	**Actual** 60.5%	**A**	**Actual** 59.7%	**A**	**Actual** **60.4%**	**A**		

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1 District Councils	The number of households in temporary accommodation as at 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire)							**Expected** 197 or less **Actual** **192**	G	56% (107) are in Oxford City 18% (34) in Cherwell 11% (21) in South 9% (18) in Vale 6% (12) in West Oxon.	
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9% in 13/14)	**Expected** 75% **Actual** 87%	G	**Expected** 75% **Actual** 86%	G	**Expected** 75% **Actual** 87%	G	**Expected** 75% **Actual** **88%**	G	The majority of people receive a service from a county wide service which means it isn't possible to accurately provide data on a locality basis	Data has been revised due to the removal of domestic violence cases. Overall figure for the year – 87%
10.3 District Councils	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)	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual** 86%	G	**Expected** 80% **Actual** 84%	G	**Expected** 80% **Actual** **86%**	G	Varies from 59% in West Oxfordshire to 89% in Oxford City.	
10.4	Establish a baseline of the number of households in Oxfordshire who have received significant increases in the						G	**Target** 550	G		Total for the year = 1,468 against a target of 550

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Affordable Warmth Network	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			**Actual** 712 (Q1&Q2)		**Actual** 328		**Actual** 428			
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 74 in 2013-14							**Target** < 74	G		
District Councils								**Actual** **68**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 11: Preventing infectious disease through immunisation											
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%	**Expected** 95%	G	**Expected** 95%	A	**Expected** 95%	A	**Expected** 95%	G	Oxford City falls below the 94% target (93.8%). Highest performing locality – North East – 98.1%	
NHS England		**Actual** 95.2%		**Actual** 94.6%		**Actual** 92.5%		**Actual** **95.0%**			
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 93.7%) and no CCG locality should perform below 94%	**Expected** 95%	R	**Expected** 95%	R	**Expected** 95%	A	**Expected** 95%	A	At Q4 North Oxfordshire = 91.7%, Oxford City = 92.1%, South West = 93.3% Others 3 are at or over 94%	
NHS England		**Actual** 92.6%		**Actual** 91.9		**Actual** 95.2%		**Actual** **92.1%**			
11.3	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (baseline 55% 13/14)							**Expected** 55%			
NHS England								**Actual**			
11.4	At least 90% of young women will receive both doses of HPV vaccination. (baseline to be confirmed)							**Expected** Over 90%			6 month delay in data being reported
NHS England								**Actual**			

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Oxfordshire's Joint Health & Wellbeing Strategy

2015 - 2019

v.4

First Version July 2012,
Revised July 2013, June 2014 and June 2015 (draft)

Oxfordshire Clinical Commissioning Group

healthwatch Oxfordshire

OXFORDSHIRE COUNTY COUNCIL

CONTENTS

1. Foreword to the Revised Version of this strategy, July 2015

This revision of our joint strategy leads us into a fourth year of work together in Oxfordshire through the Health and Wellbeing Board. In the last year we have continued to strengthen our focus on improving health outcomes for the people of Oxfordshire and have demonstrated progress in a wide range of areas. Relationships have grown across the partnership, and Oxfordshire Healthwatch continues to add a valuable contribution to the work of the Board. Each revision has built on the success of the previous version and in this way we continue to prioritise our work and ensure that the focus for the partnership is directed to the biggest issues.

We made good progress in 2014-15. Our approach of setting outcomes for all our Health and Wellbeing priorities and for receiving updates on performance each time we meet is working well. It has enabled us to keep our focus on the issues that matter and to drive improvement. The addition of "best and worst" reports on performance by the Health Improvement Board has been a good development too as it has enabled focus on variation in outcomes that affect different parts of the population.

We have made progress on several issues during the year, including

- There have been big improvements in the take up of free early education for eligible 2 years olds;
- A higher percentage of pregnant women saw a healthcare professional in the first 13 weeks of their pregnancy - 95.8% exceeding our target of 92%;
- The number of young people not in education, employment or training has continued to fallUptake of NHS Health Checks offered to 40-74 year-olds has improved
- Over 25000 people had help from the Community Information Network, which provides relevant, personalised information and advice about what is available to help us keep well and what support and care there is in local areas;
- Healthwatch Oxfordshire has reviewed the Quality Accounts of service providers and brought challenge and recommendations for improvement to the Board.
- We have continued to bring together the work of health and social care with communities and the voluntary sector - our first Neighbourhood team of social care and community health in Wantage and Faringdon is based with local GPs;
- The number of hospital admissions for acute conditions that would not normally require hospital admission continues to fall and is below the national average;
- The growth of Extra Care Housing continues and will deliver more units in 2015/16
- People who use health and social care services report a high level of satisfaction with their care, with access to information and receiving their support in a timely way
- Overall the rate of breastfeeding at 6-8 weeks is higher than the national average

However, we still have more to do. This revised strategy sets out our renewed intentions for the year ahead. We have proposed outcome measures so that we can continue to monitor improvements in 2015-16. We will hold each other to account, expect good results and continue to strive for good quality in all health and social care services.

The context for this as we look to the year ahead is the growing challenge on resources across the whole system. The County Council has announced the need for extra savings of £60m per annum by 2021/22 on top of the £88m planned savings to be made by 2017/18. The NHS is expected to deliver efficiency savings of £22 billion equating to £272m in Oxfordshire.

Working together to transform the health and social care system is now an imperative. People tell us it is what they want and it is the only way to continue to make sure that what people need is available to them at the right time, good quality and in the right place. The emphasis for all the organisations working in health and social care is changing the way we

work, focusing on prevention of ill health and needs for care and on how best people can be helped to stay well and be supported in their own communities.

Cllr Ian Hudspeth, **Chairman of the Board**
Leader of Oxfordshire County Council

Dr Joe McManners, Vice Chairman of the Board
Clinical Chair of the Oxfordshire Clinical Commissioning Group

2. Introduction

A Health and Wellbeing Board was set up in Oxfordshire to make a measurable difference to the health and wellbeing of its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire's people and the care they are offered. This Board was, therefore, very much the next logical step for Oxfordshire to take, and through it we also fulfil a key requirement of the Health and Social Care Act (2012).

The Health and Wellbeing Board is the principal structure in Oxfordshire responsible for improving the health and wellbeing of the people of the County through partnership working.

The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, Councillors, Health Watch Oxfordshire and senior officers from Local Government.

Early tasks for the board were to look at the biggest challenges facing the wellbeing of Oxfordshire's people and to set out the Board's initial ideas in this strategy for improving the situation. This formed the basis for the Joint Health and Wellbeing Strategy and it has been updated annually since 2012-13.

This strategy is the main focus of the Health and Wellbeing Board's work. We strive to make this a 'living document'. As priorities change, our focus for action will need to change with it. It is for this reason that, at the end of each year of operation, we review our performance, assess local need and are propose revised outcomes for the year ahead. We want to make sure that our planning stays 'alive' and in touch with the changing needs of Oxfordshire's people.

3. Vision

The vision of the Health and Wellbeing Board is outlined below. This sets out our aspiration in broad terms. It is fleshed out in the priorities which follow and the action plans that are now in progress.

By 2016 in Oxfordshire:

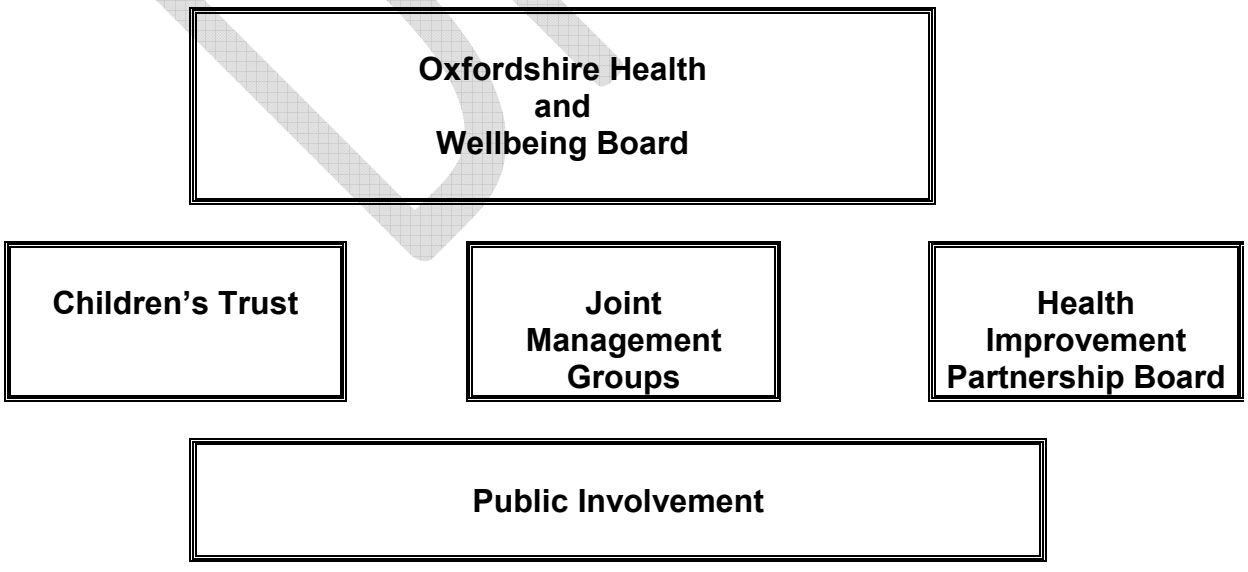
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services;
- everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs;
- the best possible services will be provided within the resources we have, giving excellent value for the public.

The priorities set out in this document put flesh on these themes. The priorities have run from 2012 - 2016 while the measures and targets set out within each priority are for the financial year 2015-16.

4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

The Health and Wellbeing Board has Partnership Boards and Joint Management Groups reporting to it and Public Involvement underpinning the whole system. Responsibilities for each are outlined below:



The purpose of each of the Boards, Groups and for Public Involvement are outlined below:

Joint Management Groups	Children's Trust	Health Improvement Board	Public Involvement
To improve outcomes and to support adults to live independently with dignity by accessing support and services they need while achieving better value for money, especially through oversight of our pooled budgets for older people and for mental health.	To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups	To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County	To ensure that the genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

4.2 How do decisions get made?

The Health and Wellbeing Board is ultimately responsible for setting a direction for the County in partnership. Its members are committed to working with its Partnership Boards, Joint Management Groups and its Public Involvement representatives to agree that direction. They are also accountable to their constituent organisations – the Oxfordshire Clinical Commissioning Group, County, District and City Councils and Healthwatch Oxfordshire.

In turn, the Partnership Boards and Joint Management Groups are committed to working with a wide range of health and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We invite these partners to formal meetings as 'expert witnesses' and to workshops during the year as a means of engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

The Health and Wellbeing Board meets in public three times a year. Each of the Partnership Boards or Joint Management Groups also meet in public at least once each year and will also host workshops which will include many more service providers, partners, informal/ volunteer carers, faith groups, voluntary sector representatives, the public and advocacy groups.

While the Health and Wellbeing Board listens carefully to the views of many groups of stakeholders and of the public as a whole, it has to be acknowledged that:

a) they want to take careful account of the evidence base provided by the Joint Strategic Needs Assessment and scientific research, and
b) given that there will never be enough resources to meet all of people's needs, it is the duty of the Health & Wellbeing Board to balance needs carefully and to influence its constituent organisations to make difficult decisions about priorities.

Details of the Health and Wellbeing Board, including membership, be found through the link below-
http://www.oxfordshire.gov.uk/cms/content/about-health-and-wellbeing-board

4.3 The Work of Other Partnerships and Cross-Cutting themes

The Health and Wellbeing Board is not the only group of its type in Oxfordshire.
Public consultation suggested including topics which are already covered by other groups and strategies. We do not want to duplicate effort and the work of these groups therefore has a key role to play. Other key partnerships and plans include:

- Better Care Programme Board
- Better Mental Health in Oxfordshire
- Carers Strategy Oxfordshire
- Urgent Care Programme Board that covers the A&E Recovery Plan
- Civilian Military Partnership
- Corporate Parenting Panel
- Dementia Plan for Oxfordshire
- Alcohol and Drugs Partnership
- End of Life Care Strategy
- Joint Management Groups
- Oxfordshire Children's and Adults Safeguarding Boards
- Oxfordshire Domestic Violence Strategy Group
- Oxfordshire Safer Communities Partnership
- Oxfordshire Stronger Communities Alliance
- Oxfordshire Sports Partnership
- Joint commissioning strategies for Physical Disability, Learning Disability, Older People, Mental Health and Autism
- Strategic School Partnership Shadow Board
- Young People's Lifestyles and Behaviours Steering Group
- Young Carers' Strategy Oxfordshire
- Youth Justice Board

A number of issues were identified in the major consultation in 2012 as ones that are of cross cutting interest to the adults, children's and health improvement boards. These were - safeguarding, carers, housing, poverty, mental health, drug and alcohol dependency, offender health, long term conditions, end of life care, co-ordination of good quality support and making a successful transition from children's to adult services. The action plans to deliver the improvements needed will take account of the cross cutting nature of these issues wherever possible.

Three of these cross-cutting issues are so fundamental and public support for them so strong, that the Health and Wellbeing Board will require that the implementation of this strategy across all priorities takes account of:

1) Social disadvantage
The aim here is to level up health and wellbeing across the County by targeting disadvantaged and vulnerable groups. This will vary from topic to topic but will include: Rural and urban disadvantaged communities, black and ethnic minority groups, people with mental health problems, members of the armed forces, their families and veterans and carers of all ages.

2) Helping communities and individuals to help themselves
As the public purse tightens, we need to find new ways of supporting people to help themselves. Since the early days of this approach there has been some progress including direct payments to people to buy their own care.

3) Locality working
Local problems often need local solutions and Oxfordshire is a diverse County. The Clinical Commissioning Group, County Council and District councils all support locality working and we should expect to see locality approaches to the priorities in this County when they are the best way to make improvements.

5. A strategic focus on Quality.

Discussion at the Health and Wellbeing Board has continually fuelled our intention to build a strategic focus on quality issues. The role of the Health and Wellbeing Board is to set strategic concerns for the whole system and to receive assurance of good practice. We have been monitoring a range of quality outcomes measures and see a fairly good picture overall, but believe there is more to do.

The Board is concerned that the issues uncovered by the Francis Report on the Mid Staffordshire NHS Trust should not be repeated in Oxfordshire and that the learning that is arising from the Child Sexual Exploitation cases locally will be implemented. In addition, the Joint Strategic Needs Assessment (JSNA), Director of Public Health Annual Reports and feedback of concerns from representatives of the public also indicate gaps in quality which need to be addressed.

The intention is to ensure that governance and assurance systems are joined up between organisations across the County. Performance measures which show patient and public satisfaction or dissatisfaction with services will be embedded in our performance framework again. The development of Healthwatch Oxfordshire has brought independent and informed views to the Board.

A process has now been established for giving more assurance on quality issues across the system. This includes continuing to include a range of patient reported outcome measures in this strategy and monitoring performance closely. From 2014-15 it was also agreed that Healthwatch Oxfordshire could take a lead role in examining the Quality Accounts of providers of health and social care and working with them to agree priorities for the year ahead. The product of this process is outlined below:

5.1 Whole system quality priorities for 2015/16

In November 2014, the Directors of Quality and Service/Patient Experience leads from Oxford University Hospitals Trust, Oxford Health Foundation Trust, Oxfordshire County Council, South Central Ambulance Service and the Oxfordshire Clinical Commissioning Group met with Healthwatch Oxfordshire to share information on the priorities for quality improvement for Oxfordshire. These priorities arise from review of the patient and service user feedback each of these organisations collects. The aim was to produce a single joint statement of quality improvement.

A set of statements have been agreed and these are set out below. Each of those partners has also agreed that the priorities identified in this statement will be reflected in their own Quality Accounts.

5.2 The statement

It was agreed by the organisations named above that the following should be the focus for quality improvement in Oxfordshire in 2015/16:

All services

- Joining up people's care when it is being delivered by a range of health and/or social care providers.
- Communication between different organisations within the system about patients.
- Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
- Carer involvement in care planning and care delivery.
- Better treatment of patients with physical and mental health needs, and recognising and addressing the psychological component of all healthcare.
- Continuing to build a culture in which staff, carers and patients feel able to raise concerns or complaints without fear of retribution.
- Supporting delivery of public education about how to use the NHS wisely and self-care programmes that might help reduce demand.

In addition to these quality improvements, the following issues have been agreed for organisations to work on:

- Oxford Health Foundation Trust will continue to work to make patient care safer through reducing harm through falls, patients going missing, aggression and violence and avoidable pressure ulcers and through the prevention of suicide.
- Oxford University Hospitals Trust will focus on providing high quality, individualised care, while meeting NHS Constitution pledges on A&E waiting times, cancer treatment times and 18 week referral to treatment targets.
- Oxfordshire County Council will work to improve the timeliness of social care assessments and access to care packages and re-ablement services.
- South Central Ambulance Service will improve ambulance rural response times.
- Oxfordshire Clinical Commissioning Group will work to address the issues of access to GPs and GP retention and recruitment.

Where relevant, the outcome measures used to monitor delivery of this strategy reflect these common priorities and the shared commitment to quality and dignity shared by all partners in the Board. This shared commitment will also be reflected in the meetings of the Health and Wellbeing Board and the work of the supporting partnerships, and in the review of annual patient experience and outcome measures collected by organisations across the health and social care system

6. The Bedrock of our Decision-making: Oxfordshire's Joint Strategic Needs Assessment

6.1 What is the Oxfordshire Joint Strategic Needs Assessment (JSNA)?

The Oxfordshire Joint Strategic Needs Assessment is a report that includes a huge wealth of information and intelligence from a number of different sources that cover the health and wellbeing of the population in its broadest terms. This information is shared between the NHS locally and Local Authorities and is available to the public. When added to local knowledge of services, it gives Oxfordshire a common and consistent evidence-base which allows us to pinpoint gaps and target improvements.

This analysis is the scientific bedrock on which this strategy rests. During 2014-15 the data collection was further improved and made more accessible on the Insight web pages. An annual summary report was accepted by the Board in March 2015 which provided a comprehensive overview of the county. It can be found here: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment-summary-report-2015

The JSNA highlights the following challenges which need to be met which are summarised in the following section:

6.2 What are the specific challenges?

1. **Demographic pressures** in the population, Oxfordshire's population is growing, and growing older. In mid-2013 the population was estimated to be 666,100, having risen by about 10% since 2001. There is an increasing number of older people, many of whom need care and may be isolated or lonely. This is markedly higher in our more **rural districts** than in the City.
2. The **proportion of older people** in the population also continues to increase which means that every pound spent from the public purse has further to go.
3. Oxfordshire remains the most rural county in the South East of England. Meanwhile, its population is becoming more diverse
4. There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
5. The persistence of small geographical areas of **social disadvantage containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns. These areas are also the most culturally diverse in the County **containing ethnic minority groups who have specific needs.**
6. The increase in **'unhealthy' lifestyles which leads to preventable disease**.
7. The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are prioritised.
8. **Increasing demand** for services.
9. The need to support **families and carers of all ages to care.**
10. The need to encourage and support **volunteering**.
11. An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (e.g. hospital beds, discharge arrangements, care at home and nursing home care).
12. The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.
13. The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.
14. The changing face and **roles of public sector organisations.**

6.3 What are the overarching themes required to meet these challenges?

A number of overarching themes required to improve health in Oxfordshire have been identified as follows –

- The need to shift services towards the prevention of ill health.
- The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.
- The need to give children a better start in life.
- The need to reduce unnecessary demand for services.
- To help people and communities help themselves.
- The need to make the patient's journey through all services smoother and more efficient.
- The need to improve the quality and safety of services.
- The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

These themes will be overseen by the Health and Wellbeing Board and will be tackled by all of the partnership boards and joint management groups.

6.4 What criteria have been followed in selecting priorities?

The priorities are based on the challenges and themes set out previously. We have also used the following criteria to help us focus our priorities:

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?

7. What are the priorities for Oxfordshire's Health and Wellbeing Strategy?

A summary of the priorities can be found in Annex 1

Each of the priorities set out in this strategy has associated outcomes to be achieved in the current year. The Board examines progress against all of these outcomes at each meeting. At the end of each year of operation the Board reviews successes, analyses on-going need as identified in the Joint Strategic Needs Assessment and proposes revised outcomes to be achieved in the year ahead.

The section below examines each priority in turn. Building on the original rationale for agreeing each, we have updated this strategy to illustrate why this issue is still a priority and the areas of focus going forward. In addition to this narrative the Board considers specific outcomes for each priority and consults the public and stakeholders on their proposals. The agreed outcomes for the year ahead become the performance framework and progress is reported at every Board meeting.

Priorities for Children's Trust

Priority 1: All children have a healthy start in life and stay healthy into adulthood

A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life. Where problems occur, we aim to provide the wide range of services that parents need to support them.

There is increasing evidence that demonstrates that outcomes across health, education and social care are determined from very early on in life. For this reason we will monitor areas that focus on a healthy pregnancy and progress up to the age of 2 years.

There are a number of indicators of which the Children's Trust will retain oversight but which will be monitored by the Health Improvement Board. These relate to breast feeding, smoking in pregnancy, childhood obesity, preventing disease through immunisation and controlling homelessness and numbers of households in temporary accommodation.

The number of children in Oxfordshire aged 4 and under has grown by 13% since the last census in 2001 whilst the Oxfordshire population as a whole has only increased by 8%. We know there is a year on year increase in the proportion of children and young people admitted to hospital in an emergency. The most common causes of emergency admission to hospital for young children (under 5) are respiratory tract infections, viral infections and gastroenteritis. We therefore need to continue to prioritise these children as a focus for our services in the community.

Young people tell us that there is much more we could do to improve the transition between young people's services and younger adults' services. This is particularly relevant to young people with mental health needs and we have already acted on this with a specific focus on looked after children. Young people also told us that they want more information and support around mental health issues and we made this a priority for the past year.

There is a strong focus on promoting wellbeing and developing resilience, particularly in children and young people. Suicide risk reduction work is already underway. There is an on-going public health campaign to promote mental health and wellbeing for all ages.

Our focus for 2015 is Mental Health and wellbeing and substance misuse, including the misuse of drugs, alcohol and tobacco.

Where are we now?

- Latest available figures (Q1 in 2014-15) show that 95.8% of pregnant women in Oxfordshire were seen by health professionals by week 13 of their pregnancy. This figure has exceeded the target of 92% and is only slightly below the national figure of 96.1%.
- There are a number of measures relating to a healthy start in life, such as rates of breastfeeding and reduction in percentage of women smoking during pregnancy, which are reported below under the Health Improvement Board's priorities. Breastfeeding rates remain above the national average. There has been a reduction in the percentage of women smoking during pregnancy although this remains a concern.
- We have continued to monitor hospital admissions for young people, and there continue to be small increases in the admission rate across a number of causes including asthma, epilepsy and respiratory infections. This is being seen across the country and is being addressed through the management of these conditions in Primary Care.

Outcomes for 2015-16

1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 8 weeks of referral by the end 2015/16

1.2 Support all secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.

Priority 2: <u>Narrowing the gap for our most disadvantaged and vulnerable groups</u>

Oxfordshire is overall a very 'healthy and wealthy' county but there are significant differences in outcomes across health, education and social care for some specific groups. We know that outcomes for children and families from vulnerable groups and disadvantaged communities can be worse than for their peers and is variable across the county.

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups starting in 'early years' has been seen as a key way of improving outcomes for children and families. Our focus will be on children and young people looked after by the Local Authority, young people leaving care, and Young Carers. We want everyone involved to have the highest aspirations for these children and young people, including the young people themselves.

There is a national focus on helping the most disadvantaged and challenged families to turn their lives around. The "Thriving Families" programme work with these families to reduce worklessness, antisocial behaviour, crime and school exclusions and to increase school attendance. The key focus is on our most resource intensive and vulnerable families with the aim of reducing the numbers needing the type of support offered by social care. This continues to be a vital strand in the on-going work locally to 'narrow the gap'.

There are attainment gaps for many vulnerable groups of pupils at all key stages. Persistent absence from school is a key factor impacting on educational attainment of the most vulnerable groups of children and young people. Persistent absence rates in secondary schools are higher than the national average. The attainment gap at all key stages of education and the number of school exclusions are greater for specific pupil groups, so there is a particular need to focus on specialist groups of vulnerable learners, in particular, children and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people 'looked after' by the County Council.

Where are we now?

- The number of eligible 2 year olds taking up free early education (2,112) has been much higher than the target of 1,800. This follows significant work by the Early Years workers and children's centres in promoting this funding. It is important to maintain the focus on this measure during times of change. Although it is not a target in this strategy for 2015/16 we will continue to monitor the take-up.
- 86% of 2 year old Looked After Children have taken up the free early education, this is above the target of 80%.
- During the academic year 2013/14, 15% of Children in Need (defined as those with a current Children in Need plan) in Oxfordshire were classed as persistently absent from school (i.e. missing 15% of sessions throughout the year). This is a reduction from the previous year when it was 19.8%. This rate remains higher than the national persistent absence rate for Children in Need, 13.8%. The overall persistent absence rate for all pupils in Oxfordshire in 2013/14 was 3.8%.
- All of the 810 families in Oxfordshire meeting the national Troubled Families criteria have been turned around, and families are now being identified for phase 2 of the national programme.
- At Key Stage 2 the gap in attainment between those with free school meals and their peers has widened to 23 percentage points in Oxfordshire, whereas nationally this has remained at 19 percentage points. The council has recently taken new steps to address this by providing overarching strategy and specific support for individual cases to ensure improved outcomes for this group of young people. This work is overseen and monitored on a continual basis by the Improvement and Development Manager for Vulnerable Learners and we expect to see improvement this year (2015/16)

Outcomes for 2015-16

2.1 Reducing inequalities as measured by Public Health measure (number 1.01i) - Children in poverty (all dependent children under 20) - such that the gap between the wards with most poverty and least poverty is reduced.

2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 50.

2.3 Reduce the level of care leavers not in employment, education or training from 50% (measured at 19th, 20th and 21st birthday of care leavers)

2.4 Increase the number of young carers identified and worked with by 20% from 1,825 at 1st April 2015 to 2,190.

2.5 Reduce the number of children with Special Educational Needs who are have at least one fixed term exclusion in the academic year from 5.1% in the academic year 2013/14.

2.6 Increase the proportion of children with a disability and are eligible for free school meals who are accessing short breaks services from 24% in 2014/15.

Priority 3: Keeping all children and young people safe

Keeping all children and young people safe is a key Oxfordshire priority. Children need to feel safe and secure if they are to reach their full potential in life. “If we don’t feel safe we can’t learn”.

Safeguarding is everyone’s business and many different agencies work together to achieve it. The aim is to make the child’s journey from needing help to receiving help as quick and easy as possible.

In Oxfordshire we have done a great deal of work together – County Council, Police, Health, District Councils and other organisations - to prevent child sexual exploitation and to protect and support its victims. This includes setting up the multi-agency dedicated Kingfisher team and increasing capacity by recruiting additional social workers. Nationally and locally there continues to be a growing awareness about young people who are victims of sexual exploitation. There is a need to place even greater emphasis on better recognition and prevention of such exploitation. In light of the findings of the Serious Care Review into Child Sexual Exploitation in Oxfordshire published in March 2015 we need to continue to focus on this important work in Oxfordshire and continue to work together as agencies to prevent this type of crime happening.

We know that going missing is a key indicator that a child might be in great danger and they are at very serious risk of physical and sexual abuse and sexual exploitation. Nationally 10,000 children are estimated to go missing from care in a year (UK Missing Persons Bureau 2012).

The safeguarding of children affected by domestic abuse is a core element of child protection. Domestic abuse affects children’s resilience, emotional wellbeing, educational attainment, behaviour and longer term life chances. Domestic abuse is a factor in a number of Safeguarding Children Board serious case reviews of child death or injury.

Quality assurance audits look at the quality of the casework that agencies deliver to reduce the risk of abuse and neglect of children and young people. In 2013/14 a baseline was established by working with independent auditors to grade the multi-agency audits. This year a new indicator has been introduced.

Keeping children safe is a key priority for all agencies.

Where are we now?

- By the end of 2014 every child considered likely to be at risk of Child Sexual Exploitation had a multi-agency plan in place.
- At the end of 2014-15 19% of children who went missing from home within a 12 month period had been reported missing more than 3 times. Work is on-going to reduce this.

Outcomes for 2015 -16

3.1 Set a baseline for and then increase the amount of times the Independent Chair is satisfied that the core group minutes show that the objectives of the CP Plan are being progressed by the Core Group

3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in child protection plans

For Neglect cases only :

3.3 Establish a benchmark and then Increase the proportion of neglect cases where the neglect tool is used

3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (Public Health measure number 2.07ii) (baseline to be reported).

3.5 More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying through increased membership of Anti-Bullying Ambassador scheme, individual support from Anti-Bullying Co-ordinator and provision of training.

In addition, the Children's Trust will maintain oversight of measures used by the Oxfordshire Safeguarding Children's Board and Oxfordshire Safer Communities Partnership measures in relation to:

Domestic abuse

Child Sexual Exploitation

Female Genital Mutilation

4 The development of the Multi-Agency Safeguarding Hub

Priority 4: Raising achievement for all children and young people

The Health and Wellbeing Board aspires to see every child being successful and reaching their potential, thriving in an outstanding learning environment throughout their education, wherever they live across the county, and to see the gap reduced between the lowest and the highest achievers. We aim for every single school to be rated at least as 'good' and to be moving towards 'outstanding'.

Early Years and primary school results are better than the national average and this can be built upon. There have been some signs of improvement in some subject areas at Key Stage 4 and we need to continue to improve with a particular focus on building on the achievements of specific groups. We know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special education needs.

There have been improvements in inspection outcomes and significant improvements in the performance of some schools though Oxfordshire has a greater proportion of schools judged by Ofsted as requiring improvement. Overall, the picture shows gradual improvement but there is inconsistency across Oxfordshire and for certain groups of children.

Where are we now?

- At the end of March only 3.6% of young people were not in education, employment or training (NEET), below the ambitious target of 5%. However, the proportion of NEETs is not evenly spread throughout the county with low numbers in the South East Oxfordshire Hub area and higher numbers in Littlemore and Banbury Hub areas.
- The proportion of young people for whom their NEET status is not known only narrowly missed the target of 5% and represents a much lower proportion than at March 2014 when it was 11%.
- The target for the proportion of pupils attending good or outstanding schools has been exceeded in secondary schools, but narrowly missed in primary schools.
- There has been increase in the number of funded 2- 4 year olds attending good and outstanding early years settings and it is now at 87.8%. However, Oxford City falls below the target of 85% and the Vale of White Horse significantly exceeds the expected number.
- 77% pupils in Oxfordshire made expected progress in Key Stage 2 reading, writing and maths – not quite reaching the target of 80%

Outcomes for 2015-16

4.1 Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2015

a) Key Stage 2: 16% points
b) Key Stage 4: 26 % points

Our performance this year (reported under priority 2, Narrowing the Gap) showed a much wider gap - 23% at Key Stage 2 and 34% at Key Stage 4. This is being addressed by providing overarching strategy and specific support for individual children and schools to ensure improved outcomes for this group of young people. This work is overseen and monitored on a continual basis by the Improvement and Development

Manager for Vulnerable Learners and we expect to see improvement this year (2015/16)

4.2 Ensure that the proportion of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan will be in line with the national average

4.3 62% of children in early years & foundation stage will reach a good level of development

There are also areas of focus within the Oxfordshire Skills Board of which the Children's Trust will retain oversight:

- Creating seamless services to support young people through their learning –from school and into training, further education, employment or business.
- Up-skilling and improving the chances of young people marginalised or disadvantaged from work.
- Increasing the number of apprenticeship opportunities.

B. Priorities for Joint Management Groups

Priority 5: Working together to improve quality and value for money in the Health and Social Care System

Integrating the health and social care systems has been a goal of public policy for the past 40 years. The successful integration of health and social care offers important benefits, for example

- Improved access to, experience of, and satisfaction with, health and social care services that place people at the centre of support
- Development of different ways of working, including new roles for workers who work across health and social care
- Ensuring that all health and social care providers deliver high quality safe services so that those receiving their services are treated with dignity and respect
- Ensuring people receive the right quality care, in the right place at the right time and achieve more efficient use of existing resources and a reduction in the demand on expensive health and social care services.

The integration of services has progressed in Oxfordshire over the last year with the agreement of the Better Care Find Plan for Oxfordshire, introduction of a joint single point of access to health and social care community services for health and social care staff. The development of integrated health and social care services in GP localities is underway and a joint vision and plan across health and social care organisations is forming as we work together more.

The County Council and Oxfordshire Clinical Commissioning Group are committed to working together to raise the quality and improve the value of health and social care services for both service users and for carers. This is what the people of Oxfordshire have said they want. Integrating health and social care is a priority because it gives us the chance to improve services, make better use of resources and meet the stated desires of the public.

Where are we now?

- Progress is being made in the integration of services, with a number of further initiatives and plans underway to improve outcomes and make services more accessible for people.
- Patient Outcome measures show high levels of satisfaction with care and support received from social care, hospital care and GP surgeries.
- Over 16,000 carers are now known and supported by adult social care which is an increase of almost 1,000 over last year
- 1027 carers received Carer Breaks accessed through their GP and jointly funded. This does not represent all the ways a carer may have accessed funding or help with arranging a break. Carers breaks jointly funded and accessed via GPs increased through the year and have now been replaced with meeting assessed support needs in line with the Care Act.

Outcomes for 2015-16

These outcomes link to the Quality Statements agreed with commissioners, partners and Healthwatch outlined earlier in this document, namely joining up people's care when it is being delivered by a range of health and/or social care providers, improving communication between different organisations and with people and their carers, and involving carers in care planning and delivery. There is also a measure to reflect the commitment to continuing to build a culture in which staff, carers and patients feel able to raise concerns or complaints without fear of retribution.

5.1 Deliver the 6 Better Care Fund national requirements for closer working of health and social care

1. Are the plans still jointly agreed?
2. Are Social Care Services (not spending) being protected?
3. Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?
4. In respect of data sharing:

   Is the NHS Number being used as the primary identifier for health and care services?

   Are you pursuing open Application Programming Interfaces (i.e. systems that speak to each other)?

   Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?
5. Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?
6. Is an agreement on the consequential impact of changes in the acute sector in place?

5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14

5.3 Increase the number of carers known to social care from 16,265 (March 2015) to 17,000 by March 2016

5.4 Increase the number of carers receiving a social care assessment from 6,042 in 2014/15 to 7,000 in 2015/16

5.5 Increase the number of carers receiving a service from 2,226 in 2014/15 to 2,450 in 2015/16

5.6 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95% based on an average from the first three quarters of 2014/15 which is 91.3%

5.7 Increase the percentage of people waiting less than 18 weeks for treatment following a referral:

Admitted patients target 90%
Non-admitted patients target 95%
Of patients who do not complete the pathway target 92%

5.8 Monitor complaints and compliments people raise about health and social care with the Clinical Commissioning Group and the County Council. Set a target to increase next year as a measure of transparency and openness to learning

Priority 6: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential

Adults living with a physical disability, learning disability, severe mental illness or another long term condition consistently tell us that they want to be independent and to have choice and control so they are able to live "ordinary lives" as fully participating members of the wider community. This priority aims to support the increasing number of adults with long term conditions to meet their full potential.

Both nationally and locally, people tell us that living ordinary lives means:

- Having improved access to information that supports choice and control
- Having improved access to housing and support
- Having improved access to employment, study, meaningful activity and involvement in the community and wider public life
- Having access to responsive, coherent services that help people manage their own care
- Having improved support for carers, to help them to help the people they care for to live as independently as possible

We will continue to monitor how easy people find it to access information and the quality of support offered to people with a long term condition. We recognise the importance of supporting people with mental health needs to find and stay in employment, and will develop a measure during this year that will help demonstrate how effectively we are in doing this.

Access to good health care is an area for improvement in Oxfordshire for people with learning disabilities and for people with mental health needs. The physical health check target we set, of at least 60% for adults with learning disabilities, will continue to be a target for 2015/16. Partners recognise that the system needs to provide better treatment of patients

with physical and mental health needs, and to improve how it recognises and addresses the psychological component of all healthcare. This is reflected in the measures below which address access to treatment for mental health problems and access to psychological therapies

Where are we now?

- Over 25,000 people had information and advice about areas of support through the Community Information Networks, against a target for the contract year of 6800.
- More people moved to recovery having completed psychological therapies with at least two treatment contacts (61% against a target of 50%)
- People with Learning Disabilities still do not have good enough access to physical health checks. We have kept the target for next year and are working on developing a 'Reasonable Adjustments' team to make sure people have the access to health care they need and are treated fairly. We do not have data from all practices yet, but many practices update their health checks in Q4 and we anticipate a substantial increase when that data is available. All OCCG practices have signed up to the scheme for 2015-16.
- Emergency hospital admissions for acute conditions have reduced, although are still more than the target of 951.4 per 100,000 population at 964.6. Nationally the figure is higher.
- There have been fewer unplanned admissions for chronic conditions which can be actively managed (such as diabetes and asthma). The target was 565.4 per 100,000 population and the actual figure was better at 536.4.

Outcomes for 2015-16

6.1 20,000 people to receive information and advice about areas of support as part of community information networks

6.2 15% of patients with common mental health disorders, primarily anxiety and depression will access treatment

6.3 Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery

6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP

6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)

6.6 Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14

6.7 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 8 in 2015/16 from 20 in 2014/15

6.8 Reduce the length of stay of hospital episodes for adults with a learning disability so that by March 2016 no one has been in a NHS Assessment & Treatment Unit for more than 2 years. It is acknowledged that 2 years remains an unacceptable length of stay and are working to develop a new approach which will improve the pathway.

Priority 7: Support older people to live independently with dignity whilst reducing the need for care and support

We know that living at home with dignity is key to the quality of life that older people want to enjoy and that older people and their carers require access to good quality information and advice.

In Oxfordshire we know that the proportion of older people in the population continues to increase and that the number of referrals for support is also increasing along with the cost of caring for older people which increases markedly with age. This is true for both health and social care.

Oxfordshire has one of the highest levels of delayed transfers of care from hospital in the country. All organisations continue to be committed to working together to improve the situation. One of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently and to prevent ill health. These services are called "reablement services". We are committed to offer these to more people.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this we are focusing together on better use of reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated community services; improved diagnosis of people with dementia; providing additional extra-care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We have also continue to set a challenging target for reducing the number of people admitted to a care home, because this is the ultimate test of whether these alternative services and options are working.

Loneliness and social isolation are increasingly acknowledged as root causes of poor health and wellbeing and we know they influence people's choices about staying at home. More local information is needed to identify the key issues in this area for Oxfordshire.

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. In Oxfordshire we have increased our ambition for 2015/16 to 67% of the expected population having a diagnosis.

Where are we now?

- Delayed transfers of care remain a priority issue for organisations involved in health and social care across Oxfordshire.
- The rate of permanent admissions to care homes has dropped, though the overall number exceeded the target set for the year. The target was 546 for the year, and the actual figure was 598.
- The proportion of older people (65 and over) with on-going care supported to live at home has increased and is now 62.7% against a target set for the year of 61.9%.
- A new national tool has been introduced for estimating the number of people with dementia and this has increased the estimate for Oxfordshire. A number of initiatives have been put in place to increase the number of diagnoses made. The percentage of the expected population with dementia with a recorded diagnosis has increased
- There have been increasing numbers of people starting reablement each month but

the total remained below the target for the year. This issue remains and particularly reflects low referral rates from community settings.
- High numbers of people reported that they had been treated with dignity and respect and were involved in planning their care at home - 96%, higher than the target 95%
- The growth in supply of Extra Care Housing continues - slightly below the target of 768 at 714 units. However, we are on track to deliver more units in 2015/16
- Service users report high levels of satisfaction with access to information and that they receive support and care in a timely way
-

Outcomes for 2015 - 16

7.1 Reduce the number of people delayed in hospital from an average of 145 per day in 2014/15.to an average of 96 for 2015/16

7.2 Reduce the number of older people placed in a care home from 11.5 per week in 2014/15 to 10.5 per week for 2015/16

7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016

7.4 Over 67% of the expected population (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline 59.5% or 4948 people)

7.5 Increase the number of people accessing the reablement pathway including
- Increasing the number of people accessing the reablement pathway from a hospital pathway to at least the national average. The national average will be published in October 2015.
- Increasing the number of people accessing reablement from the community. Our target for the year is 1875.

7.6 Reduce the proportion of people who do not complete their reablement episode from 20.3% in 2014/15 to 17% in 2015/16

7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC and take appropriate action where required.

7.8 Increase the number of people supported through home care by social care in extra care housing by 10% (from 114 to 125)

7.9 Increase the proportion of people on the end of life pathway who die in their preferred place.

C. Priorities for Health Improvement

Priority 8: Preventing early death and improving quality of life in later years

This priority aims to add years to life and life to years – something we all aspire to.
The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening.

A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men and those in more deprived areas likely to die sooner and be ill or disabled for longer before death. The gap is slowly being closed as life expectancy for men is increasing, but there is still an inequality both by gender and across the social gradient.

Promoting healthy lifestyles and access to screening programmes is a cost effective way of reducing the risk of chronic disease and premature death

The following priorities for action will continue to be the priorities in the year ahead:

- To reduce levels of smoking in the county by encouraging more people to quit as smoking remains a major cause of heart disease and cancer.
- To boost our cancer screening programmes so that more people are protected, focusing on the bowel cancer screening programme.
- To promote the 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, exercise, smoking, blood cholesterol levels ,diabetes, blood pressure and alcohol consumption.
- Reducing the harm caused by the over-consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Alcohol and Drugs Partnership and progress will be monitored by the Health Improvement Board.
- To continue to monitor measures of success for those in drugs or alcohol treatment services with the aim of improving recovery rates.

In addition to this, our work must be even more focused on those who are most at risk. The Joint Strategic Needs Assessment shows that there are differences between different groups of people and different places in the County, with some faring better than others both in terms of their life expectancy and in their chances of living healthy lives into old age. Outcomes will be set to target the groups with worst outcomes as well as the overall average and reports will continue to show the groups or localities with the best and worst outcomes wherever such reporting is possible.

A programme of public awareness campaigns will support this work by raising awareness of prevention and early intervention services.

Where are we now?

- Bowel screening kits are being sent out to 60-74 year olds and there are plans in place to improve uptake, but a large proportion of the target group are still not returning them for analysis and the aspiration for 60% uptake has not been achieved.
- Uptake of invitations to attend NHS Health Checks has improved quite markedly during the year but still did not meet the aspirational target of 66%.
- Smoking quit rates in the county failed to meet the target in the last year.

Reports of quit rates in pregnancy have been received but there is still concern that some women are continuing to smoke.

- The Health Improvement Board has been monitoring the rates of successful completion of alcohol and drugs treatment in the last year. There have been some improvements and the Recovery Plan is making a difference, but Oxfordshire still lags behind national averages.

Outcomes for 2015-16

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years). ***Responsible Organisation: NHS England***

8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, 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 55% with all aspiring to 66%.(baseline 53% 2014-15) ***Responsible Organisation: Oxfordshire County Council***

8.4 At least 3650 people will quit smoking for at least 4 weeks (achievement in 2014-15 to be reported). ***Responsible Organisation: Oxfordshire County Council***

8.5 The number of women smoking in pregnancy should decrease to below 8% recorded at time of delivery (baseline 2014-15 8.1%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***

8.6 The 2015-16 target for opiate users should be at least 7.6% successfully leaving treatment (baseline 7.8%) ***Responsible Organisation: Oxfordshire County Council***

8.7 The 2014-15 target for non-opiate users should be set at 39% successfully leaving treatment (baseline 37.8%). ***Responsible Organisation: Oxfordshire County Council***

Priority 9: <u>Preventing chronic disease through tackling obesity</u>

After smoking, obesity is the biggest underlying cause of ill health. It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be.

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.
- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates,

but show over 15% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

To tackle obesity we propose to keep our focus in the following areas:

Promoting breastfeeding
Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. Increasing the number of breastfed babies is still the foundation of an obesity strategy for the County. The national figure for breastfeeding prevalence at 6-8 weeks is 47% but in Oxfordshire we want to keep the stretching target of 63% and will only achieve this if we focus on the areas where rates are low.

Halting the increase in childhood obesity
Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and over 16% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity, so some targeting of effort is called for here too.

Promoting physical activity in adults
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire still doing well according to the 'Active People' survey. However, the survey showed that 23% of the population are inactive – not even attaining 30 minutes of physical activity a week. Regular participation in physical activity will have an impact on mental wellbeing and be critical to good health in the county. For the years ahead we will be encouraging those who are inactive to start to move more.

Where are we now?

- There was an increase in obesity rates for children in year 6 and it has reached above 16% across the county. There are some variations in different parts of the county with the latest figures showing the highest rates in the City at 19%.
- 62% of adults do at least 150 minutes of physical activity a week but over 23% of our population do less than half an hour a week. The target for reducing the number of inactive people has not been met
- The overall rate for breastfeeding at 6-8 weeks is still higher than the national average and has been maintained at about 60% but the aspirational target of 63% has not been met.

Outcomes for 2015-16
9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2014 this was 16.9%) No district population should record more than 19% ***Data provided by Oxfordshire County Council***

9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey). ***Responsible Organisation: District Councils through Oxfordshire Sports Partnership***

9.3 63% of babies are breastfed at 6-8 weeks of age (currently 59.7%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

Priority 10: <u>Tackling the broader determinants of health through better housing and preventing homelessness</u>

Housing and health are intimately connected and inextricably linked. Having a home, living in good housing conditions and in a good neighbourhood with the right kind of support, are vital ingredients to health and well-being.

There are several ways in which housing issues impact on health, including the following:

- 'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses
- Homeless people die earlier and suffer worse health than people with a stable home. The threat and experience of homelessness also has an impact on mental wellbeing.
- Safe, secure housing contributes to improving health outcomes. Some vulnerable people need support to maintain their tenancies and live ordinary lives as fully participating members of the wider community. This is an essential ingredient for preventing ill health and homelessness.

These housing issues all have to be tackled in partnership.

Surveillance and sharing of good practice over the last few years through the Health Improvement Board has already seen a higher profile for this area of work. Concerns remain including

- Changes to the welfare benefit system have potential to put more households at risk of homelessness
- New ways of working to provide Housing Related Support will need time to develop
- Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established.
- Fuel Poverty work is not funded sustainably.
- Young people, especially those who have been Looked After, may need support to find and remain in appropriate housing.

Where are we now?

- District councils have reported similar success rates as last year in preventing homelessness and have taken positive action to prevent a higher number of households from becoming homeless. This reflects more activity as changes in the welfare system have been introduced.
- The number of households in temporary accommodation has remained at similar levels to last year with 192 households reported (197 last year).
- A large proportion of people who had received housing related support services

were able to leave the services and live independently. A review of the impact of changes in the levels of support available will be carried out in the year ahead.
- High numbers of contacts were reported by the Affordable Warmth Network who have disseminated information but there is little evidence of whether this has been translated into improved energy efficiency of homes
- The number of people estimated to be sleeping rough in the county has remained high.

Outcomes for 2015-16

10.1 The number of households in temporary accommodation on 31 March 2016 should be no greater than the level reported in March 2015 (baseline192 households in Oxfordshire in 2014-15) ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 2014-15). ***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 83% in 2014-15 there were 2454 households known to services). This can now be reported 6 monthly. ***Responsible Organisation: District Councils***

10.4 More than 700 households in Oxfordshire will receive information or services to enable 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. ***Responsible Organisation: Affordable Warmth Network.***

10.5 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2013-14 (baseline 70) ***Responsible Organisation: District Councils***

10.6 A measure will be included in the performance framework to monitor the success of supporting vulnerable young people in appropriate housing (Measure to be discussed at the Health Improvement Board in July 2015) ***Responsible organisation: Oxfordshire County Council***

Priority 11: **Preventing infectious disease through immunisation**

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve but it is imperative that this is maintained. Constant vigilance is needed to make sure that individual children have access to immunisation. This means working closely with GPs, community nurses and individual families.

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services sits with NHS England. High levels of coverage need to be maintained in order to continue to achieve the goal of protection for the population.

New immunisations were introduced in 2013-14. From July 2013, a rotavirus vaccination was offered at 2 months and at 3 months, flu immunisation is being given to children, (starting with 2-3 year olds and adding more ages each year), and Shingles vaccinations are offered to people aged 70 and 79.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met and there are signs that our high rates have begun to slip a little. The leadership for these services has changed profoundly during the last two years and maintaining our current position will be a real challenge.

We are proposing priorities for improving immunisation levels across the board, focussing on childhood immunisation, immunisation of teenage girls to protect against cervical cancer and flu vaccinations in the elderly and vulnerable.

Where are we now?

- High coverage rates for most childhood immunisations were achieved across the county. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target, though parts some districts remained below 94%.
- Rates of flu immunisations for people aged under 65 who are at risk of illness did not meet targets last year. It remains important to keep these indicators under surveillance and for the Public Health Protection Forum to ensure that good performance in Oxfordshire is continued.

Outcomes for 2015-16

11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 92.5%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 – At least 60% of people aged under 65 in “risk groups” receive flu vaccination (baseline from 2014-15 to be confirmed) ***Responsible Organisation: NHS England***

11.4 At least 90% of young women to receive both doses of HPV vaccination. ***Responsible Organisation: NHS England***

Annex 1: Summary of Priorities for the Oxfordshire Health and Wellbeing Strategy

Children's Trust

Priority 1: All children have a healthy start in life and stay healthy into adulthood
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups
Priority 3: Keeping all children and young people safe
Priority 4: Raising achievement for all children and young people

Joint Management Groups (for Older People, Mental Health etc)

Priority 5: Working together to improve quality and value for money in the Health and Social Care System

Priority 6: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems lving independently and achieving their full potential

Priority 7: Support older people to live independently with dignity whilst reducing the need for care and support

Health Improvement

Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

Annex 2: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment.
Child Poverty	Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income.
Child Protection Plan	The plan details how a child will be protected and their health and development promoted.
Commissioning	The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Delayed Transfer of Care	The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed.
Director of Public Health Annual Report	http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx
Extra Care Housing	A self-contained housing option for older people that has care support on site 24 hours a day.
Fuel Poverty	Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth.
Healthwatch Oxfordshire	Healthwatch is the independent 'Consumer Champion' for health and social care for people of all ages
Joint Health and Wellbeing Strategy	The strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	A tool to identify the health and wellbeing needs and inequalities of the local population to create a shared evidence base for planning.
Not in Education, Employment or Training (NEET)	Young people aged 16 to 18 who are not in education, employment or training are referred to as NEETs.

Oxfordshire Clinical Commissioning Group	The Oxfordshire Clinical Commissioning Group is the new organisation in Oxfordshire that has the responsibility to plan and buy (commission) health care services for the people in the County. It is currently in shadow form until it takes over from Oxfordshire Primary Care Trust in April 2013.
Oxfordshire's Safeguarding Children Board	Representatives from the main statutory agencies who ensure there are suitable robust arrangements for protecting children in Oxfordshire.
Pooled budget	A mechanism by which the partners to the agreement bring money to form a discrete 'fund'. The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group.
Quality Assurance Audit	A process that helps to ensure an organisation's systems are in place and are being followed.
Reablement	A service for people to learn or relearn the skills necessary for daily living.
Secondary Mental Health Service	Services for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services.
Section 75 agreement	An agreement made under section 75 of National Health Services Act 2006 between a local authority and PCT(s), NHS trusts or NHS foundation trusts. This can include arrangements for pooling resources and delegating certain functions to the other partners if it would lead to an improvement in the way those functions are exercised.
Thriving Families Programme	A national programme which aims to turn around the lives of 'Troubled' families by 2015.
Transition	This is the process through which a person with special needs transfers from children's services to adult's services.

Oxfordshire
Clinical Commissioning Group

Prime Ministers Challenge Fund (PMCF) Briefing

Background

In September 2014, the Prime Minister announced a second wave of funding of £100m for a Challenge Fund for 15/16 to help improve access to general practice and stimulate innovative ways of providing primary care services.

There was a pan-Oxfordshire submission by the three GP Federations covering the County's population. It comprised three complementary sets of interventions to address a patchwork of local need. The aim of the schemes is to enhance patient access to Primary Care (physically and digitally), increase focus on patients with complex needs, and support patients to manage their own care better. At the end of March 2015 it was announced that Oxfordshire Federations were successful in securing funding to £4.9M

A summary of the schemes approved can be found in the table below. Further information on the schemes can be found in Appendix A.

Category	**Initiative**	**GP Federation**		
	Percentage of total Oxfordshire population covered by Federation	PML	OxFed	Abingdon
		65%	30%	5%
Improved access	Neighbourhood Same-day Care Hubs	✓		
	Early Visiting & Home Support Teams	✓	✓	
	Tele-health & E-Consultations	✓		✓
Enhanced Complex Care	Care Navigators		✓	✓
	Enhanced OOH Access		✓	
	20-minute GP appointments	✓		
Empowered Patients	Online Health Resource	✓	✓	✓
	Total funding	£2,608,633	£892,207	£419,946
	Evaluation & programme management support for federations	£608,500		
	Capital funding	£390,000		
	TOTAL	**£4,919,286**		

Commissioning / Contracting for PMCF pilots

The CCG recognise that it is strategically important to invest in primary care and to develop commissioning arrangements with its federations. Co-commissioning is one of a series of changes set out in the NHS Five Year Forward view and is the first step in CCGs having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. The CCG consider holding the contracts for the PMCF pilots to be important in establishing the sustainability of access to primary care through different initiatives. Such initiatives also support the Better Care Fund.

An agreement has been reached with NHS England for OCCG to have delegated authority to contract for the PMCF schemes with the GP Federations, working within the framework permitted through the co-commissioning agenda in line with section 13Z of the NHS Act.

Governance

The CCG has set up a PMCF Commissioning Board to oversee and provide scrutiny of the CCG process as well as overseeing the delivery of the projects by the Federations. It will be responsible for assuring successful mobilisation and monitoring ongoing performance. Membership of this board includes OCCG Director of Finance, OCCG Director of Delivery and Localities, CCG GP Lead for Primary care as well as a representative from Local Authority and NHS England.

The CCG is in communication with the Federations every two weeks with more formal monthly meetings to ensure delivery. High level milestones have been agreed with them against which they are being monitored prior to release of funding.

Mobilisation of Services

As at 28 June 2015, two of the schemes have started: an early visiting service in the north of Oxfordshire and e-consultations provided by two practices in Abingdon (commenced 19 June). In the first three weeks of operation the early visiting service has seen 120 patients. Roll out of the early visiting schemes to Bicester is planned for the beginning of July and then to Witney and Wantage by early August. The neighbourhood same day care hubs and enhanced out of hours service and skype consultations are due to commence in September. OxFed are working closely with Age UK's Circles of Support to recruit and train practice care navigators with the view that the first of these will be in post in August. Abingdon Health Federation has commissioned a new local online health resource which is in the process of being designed and developed with the help of patients for launch in August. It should be noted that all schemes are subject to a 7 week delay as the federations were informed about the award of funding on 27 March rather than mid-February.

A county wide newsletter has been produced to brief patients, other providers, and third sector agencies about PMCF (see Appendix B). OCCG communications leads are liaising closely with federation communication leads to coordinate subsequent publicity as schemes begin operation.

Evaluation

OCCG has commissioned Oxford University's Centre for Evidence Based Medicine to undertake a detailed evaluation of all the projects. The evaluation has been scoped and following input

from the federations, patients and OCCG has been finalised. The evaluation will consider the impact of the schemes in terms of:

- Increased access to primary care
- Patient satisfaction
- Impact on A&E attendance
- Impact on non-elective admissions
- Impact on referrals to social care and community health services
- Impact on the sustainability of primary care

It will inform the CCG's business case to secure funding to continue/adapt the initiatives into 16/17.

The Health & Wellbeing Board is asked to

1) Note the progress in mobilisation
2) Note plans to evaluate the impact of the schemes

Rosie Rowe
29/6/15

Appendix A – Summary of interventions as presented in the bid

The Interventions:

1. Improved Access

   Introduce Neighbourhood Hubs providing same day access and extended 8-8 working, delivered by GP-led Multi-disciplinary Teams (MDTs). Patients will be triaged into this service if their own practice is unable to offer them a same-day appointment for urgent assessment. *Evidence* - 77% of respondents said they would like access to weekend and evening appointments (*Healthwatch-Oct '14*). 19% regularly experienced unsatisfactory waiting times (*OCCG-'14*). Outputs - 27,500 additional appointments by the end of the first year.

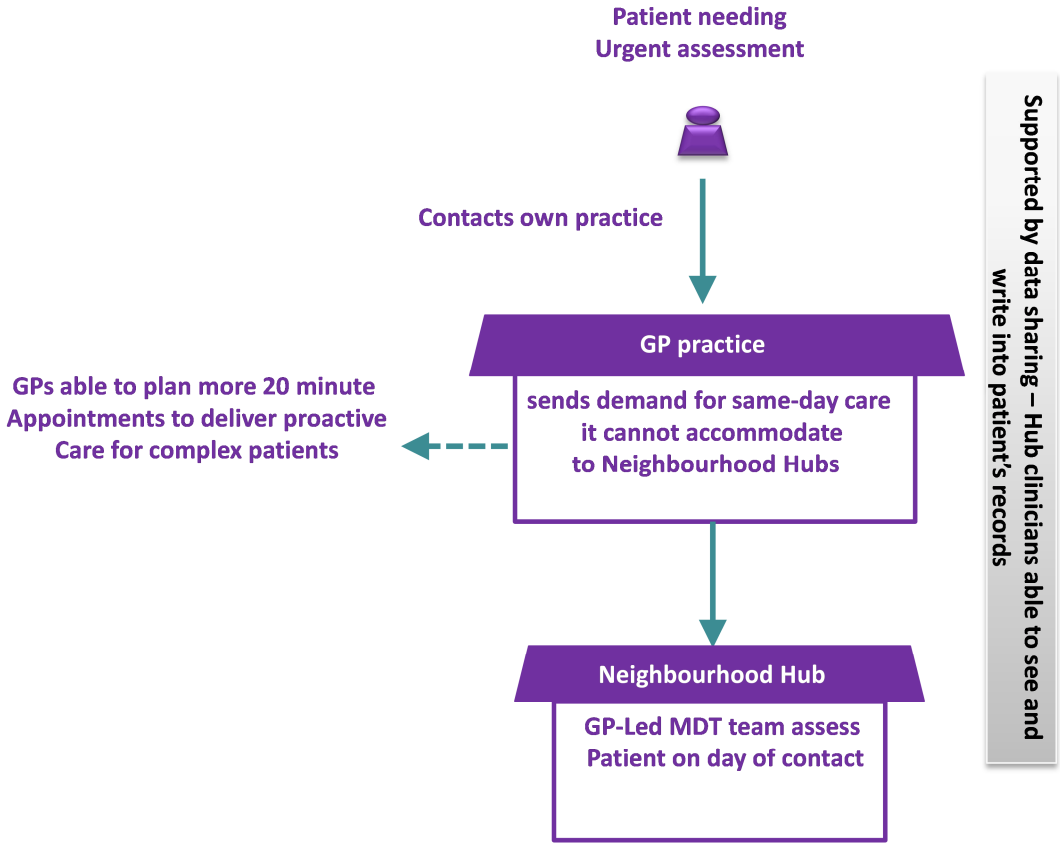


Figure 2 – Neighbourhood Hubs in Practice

- Introduce Early Visiting and Home Support Team provided by ECP/ANP* teams supporting GPs to respond to some urgent visit requests early in the day, releasing GP time for more complex patients. Output -21,500 per year delivered by 16 ECP/ANPs county –wide each conducting six visits daily.

* Emergency Care Practitioner/Advanced Nurse Practitioner

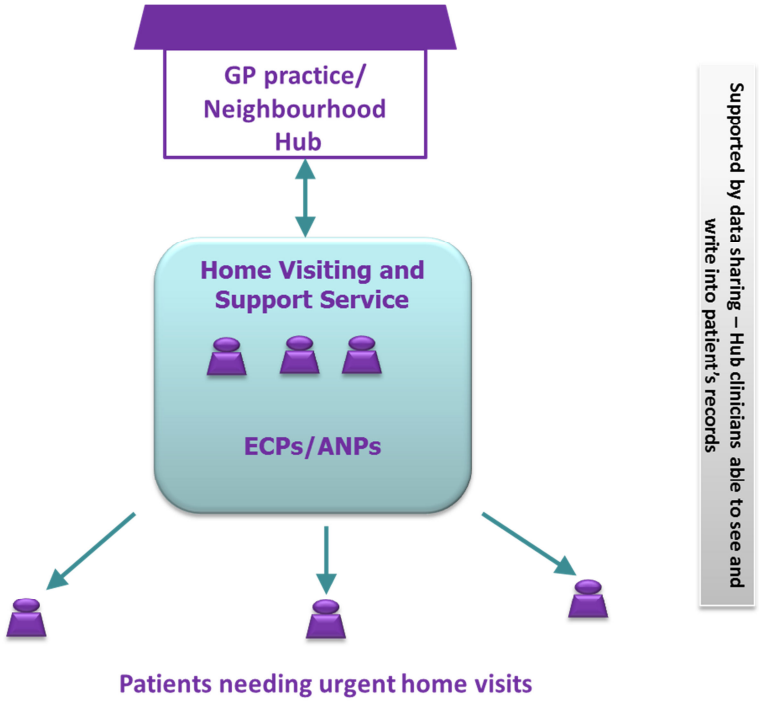


Figure 3: Home Visiting and Support Services in Practice

- Introducing 'Tele health' consultations providing enhanced GP support to other healthcare professionals in care homes and Emergency Medical Units.

- Piloting E' consulting outside core hours with pre-bookable email appointments with a 2 hour response target for urgent queries to identify demand and satisfaction levels for alternative access. Evidence-18% of respondents were dissatisfied with the time taken to answer calls expressing interest in alternative methods (*Healthwatch-Oct '14*). Output – 344 email consultations per week or 17,000/year.

2. Enhanced Complex Care
   - Introduce Care Navigators dedicated to tracking, implementing and supporting care for 2% of most complex patients on practice registers, liaising directly with GPs, patients, families and carers, within practices and in patients' homes. Evidence effective co-ordination support enables GPs to provide more proactive, preventive care, uncompromised by time constraints. Output Five Care Navigators covering 35% of the county population, with particular focus on Oxford City. Assume each Navigator will undertake 20 face to face patient meetings per week, collectively almost 5,000 per year.

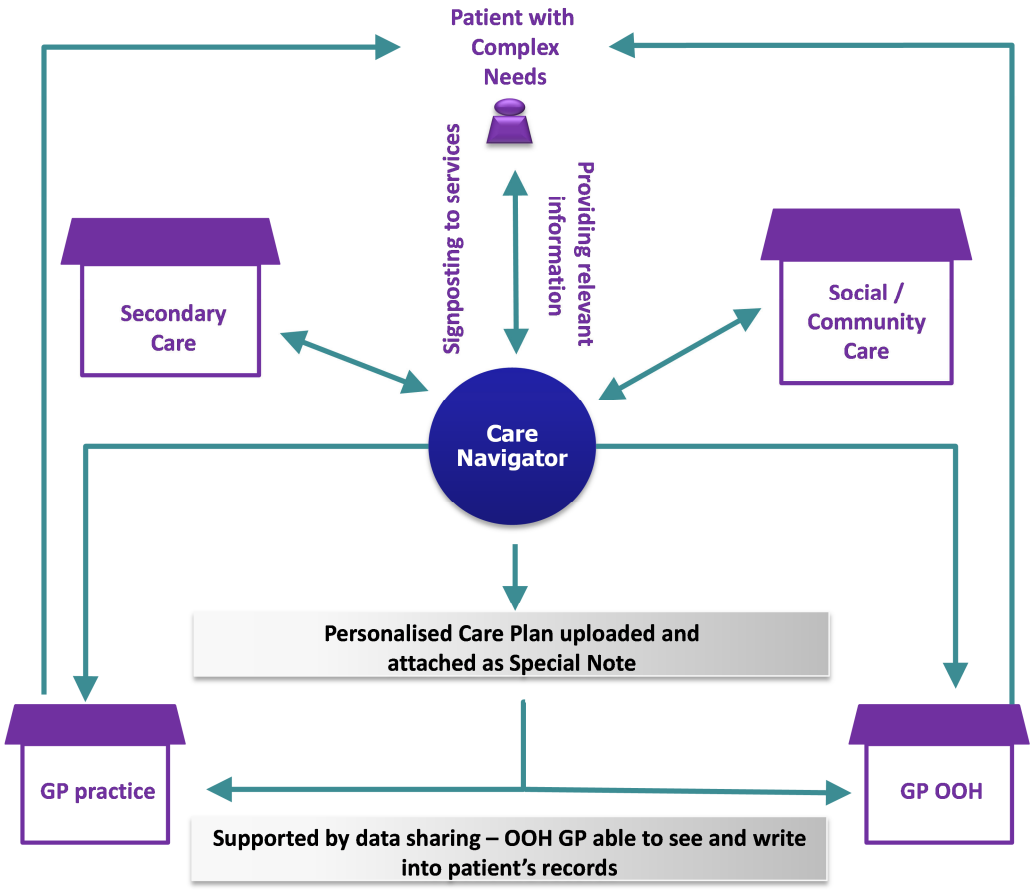


Figure 4: Overview of Care Navigator Approach

- Enhanced OOH Care Access, 24 hours a day, 7 days a week giving OOH GPs access to full patient records for the 2% most complex patients (with prior consent) enabling them to add directly to records, improving patient continuity and integration of in- and out-of-hours care.

- Attaching Personalised Care Plans (PCPs) flagged by a Special Note to records of those 2% ensuring the PCP is always viewable by OOH GPs (beyond existing DES requirements), improving continuity of care and patient safety.

3. Introduce 20min appointments for the most complex patients focusing on preventative care and building their health resilience. absorbing some of the demand for same-day assessment through Neighbourhood Hubs

4. Empowered Patients and Carers

- General Practice Interactive online health resource available via practice/federation websites, providing comprehensive locally-tailored information, promoting self-management and health resilience among people with long-term conditions, support carers, improving patient health literacy.

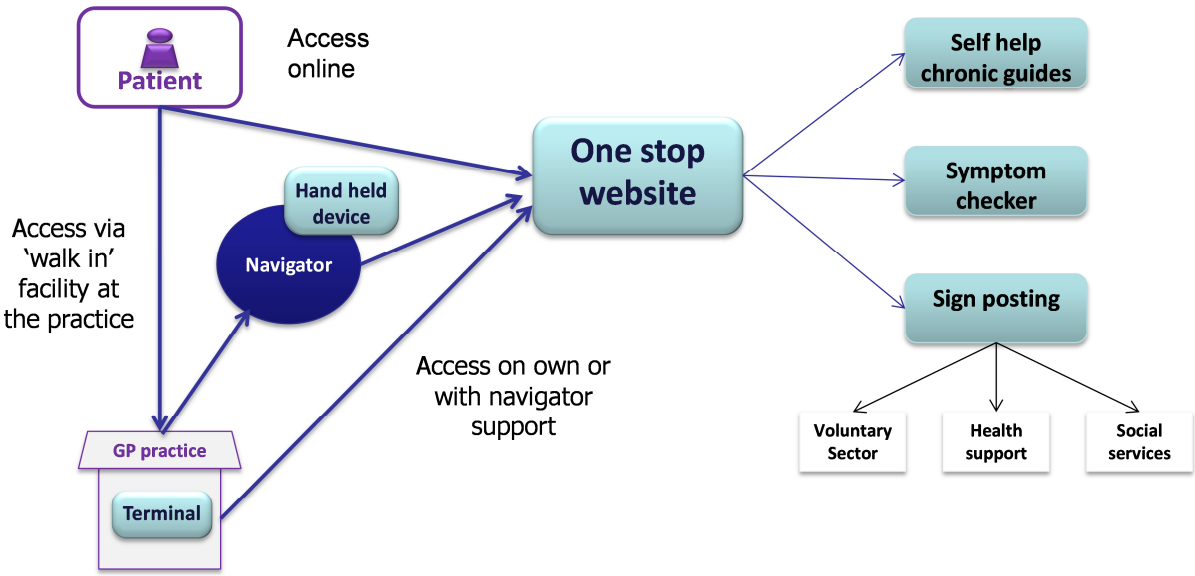


Figure 5: Overview of Online Health Site

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ISSUE 1

Oxfordshire GP pilot scheme
Prime Minister's Challenge Fund News

NHS Oxfordshire Clinical Commissioning Group

Stay up to speed on pilot schemes

This is the first of a series of regular newsletters to let you know how the GP pilot schemes are progressing. Information will also be posted on the OCCG website www.oxfordshireccg.nhs.uk

If you have further questions, please contact Rosie Rowe, Head of Provider Development (Out of Hospital), Oxfordshire Clinical Commissioning Group. rosie.rowe@oxfordshireccg.nhs.uk

GP FEDERATION CONTACTS

North, North East, West and South West Oxfordshire
NoxMed, OneMed, ValeMed and WestMed, supported by Prinicpal Medical Limited – Helen Robins, Director,
helen.robins@principal-medical.co.uk

Oxford City
For OxFed (Oxford City), please contact Dr Louise Bradbury, Dr Ben Riley or Dr Rebecca Hollaender at oxfed.admin@nhs.net

Abingdon and surrounding area
Abingdon Health Federation, David Ridgway, Malthouse Surgery Practice Manager,
david.ridgway@nhs.net

South East Oxfordshire
SEOX, South East Oxfordshire Federation, Dr Mark Bish, markbish@nhs.net

Website:
www.oxfordshireccg.nhs.uk/about-us/work-programmes/GPpilotschemes

GPs pilot schemes supported by national Prime Minister's Challenge Funding begin

Pilot projects to test ways of offering more primary care services to patients in Oxfordshire begin this month following a successful bid to the Prime Minister's Challenge Fund earlier this year.

GPs across the county, working as four federations, secured £4.9 million of funding to trial a number of projects during 2015-16, to see which best improve patient care and keep people out of hospital.

The projects include; Neighbourhood Access Hubs; Home Visiting Teams; Care Navigators; Email Consultations and an online project offering a Local Health website. All schemes are set to begin during the summer.

It is estimated that through these measures an additional 70,000 appointments, consultations or assessments will be offered this year and 1,000 hospital admissions and 3,000 A&E visits will be avoided.

The pilot projects target populations in the county that need greater health care support, respond to demand for more out of hospital urgent care and offer further options for patients to get health care advice and take greater responsibility for managing their care.

At the end of the year, the pilot projects will be evaluated and their impact analysed by GPs and commissioners to ensure the lessons learned can be applied across the county.

GP Pilot schemes around Oxfordshire

Each pilot project is designed to support patient populations that need greater health care support. The map illustrates where the projects are being rolled out.

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Oxfordshire GP pilot scheme
Prime Minister's Challenge Fund News

NHS Oxfordshire Clinical Commissioning Group

Involving patients

Patients across the county are lending their support as GP federations develop the pilot projects.

During April and May, patients have shared their views on project plans.

North Oxfordshire
In North Oxfordshire, Principal Medical Limited, discussed pilot projects to run in the north of the county and gathered useful feedback from patients at the North Oxfordshire Patient and Public Locality Forum.

Oxford
In Oxford, OxFed are discussing their plans for new services with the City Locality Patient forum, ensuring their schemes will be responsive to the needs of patients and carers. They will also be providing information on options for patients to make their medical information more available to local emergency GPs when their practice is closed, to improve the safety and quality of their care.

Abingdon
In Abingdon, Abingdon Healthcare Federation are leading on a project to develop an online health resource. Regular patient feedback and input to recent surveys identified the need for such a resource to better signpost and support patients, carers and families. Initial responses to the proposal have been positive and patient representatives are part of the team involved in working with the software developer to create the website.

OxFed

PML PRINCIPAL MEDICAL LTD

Snapshot of Pilot schemes

Neighbourhood Access Hubs – The hub will provide same day urgent appointments between groups of practices for patients unable to get an appointment at their own practice. Additionally, more 20 minute appointments will be introduced by participating GP practices for patients with more complex conditions to focus on preventative care. This will run in Banbury, Bicester, Wantage and Witney initially. Phase two: Chipping Norton, Carterton, Faringdon, Kidlington.

Early Visiting and Home Support Teams – These teams will help GPs to respond to requests for urgent same day home visits. The aim is to provide a more responsive service for patients at risk of admission, visit in a timely manner and identify early support before their condition deteriorates and they need to be admitted to hospital. This service will work closely with the Neighbourhood hubs and with colleagues from other community health and social care services, offering greater support to patients.

The teams will consist of emergency care practitioners who will have remote access to the medical records of the patients they are visiting. These teams will operate in North, West and North East Oxfordshire, Oxford City and could later be extended to South East Oxfordshire. In Oxford, a team of advanced nurse practitioners will help GPs assess housebound patients more quickly, enabling earlier treatment and avoiding hospital visits, as well as providing additional preventative care.

An online project will test the impact of an online health resource to empower and coach patients to use appropriate 'e' health information, apps and advice to better manage their care and health needs, initially in the Abingdon area and will then be rolled out countywide.

A skype-type consultation service will also be trialled with care and nursing homes around Banbury. GP practices in South East Oxfordshire (SEOX) are examining the work underway in Abingdon with a view to looking at how this type of web based consultation service might be offered in this part of the county.

Access to GP records Out-of-hours access to GP records will be trialled in Oxford. This will give GPs working during evenings and weekends access to the medical records of patients with personal care plans, improving coordination of care and safety.

Practice Care Navigators – GP practices in Oxford will work with staff in hospitals and social care to offer better, joined up care for patients registered with city practices with the most complex conditions. Practice Care Navigators will co-ordinate support for these patients and liaise with their GPs, families and carers in practices and in patient's homes to ensure care is proactive. There will be six Practice Care Navigators working in GP practices in Oxford. While in Abingdon, Care Navigators will be supported by the new online health resource to provide an information and signposting service, liaising with patients, their GPs, families and carers in the Abingdon and Malthouse Practices to support better self care and improve health literacy.

E-consultations will also be trialled in Abingdon, where patients will be able to book quick response e-consultation appointments during the early mornings and evenings and Saturday mornings. Additional routine 'e' consultation appointments with a 1 day turnaround will also be available during normal opening hours.

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Oxfordshire GP pilot scheme
Prime Minister's Challenge Fund News

NHS
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Schemes coming online

E-consultations
This month sees the start of the e-consultation trial in two practices in Abingdon. Both Abingdon and Malthouse surgeries will offer patients urgent appointments by email. Appointments will be booked online at set times early morning, early evening and Saturday mornings outside of the practices normal opening hours, with a two hour response target from the appointment time. Alongside the new urgent service they will also introduce a routine in hours email consultation service. If the email consultation pilot proves a success and is found suitable for a significant number of patients, it could be expanded to other practices and drive change in the balance of appointment slot type for GPs that would allow longer appointment times for those patients where a face to face consultation is necessary.

Home Visiting Teams
On Monday 1 June, the first visits were made to patients by these newly formed teams in Banbury and Chipping Norton. By the end of June, around 260 patients will have been contacted by the team. The team consists of Emergency Care Practitioners who carry out home visits requested by practices to reduce avoidable admissions to hospital and free up GP time to care for patients with complex conditions.

Watch this space

Further pilot projects will be coming online in July and August:

Home Visiting Teams
From June to the end of July, the Home Visiting Team service will be rolled out to support GP practices in West, North East and South West Oxfordshire.

Online Health Resource
The health website, being developed by Abingdon Healthcare Federation on behalf of all GP Federations in the county, is set to launch in Abingdon in August supported by care navigators. The website will be rolled out across Oxfordshire in September.

Care Navigators
Later this summer in Oxford, Care Navigators will help coordinate care for patients who are elderly, frail or just out of hospital, linking up practice teams with other health and care agencies.

Future editions of this newsletter will feature updates on the pilot schemes. See also www.oxfordshireccg.nhs.uk/about-us/work-programmes

What is a GP Federation?
A GP Federation is a group of GPs who have come together to enhance the delivery of health and social care services locally. They are a membership organisation formed from a number of GP practices. The federation operates as a hub for member practices, to enable them to offer better access to service and deliver economies of scale by working together to share resources such as back office functions including administration and finance support.

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Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board – 16 July 2015
Better care Fund Update

1.0 Introduction

The Better Care Fund (BCF) plan for Oxfordshire was submitted in January 2015 to NHS England, supported by Swindon CCG, Aylesbury CCG and the Oxfordshire County Council and Chair of the Health and Wellbeing Board and the main providers in Oxfordshire, including the Oxford University Hospitals Trust and Oxford Health Foundation Trust. The system signed up to a 2% reduction in non-elective care episodes and improving delayed hospital discharges. The plan commits to protecting adult social care with an investment of £8million and £1.35 million to support implementation of the Care Act 2014.

The principles underpinning the schemes are:

- Integrate services across organisational/sector boundaries,
- Enhance individual self-care management,
- Provide rapid access to community/primary care based urgent care 24/7,
- Provide a greater range of services closer to home,
- Increase the number of patients who can be managed on ambulatory care pathways,
- Reduce delayed transfers of care in the acute sector.

2.0 Overview of projects, management and reporting governance

The BCF Programme Board has established 12 initiatives of which 11 were enshrined in the original plan, and to which an additional initiative for primary care has been added following the successful Prime Ministers Challenge Fund (PMCF) Bid. These projects are:

1. Emergency Multi-disciplinary Units (Reshaping of an existing scheme)
2. Reablement Services (Reshaping of an existing scheme)
3. Reducing delayed transfers of care (New scheme)
4. Ambulatory emergency care (New scheme)
5. Integrated neighbourhood teams (New scheme)
6. Care closer to home (New scheme):
7. Hospital at home (Reshaping of an existing scheme)
8. Oxfordshire Care Summary - proactive care planning (Existing scheme
9. Protecting adult social care (Existing scheme)
10. Care Act Implementation (Existing scheme)
11. Carers Breaks (Existing scheme)
12. Prime Ministers Challenge Fund (New scheme)

From a project management perspective, out of the 12 schemes 11 are fully established with steering groups meeting and project plans in place, with the exception of Hospital at Home. The reshaping of this scheme is considered alongside the Community nursing review as well as the reablement developments.

There are some challenges of competing timeframes with strategic developments such as outcomes Based Commissioning and set up issues.

2.1 Overall Progress

1. A key tenet of the Oxfordshire approach to supporting the top 2% of the population most at risk of an emergency admission, has been supporting the role of the GP co-ordinator through the implementation of advanced care plans for all in the high risk group, with case management to avoid unplanned admission. This was implemented last year using the ACG risk prediction tool. In addition the GP has been identified as having a key role in earlier diagnosis for those with dementia, as well as identifying individuals who are a 'caring' role.

   The top 2% has been identified through a risk stratification exercises involving:

   - Age: those over 65 years where Oxfordshire is experiencing above national average population growth.
   - The top 2% of patients (9,700) identified as most at risk of an emergency admission using the ACG risk stratification tool.
   - Disease prevalence across Oxfordshire against 9 of the 12 top ambulatory care sensitive conditions (ACSC) which have shown to have a significant impact on emergency admissions.
   - The role of integration across services: to improve locally provided responsive and preventive care; to build community resilience and self-care management; and to enable earlier discharge from acute care.

2. A significant proportion of those most at risk of emergency care in Oxfordshire reside in residential care and nursing homes. It is for this reason that the Oxfordshire BCF plan includes an initiative to provide greater health prevention support to the independent residential home sector, through 'proactive medical support to care and nursing homes'. This involves engaging with GP practices so that one practice becomes responsible for the entire population of one care/nursing home. The service includes a proactive approach to medicines management and gerontology care, ensuring that all patients in residential care are actively 'care-managed' with advanced care plans in place. Since the launch of the scheme in February 2015 40% of residential homes across Oxfordshire have been 'partnered' with a GP practice and a plan is in place to achieve 95% by the end of 2015. This scheme is expected to reduce non-elective admissions by 1,700 per year.
3. The 'Integrated Neighbourhood Teams' is another of the 12 BCF initiatives designed to deliver the full range of support and care to the adults with physical needs and older peoples mental health needs out of hospital. The transformational changes in working and delivery have begun the implementation process in June 2015 and will bring together multi-professionals from health and social care, building on the foundation of community health integrated teams, the OHFT single point of access (SPA) and the pooled budget arrangements. The hubs will be based around an adult GP-registered population using a single assessment process, proactive digital integrated care plans and personal support plans, linked to the OCS initiative.

4. The Prime Ministers Challenge Fund (PMCF) aims to support access to primary care by via the neighbourhood hubs, which will offer an additional 8400 appointments outside of core working hours. In addition the implementation of telemedicine and virtual 'e-consultations' will increase access to primary care for those who find it difficult to get to the surgery. The programme is currently in the process of implementation, including:
    - The Early Visiting Service, which went live in early June and has visited 58 patients in the first 2 weeks. Four more teams will be launched by the end of July.
    - E-consultations are now live in Abingdon.
5. The Better Care Fund includes funding to protect adult social care, and to support the implementation of the Care Act 2014 including ongoing support for carers. To date, the County Council has developed and implemented a new policy framework to ensure compliance with the Act, improved information and advice provision online and face to face, and a completely new process for assessing and meeting the eligible support needs of carers in line with national criteria. This includes on-line supported self-assessments, which have proved to be very successful with 70% of applications coming via this route. This provides important intelligence in developing an online self-assessment for all adults seeking support from social care, which is an important component in plans to meet increased demand for assessments from self-funder if funding reform is implemented from April 2016 as proposed.

3 Performance

Please find below the quarterly monitoring for the headline Better Care Fund monitoring:

1. **A 2 % reduction in non-elective admissions (general & acute):** The target is for a 2% reduction in NELs admission from calendar year to calendar year. The table below compares Q4 13/14 to Q4 14/15 and shows a 2% reduction between the two.

			13/14	14/15				15/16			
			Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non Elective Reduction: in G&A Non Elective Admissions from the Baseline Period	**Baseline**	**& Plan**	**12,586**	**13,234**	**13,277**	**13,309**	**13,305**	**12,684**	**12,684**	**12,684**	12,684
		Actuals	12,586	13,234	13,277	13,309	12,328				
	Target	-2%					**-2%**				

2. **Residential admissions:** This is an annual figure which has been submitted to NHS England and shows an 8% improvement in the year and is likely to be in the top quartile nationally in terms of performance.

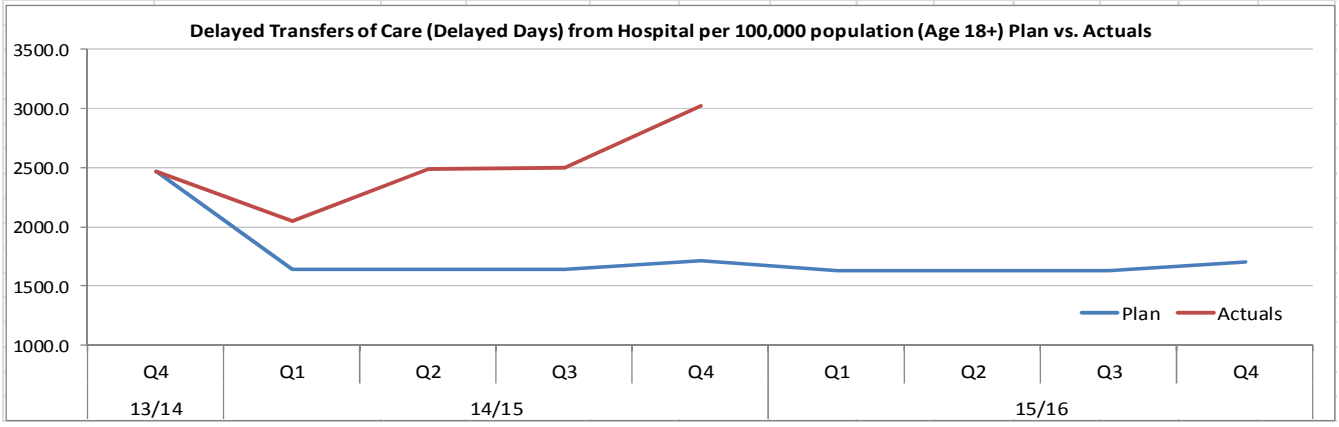
Annual					
			Baseline		
Social Care Admissions			(2013/14)	14/15	15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Plan	Annual rate	**574.2**	**471.9**	**437.8**
		Numerator	625	546	520
		Denominator	109,015	115,693	118,780
	Actuals			**529.3**	

3. **Number of people supported to live at home**: More people receiving on-going support from the council are living at home.

Local Measure		Baseline (2013/14)	Planned 14/15	Planned 15/16
Increase the proportion of older people (aged 65 and over) with an on-going care package supported to live at home	Annual %	**60.0**	**61.9**	**62.8**
	Numerator	2122	2301	2391
	Denominator	3,537	3,716	3,806
	Actuals		62.7	63.0

4. **A reduction in excess bed days as indicated by reduced Delayed Transfers of Care (DTOCs) and a reduction in length of stay.** This continues to be challenge for the Oxfordshire System. A number of initiatives have recently been agreed and are in the process of implementation to reduce the number of DToCs.

Quarterly view		13/14	14/15				15/16			
		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Delayed Transfers of Care (Delayed Days) from Hospital per 100,000 population (Age 18+)	Plan	2464.8	1636.2	1636.2	1636.2	1707.9	1626.4	1626.4	1626.4	1697.7
	Actuals	2464.8	2052.1	2486.5	2493.5	3018.8				



5. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services: The provisional figure is 80%, final deadline for submission is July 24th and figures may change

Local Measure			Baseline (2013/14)	14/15	15/16
Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home	Plan	Annual rate	**60.0**	**61.9**	**62.8**
		Numerator	2122	2301	2391
		Denominator	3,537	3,716	3,806
	Actuals			***62.7***	

3.1 Update on the 2% target to reduce non-elective admissions

The Oxfordshire System signed up to a target 2% reduction in non-elective admissions against the 2013/14 baseline as part of its original Better Care Submission. This amounts to a net reduction of 1,050 in non-elective admissions for 2015. The actual number is affected by any growth which needs to be ameliorated.

In line with national guidance, the Oxfordshire BCF submission was reviewed to ensure our target of a 2% reduction in non-elective admissions was still valid. This was done as part of a national exercise to provide Health and Wellbeing Boards across the country with an opportunity to revise the original BCF plans (baselines and trajectories only) if necessary.

Based on analysis it has been determined that there is no significant change in the original BCF plans of a 2% reduction against calendar 2014-2015. The original target of **995** NELs has been revised to **1,050**, however this is not deemed substantive; therefore Oxfordshire does not need to submit a revised BCF. We believe that 2% is both realistic and a stretch target.

	Baseline - Non-Elective Activity					Revised HWB Plans - Non-Elective Activity						
HWB Name	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	Baseline Total	14-15 Q4 revised	15-16 Q1 revised	15-16 Q2 revised	15-16 Q3 revised	Total	NEL target	% Change
Oxfordshire	12,603	13,305	13,305	13,305	**52,518**	13,305	12,721	12,721	12,721	**51,468**	1,050	2.0%

Table 1: Revised NEL targets

The table below illustrates the change in elective activity required as part of the BCF and the related costs.

1. Reduction in non-elective activity	
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	51,468
Change in Non Elective Activity	-1050
% Change in Non Elective Activity	-2.0%
2. Calculation of Performance and NHS Commissioned Ring fenced Funds	
Figures in £	
Financial Value of Non Elective Saving/ Performance Fund	1,482,550
Combined total of Performance and Ring fenced Funds	9,796,821
Ring fenced Fund	8,314,271
Value of NHS Commissioned Services	12,545,000
Shortfall of Contribution to NHS Commissioned Services	0

1. Conclusion

The BCF plan is an ambitious set of projects which have the potential to provide more appropriate care for Oxfordshire residents and in doing so address enduring problems such as reducing delayed transfers of care and contribute to consistently achieving the 95% A&E 4 hour target.

The plan also aims to address the increasing demand for urgent and emergency care posed by demographic change in over 65s, which is growing at an annual rate of 1% per year. The impact of this growth is an average 4.3% growth a year in demand for non-elective admissions. Reaching a 2% reduction overall therefore compensates for growth and a further reduction to reach the 2% target.

2. Recommendation

The Health and Wellbeing board are asked to:

- Note the report;
- Support the 2% calculation figures above submitted as part of the Better Care Fund submission to NHS England. This will mean that a further submission is not required.

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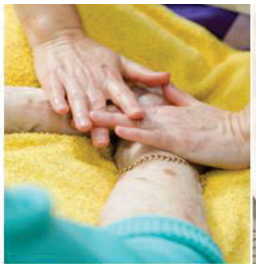
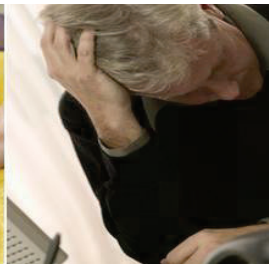
Oxfordshire Safeguarding Adults Board Annual Report 2013-2014

Safeguarding is everybody's business…

Agencies working together to ensure a coherent policy and a consistent and effective response for the protection of vulnerable adults at risk of abuse





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Foreword

Welcome to the Oxfordshire's Safeguarding Adults Board Annual Report for 2013/14. As Independent Chair I would like to take the opportunity to comment on how I believe The Board is contributing to reducing the risks of abuse, neglect or exploitation of vulnerable adults in Oxfordshire. It must be emphasised that a Safeguarding Board does not directly protect the vulnerable. What it does do however, is to coordinate the efforts of those professionals from many disciplines who work to keep people safe. It develops the best practices and policies, it quality assures service delivery and it investigates when things go wrong in an effort to learn and improve. Equally importantly, it challenges and holds to account both its own constituent agencies and other partnerships.

Safeguarding vulnerable adults continues to be at the centre of media attention nationally, and one cannot help but be concerned at the findings of the Francis Report and more latterly the Keogh Report, both of which highlight the quality of care in hospitals. Though abuse in hospitals and care home settings are an obvious focus for our Safeguarding Board, the fact remains that the majority of abuse and neglect does occurs in a person's own home.

This illustrates the complexity of the issue and the need for agencies to strive for optimum response to abuse of all types and in all settings. Complexity is further compounded by scale and the main body of the report indicates that the number of safeguarding concerns received by Oxfordshire County Council rose by 49% in 2013/14 compared to the previous year. Such a rise in demand for services would be challenging in the best of times, but is particularly formidable in light of the current public sector budget reductions. It is to the credit of the partnership that it has remained strong and committed to working together throughout the year. It is my responsibility to request that such commitment continues despite the challenges from competing demands and reduced resources.

On the continued subject of support to the safeguarding adults agenda, the Care Bill 2014 can do much to strengthen both involvement in, and delivery of, safeguarding services. New proposed powers in respect of duty to report, right to access and the creation of a specific offence of neglecting or ill- treating an adult at risk of abuse, will provide a degree of legislative muscle hitherto quite sadly lacking. The standing item on the Board's agenda to be informed of capacity issues and organisational change has provided clear information about the continuing rise in the demand for safeguarding services which impact on all agencies.

The data provided by Adult Social Care is consistent with agency reports of greater activity which has been challenging for all agencies to respond to. The Board is now receiving more cases to be considered as case reviews and this demonstrates a greater awareness of the Board, and greater understanding of the Board's role in considering situations for potential case review.

A critical issue that emerged at the end of the year was the 'Cheshire West' judgment in respect of deprivation of liberty. The Board recognised the implications of this judgment and has put in place governance systems to be able to understand the challenging issues of capacity to meet the new threshold established within the judgment.

All of the above is of little consequence if we are unable to answer two simple Questions; are vulnerable adults in Oxfordshire safe and how do we know that they are? The answering of these questions should be the sole focus of the Safeguarding Board as it moves from a process of inward looking self-development, which has made it fit for purpose, to a position of positive influence to drive up standards of service delivery and identify and protect those in need of our help.

Finally, I would like to thank all of those agencies that continue to support the Board's important work, but most importantly our frontline practitioners who continue to work hard in protecting vulnerable people, often in difficult circumstances.

Donald McPhail
Independent Chair
Oxfordshire Safeguarding Adults Board

Introduction

High quality adult safeguarding systems are in place in Oxfordshire. Under the stewardship of the Oxfordshire Safeguarding Adults Board, these systems and services continue to protect adults at risk from abuse and harm and to support community safety.

The term 'safeguarding' is used to mean both specialist services that intervene, investigate and support the person where harm or abuse has, or is suspected to have, occurred, and any other activity designed to promote the wellbeing and safeguard the rights of adults. In its broadest sense, safeguarding is everybody's business: the public, volunteers and professionals. It covers a wide range of activities and actions taken by a large number of people, not least by people in the community.

This annual report describes the current arrangements for ensuring the safety of "adults at risk" in the county and provides an assessment of the key developments in local multi-agency adult safeguarding systems in 2013/2014 along with a statistical analysis of the casework activity, outcomes and reports from individual agencies.

The Board has followed current government guidance in considering an adult at risk to be someone aged 18 years or over "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (DOH, No Secrets, 2000). The Board notes however that implementing the Care Bill (see below) may have an impact on the numbers of people for whom safeguarding enquiries will be necessary. This will be analysed in next year's annual report.

Developments in National and Local Policy in 2013/14

Mental Capacity Act 2005: House of Lords post-legislative scrutiny report

In March 2014 the House of Lords Select Committee on the Mental Capacity Act published its post-legislative scrutiny report. The Committee concluded that so far the potential of the Act to bring about real change in the support and protection of people who struggle to make their own decisions had not been realised.

The main findings of the Report are as follows:

- The ethos of the Mental Capacity Act is widely welcomed but it has not been adequately implemented due to lack of "ownership" by a dedicated independent oversight body;
- Too much decision-making in health and social care is still motivated by paternalism and risk-aversion rather than the principles of the Act;
- There is a lack of adequate information for all stakeholders – individuals, family members, professionals – leading to confusion over rights, roles, and responsibilities;
- The Deprivation of Liberty Safeguards are not working and need to be replaced;
- The Court of Protection needs more resources and should place more emphasis on mediation prior to court action.

In its response to the report the Government acknowledged many of the concerns raised by the House of Lords. The Government has set up a Mental Capacity Advisory Board and will seek to work with partners such as NHS England, Association Directors of Adults Social Services (ADASS) and Care Quality Commission (CQC) to implement the Act more effectively. The Government has also asked the Law Commission to review the operation of the Deprivation of Liberty Safeguards (see below) and will provide more resources to the Court of Protection.

Oxfordshire Adult Safeguarding Board remains committed to undertaking its duties in seeking assurances that the application and implementation of the Mental Capacity Act is robust and has the vulnerable adult at the centre of the process.

Deprivation of Liberty – the "Cheshire West" Supreme Court Decision

In March 2014, a Supreme Court judgement known as the "Cheshire West" decision changed the criteria for assessing whether a person lacking mental capacity is being "deprived of their liberty" in a care home, hospital or other care setting. The judgment overturned a number of previous rulings from the Court of Appeal which had progressively restricted the application of the Deprivation of Liberty Safeguards (DoLS).

The judgement will lead to a significant increase in the number of capacity assessments for people with cognitive impairments who are held to require formal authorisation of "deprivation of liberty", either under a) the deprivation of liberty safeguards (DoLS) (for hospital patients and care home residents), or b) through the Court of Protection (for people in supported living schemes

The judgement introduced an “acid test” to identify deprivation of liberty in cases where a person is deemed to lack the capacity to give valid consent to their care arrangements. There are two key questions in the test; (1) is the person subject to continuous supervision and control, and (2) is the person free to leave?

If the answer to both questions is “yes”, then the person would now be considered to be deprived of his/her liberty and in need of the protection of an appropriate legal framework. Under previous case law deprivation of liberty was deemed to occur only when there were aggravating factors such as the person or their family objecting, high levels of restraint etc.

This means that more people in care homes, hospitals, independent supported living schemes, mental health hospitals and institutions require assessments in order to consider whether they are being “deprived of liberty” and whether this is in their best interests. This has already seen significant financial and operational implications for the local authority overseeing the process and for service providers.

The “Cheshire West” judgment was handed down at the very end of the year and had had an initial impact on the numbers of referrals for a DoLS in Oxfordshire in 2013-2014. It is already clear that the situation for 2014-2015 will mean increased rates of activity for the service and will need the Oxfordshire Safeguarding Adult Board oversight.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector-led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the ‘No Secrets’ consultation and other engagement with Councils and their partners. It aims to develop outcomes-focused, person-centred adult safeguarding practice and a range of responses to support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people. This is in keeping with the focus on individual wellbeing promoted by the Care Bill.

Oxfordshire is committed to implementing Making Safeguarding Personal. The authorities’ work to implement the Care Bill will draw on the principles and resources of the MSP programme to ensure that staff have the skills and expertise to engage with service users and support them to achieve their preferred outcomes wherever possible.

Changes in the Care Quality Commission (CQC)

In the past year, the CQC have made significant changes to the way they inspect and regulate health and social care services to make sure services provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements.

CQC's Strategy for 2013-16 outlines the changes that apply to many services regulated by the Commission. During 2013–14, national teams have been introduced to inspect NHS hospitals and mental Health Trusts.

Response to Winterbourne View

In December 2012, the Department of Health published *Transforming Care: A National Response to Winterbourne View Hospital* Final Report. This report made a number of recommendations aimed at strengthening accountability and corporate responsibility for the quality of care and defined actions for the Department of Health, CQC, secure services (including prisons), the police, LGA, Healthwatch, as well as health and social care services.

The Department of Health Report was followed by the launch of the "Winterbourne View Concordat and the Interagency Programme of Action".

Oxfordshire Safeguarding Adults Board has been proactive in seeking assurances through robust monitoring that the needs of individuals with Learning Disability have been met and that agencies and commissioners have worked together to ensure the welfare and dignity of those who are provided with services are safe.

The Care Bill 2014

The Care Bill is due to receive Royal Assent in early 2014/15. The Act will set out the statutory framework for adult safeguarding and will place Adult Safeguarding Boards on a statutory footing. Once enacted, the Safeguarding Adults Board will need to review the responsibilities and duties placed on the Board and its partners, developing an action plan for its own compliance and a clear mechanism for monitoring partners' compliance.

Safeguarding arrangements in Oxfordshire

What is the Oxfordshire Safeguarding Adults Board?

The Oxfordshire Safeguarding Adults Board (OSAB) is a non-statutory multiagency partnership that has a remit to protect adults-at-risk from abuse, neglect and significant harm. The Board seeks to bring about positive outcomes for adults-at-risk who live within Oxfordshire.

Governance arrangements

- Provide assurance and act as a multi-agency partnership board of lead officers and key representatives that takes strategic decisions aimed at safeguarding adults at risk of abuse/harm.
- Co-ordinate the work of each partner agency to minimise the risk of abuse/harm in community and service settings.
- Promote the safeguarding interests of adults to enable their well-being and safety.
- Promote inter-agency co-operation, to encourage and help develop effective working relationships between different services and agencies.
- Develop inter-agency safeguarding adult procedures to ensure an effective and consistent response to instances of abuse/harm.
- Monitor the effectiveness of what is done to safeguard and promote the welfare of adults, reviewing performance on safeguarding adults and making recommendations about changes within partner agencies.

The board meets bi-monthly and reports directly to the Oxfordshire Health and Wellbeing Partnership Board, with members having responsibility to report to their respective executive boards.

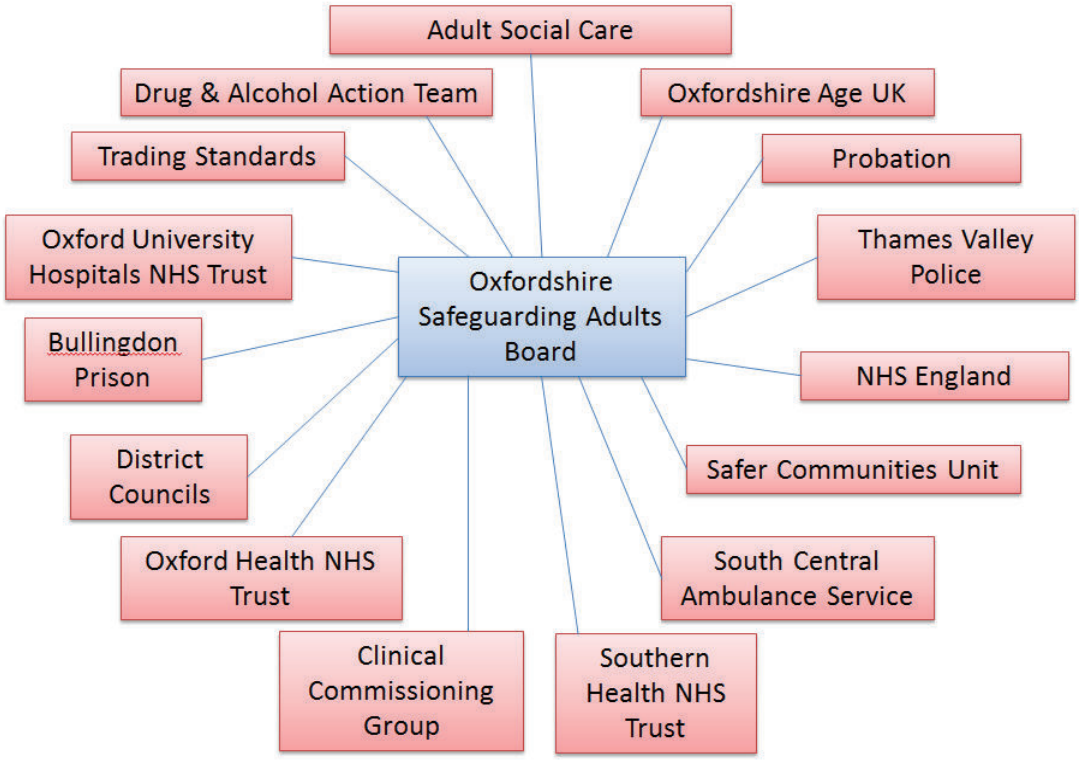
The board's structure ensures that effective interfaces and robust governance arrangements are in place to promote the safeguarding of vulnerable adults and ensure accountability for performance.

The board's multi-agency approach ensures that effective collaborative leadership is in place to drive forward the government's principles to safeguard adults from the risk of abuse or neglect which are:

- **Empowerment** - Presumption of person-led decisions and informed consent
- **Prevention** - It is better to take action before harm occurs
- **Proportionality** - Proportionate and least intrusive response appropriate to the presented
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

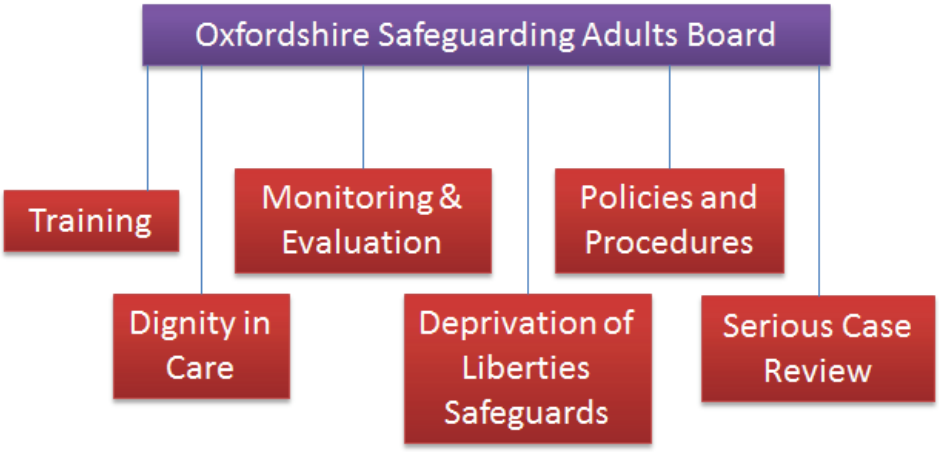
Who are the members?

The Board has membership from a wide-range of partners including:



What is the structure?

The board is supported in its work by a variety of subgroups. The structure is outlined in the diagram below.



How Safeguarding works in Oxfordshire

The Social & Health Care Team acts as the single point of entry for all safeguarding concerns. The Team determines whether the adult at risk is known to social services or health services and asks the appropriate department to investigate. Each investigation is led by a trained Safeguarding Adults Manager.

The Safeguarding Adults Manager identifies all those who can help to protect the adult at risk or help with the investigation. These may be family members, service providers, health professionals, the police or Oxfordshire Client Financial Affairs Team.

An initial risk assessment is completed to determine what response is needed. If further action is required then a strategy meeting will take place chaired by the Safeguarding Adults Manager.

This will confirm the protection plan for the adult at risk and identify who will carry out the investigation. Further meetings will be arranged to confirm the outcome of the investigation and to review the protection plan. The person and their carer/family will be supported to be involved as much as possible.

Sometimes the person causing harm is also an adult at risk of abuse. In such cases the safeguarding process will consider whether they need their own protection plan to help them avoid facing any allegations in the future.

The desired outcome from review of the post-safeguarding interviews is to feel safer and have a better quality of life. If the person cannot make their own decisions about their care then they may need to be protected in their best interests.

Types of protection include:

- Increased monitoring – e.g. more frequent reviews, more contacts with staff
- Enabling the adult at risk to stay away from the person causing harm
- Better management of the finances of the adult at risk
- Application to the Court of Protection (a court that makes decisions based on best interests where there are disputes over serious decisions regarding a person's welfare)

Whenever possible the person causing harm should be held to account. This can be done through criminal and /or civil law, or by the employer.

The Work of the Board 2013/14

Neighbourhood Return Scheme

The Board was informed of the scheme that has been introduced in Oxfordshire to assist in raising the profile of those living with dementia and to assist them in leading a more active life in the community. The scheme is currently funded from Lottery Funding and is being delivered in conjunction with Oxford University.

Volunteers are recruited to support vulnerable adults who have become confused to find their way back home.

The neighbourhood scheme is being advertised across the county to all practitioners across all agencies to widen both an understanding and take up of the Scheme. The Project Manager of the Scheme will engage directly with the agencies of the Board.

The Board was assured that there was already good engagement with community safety groups, and in particular Oxford City Council.

Hospital Safeguarding Reviews

The Mid-Staffordshire Review examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations, including:

- openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers,
- improved support for compassionate caring and committed care and stronger healthcare leadership.

The Board received a presentation on the main factors identified in the review. It was recognised that the report found that there a number of managerial issues that needed to be addressed, but that as important, were issues of attitude and respect, and support to staff to be able to provide good quality services.

As a result of this presentation, the Board decided to:

- include whistle-blowing in the Board's Quality Assurance Tool,
- recommend that value-based interviewing techniques are employed,
- request all agencies present annually to the Board on the key issues from their complaints processes.

Governance arrangements and progress in respect of this review will be overseen by the Clinical Commissioning Group and the County Council contract monitoring team.

Giving Victims a Voice

In the aftermath of revelations about Jimmy Saville, the Board received a presentation on an overview report 'Giving Victims a Voice', outlining concerns about the key issues for hospitals to strengthen the safeguarding of vulnerable adults.

The key issues identified were:

- Vulnerable adults were specifically targeted
- Staff and volunteers need to speak out and whistle blow when necessary
- There is a need to ensure that there are safe recruitment and supervision processes for fundraisers and volunteers
- Policy and practice have developed in the course of the decades that the report covered

Actions taken by Board members include:

- Revised their policy on the use of volunteers, and recruitment checks are in place.
- A review of the use of volunteers and the CQC template for action is in place.

On-going assurances regarding agreed board actions will be presented by agencies on their submissions to the CQC.

Development of Safeguarding Board Audit Tool

It was agreed that an audit tool would be developed to enable organisations and the Board to be assured that their framework for providing safeguarding services was robust. This tool should take account of the section 11 tool used by the Safeguarding Children Board and should address the requirements set out in the ADASS document.

Hate Crime Update

The Board representative from the Community Safety Partnership informed the Board of action being taken by the Community Safety Partnership to address Hate Crime across Oxfordshire. The Board requested that links be made with advocacy groups and with anti-social behaviour teams across the County. It was confirmed that these links were being established.

There is an evaluation of Stop Hate UK, and it was agreed that the Board would link with the Community Safety Partnership to establish the extent to which vulnerable adults were targeted in Hate Crime.

Crown Prosecution and Safeguarding Adults

The Crown Prosecution Service has been active in developing links with the Safeguarding Adults Board and invited the Board to attend a conference on how the Crown Prosecution Service manages children and vulnerable adults in Court processes. The Business Co-ordinator of the Board attended the conference and fed back to the Board on the arrangements being made for vulnerable adults when they are required to appear in Court.

It was agreed that the Crown Prosecution service would be invited to the Board annually to ensure that the Board remained up to date with an understanding of the support needs of vulnerable adults when they appear in Court.

Suicide Reduction Strategy

Following a joint approach by the Oxfordshire Safeguarding Adults' and Children's Boards the Health and Wellbeing Board commissioned development work on a Suicide Reduction Strategy. The Board received a presentation from Public Health on the development work on the suicide reduction. The Board will be further consulted before the strategy is finalised.

Link between Serious Case Review Policy and Domestic Homicide Reviews

The Board's serious case review policy was amended to incorporate links with domestic homicide reviews to ensure that the parallel processes could be managed efficiently.

Review of service provision for homeless people

A review had been undertaken because of a peak in the number of deaths amongst hostel residents.

The review undertaken by Safeguarding Services concluded that there was no systematic or individual neglect in the service. It was noted in the report that deaths fitted the demographic norms.

The review did identify how policy and practice could be strengthened, and it was recommended that:

- there was more pro-active work with residents
- a health and safety protocol should be revised
- that staff should engage in multi-agency training
- that there should be a review of the alcohol policy, and
- there should be improved recording

An action plan was developed and implemented and work is currently underway to address the issues.

Link with Safeguarding Children's Board E-Safety Strategy

Although mainly focusing on children this strategy does also link to the abuse of vulnerable adults. A representative from the Safeguarding Children's Board presented the strategy and the Board was able to agree it in relation to vulnerable adults.

Communication Strategy

As part of the learning and improvement strategy, a communication strategy for the Board was agreed. This provides the framework for the Board to achieve communications across agencies and within agencies to ensure that key policies are implemented and that practice improvements are communicated effectively

Section 136 Detentions under the Mental Health Act

The Board considered the position of vulnerable adults who were being held by the Police under section 136 of the Mental Health Act pending a formal assessment by mental health professionals. There was concern by the Police that the interests of some vulnerable people were not being serviced by a delay in finding a suitable environment for the vulnerable adult pending the formal assessment. Too frequently the vulnerable adult was being held in a Police station awaiting the assessment.

At a subsequent meeting of the Board it was reported that that the response to vulnerable adult could be improved by increasing the capacity within the health service to provide suitable holding accommodation and that the earlier involvement of a mental health professional to provide a triage service could help to reduce the number of vulnerable adults who required to be held under section 136.

The Board was assured that there were plans to 1) increase capacity and 2) to pilot a triage service.

Human Trafficking and Slavery

The Human Exploitation Coordinator from Oxford City Council who provides a lead across the County on Human Exploitation informed the Board of an increased national awareness of the human trafficking and slavery of adults. They also outlined current work being done across Oxfordshire to develop an awareness of the problems and the strategy to respond. The main lead has been Safer Communities and it was agreed that the Board needed to remain informed of further developments.

Making Safeguarding Personal

Making Safeguarding Personal is a sector-led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the 'No Secrets' consultation and other engagement with councils and their partners. It aims to develop an outcomes focus to adult safeguarding work and a range of responses to

support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people.

The Training Manager of the Board up-dated the Board on the Oxfordshire pilot of the national programme of Making Safeguarding Personal. This programme aims to provide structure to the way of working to ensure that the focus remains driven by the service user, and in particular seeks to establish the service user's view of how well agencies have met their needs.

It was reported that the pilot in Oxfordshire was well received and service users rated their being at the centre of their service provision highly.

The Board supported the wider implementation of Making Safeguarding Personal. It was recognised that the lead for the pilot was leaving the Council and a new lead would be required to be identified to ensure this is embedded in practice across all agencies. .

Making Safeguarding Personal Case Studies

Sarah

Sarah is a 19-year-old young woman with a physical disability who was living at home with her parents and younger brother when she alleged to her teacher that she had been sexually abused on a number of occasions by her father.

The school immediately reported this to adult social care. Her social worker met with her and with her agreement her allegation was reported to the police. An immediate strategy meeting was held at which it was agreed that Sarah wanted to move out of the family home at which point a criminal investigation would commence. A shared lives placement was identified and Sarah moved the next day.

Using MSP guidelines adopted by Oxfordshire the social worker met with Sarah to identify what was important to her and what outcomes she wanted. Sarah was able to identify 3 outcomes that she wanted:

1. To continue attending school
2. To continue going to her riding lessons
3. To go to university

Whilst supporting Sarah with her placement and the criminal investigation, the social worker was able to focus on working with the school and arranging transport to ensure that Sarah was able to continue at school.

The criminal investigation was unable to proceed due to lack of evidence. However, Sarah achieved her goal and is now at university studying computer design.

Miss J

Miss J has a severe physical disability and communication difficulties and lives at home with support being provided by a care agency four times a day. The safeguarding team received a high number of alerts about bruises and other injuries sustain by Miss J apparently as a result of poor moving and handling. The care agency seemed unable to address these concerns.

The team approached Miss J's social worker asking him to review the care package with a view to identifying an alternative agency to support her.

The social worker met with Miss J to discuss with her what Miss J wanted to happen. Instead of saying she wanted to change the agency Miss J said that she liked most of the carers and wanted to keep them. Instead, she wanted to be assured that she could have a group of regular carers to support her and that she wanted to be directly involved in the training they had.

The social worker worked with Miss J and the agency manager was able assure a regular group of carers and that training was much more personalised to Miss J's needs in the way that Miss J had wished for. No further concerns were raised.

Multi-agency Safeguarding Hub

The Board was informed of the plan for adult services to be included in the future development of the Multi-agency Safeguarding Hub (MASH).

The Oxfordshire MASH was initially set up to manage referrals relating to children but it has been agreed that this will be extended to include safeguarding alerts in relation to adults due to its success and the benefits and outcomes for vulnerable adults.

What is a MASH?

The Multi Agency Safeguarding Hub (MASH) will provide triage and multi-agency assessment of safeguarding concerns in respect of vulnerable adults. It brings together professionals from a range of agencies into an integrated multi-agency team. The MASH team makes assessments and decisions depending on the referral information and is able to sign post to other services if the safeguarding threshold is not met.

The MASH team shares information from every agency to decide the most appropriate intervention in response to the person's identified needs. This ensures that vulnerable adults are responded to quickly and efficiently by the most appropriate professional.

Outcomes of the MASH

- A faster, more co-ordinated and consistent response to safeguarding concerns about vulnerable adults.
- An improved 'journey' for the adult, with greater emphasis on early help and better informed services delivering intervention at the right time.
- A clearer process for the professional or member of the public raising a concern about a vulnerable adult.
- Closer partnership working, clear accountability and improved multi-agency communications.
- A reduction in the number of inappropriate referrals and re-referrals.

Benefits to agencies of the MASH model

- Safeguarding of vulnerable adults is a collective priority.
- Efficiency savings – financial savings through economies of scale and avoiding duplication of work.
- Efficiencies through centralisation of business support/back office, accommodation and utilities.
- Quicker response times with a better co-ordinated approach to resources meaning each agency works more effectively and efficiently in their own field of expertise.
- A better understanding and appreciation of each other's roles and responsibilities, leading to effective multi-agency working.
- Development of flexible working patterns and providing enhanced customer service.

Establishing a Monitoring and Evaluation Sub-Committee of the Board

A Monitoring and Evaluation sub-committee was established. The terms of reference were agreed as:

- To agree a data set for agencies of the Board to report on to establish their performance in meeting the needs of vulnerable adults.
- To receive the audit programme of Board agencies, to identify audits which provide information on services to vulnerable adults, and to have these reported to the Sub-committee.
- With the Board, to identify priorities for multi-agency audits.
- To commission multi-agency audits and have these reported to the sub-committee.
- To maximise the potential for audits to incorporate the views of vulnerable adults and their carers.
- To oversee the implementation of actions plans from audits.
- To inform the Board of quantitative and qualitative information that indicates the effectiveness of agencies in meeting the safeguarding needs of vulnerable adults.
- To prepare an annual report on the work of the sub-committee to the Board.
- To propose a multi-agency audit programme to the Business Planning day of the Board.

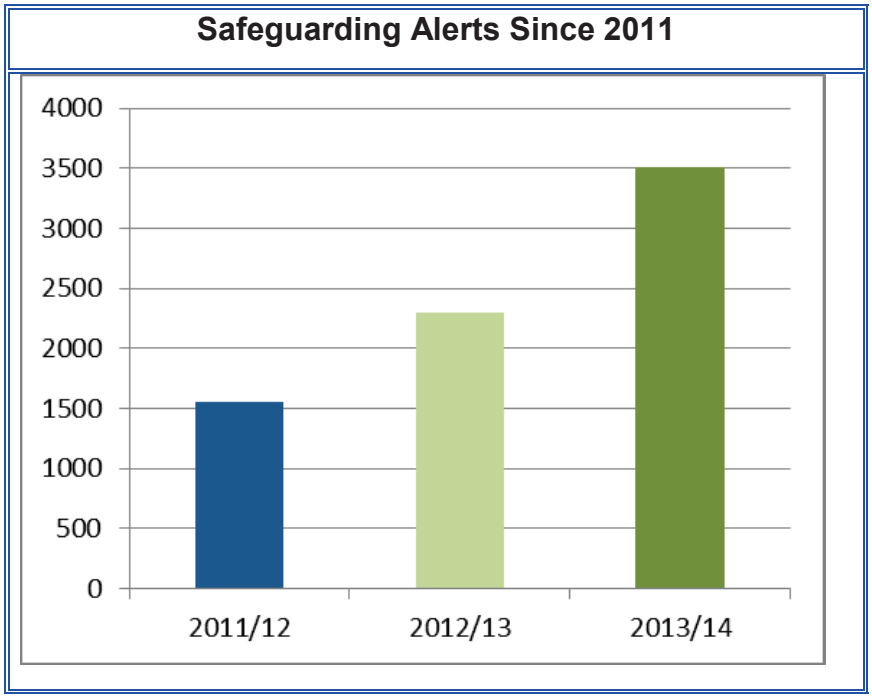
The group will report annually to the OSAB Full Board to inform the OSAB Annual Report and to provide robust information that helps to inform the business planning process.

Safeguarding Adults Activity in Oxfordshire 2013-2014

Overview of Safeguarding Alerts

When concerns about possible abuse or neglect are reported into the multi-agency safeguarding process, this is now called a Safeguarding Alert.

During 2013-14 there have been 3515 safeguarding alerts raised. The graph below shows the total number of alerts over the last three years broken down by year



During 2013/14 there have been 1135 more safeguarding alerts than in the previous 12 months, an increase of 49%. This is an indication of increasing awareness of safeguarding adults.

Whilst initial enquiries are made in relation to all alerts and records of all alerts are retained and reviewed, not all will require a formal strategy discussion or investigation in accordance with adult safeguarding procedures as there may be more appropriate ways of responding to the concern, e.g.:

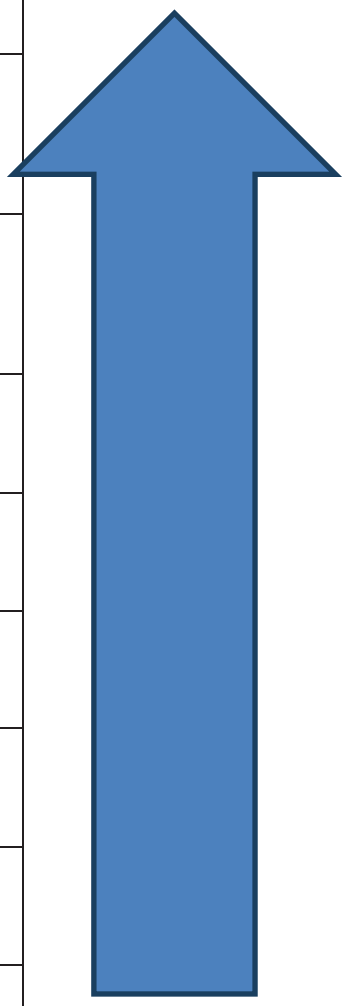
- Signposting or the provision of information or other forms of help
- Other forms of assessment e.g. a carer's assessment

Where further action is require the alert is progressed to a referral and a strategy discussion or investigation is held.

Oxfordshire Safeguarding activity	2013/14
Alerts made	3515
Alerts progressed to Referrals	1540
Conversion rate	44%

Source of Safeguarding Alerts

	2012/13	2013/14	Trend
Care Quality Commission	12	20	
Education/training or employment	6	8	
Family, friend or neighbour	266	343	
Health	557	740	
Housing	31	48	
Other	238	342	
Police	162	260	
Self	52	70	
Social care	1097	1623	



This table shows where these alerts have come from over the last 2 years. There has been an increase in the proportion of safeguarding alerts made by different groups has remained very similar meaning that awareness has grown at the same level across all group.

Overview of Safeguarding Enquiries

Safeguarding by Clients Group

This table sets out the groups of people who are affected by the safeguarding concerns raised.

	2012/13	2013/14	Trend
Learning Disability	519	691	
Mental Health	305	334	
Other	155	106	
Physical Disability/Sensory Impairment	1346	2121	
Substance Misuse	20	18	
Unpaid carer	36	26	

Safeguarding by Age

This table details the proportion of people who are affected by the safeguarding concerns raised by both gender and age.

	2012/13	2013/14	Trend
Age 18-64	893	1136	
Age 65-74	264	386	
Age 75-84	553	811	
Age 85+	658	1115	

The majority of safeguarding investigations concern females (63%). Considering that 57% of safeguarding investigations concern people aged 75+, this is most likely explained by differences in mortality rates and the resulting differences in population size.

Safeguarding Investigations by Type of Alleged Abuse

This table outlines the type of abuse reported.

	2011/12	2012/13	2013/14	Trend
Emotional/Psychological	13%	12%	11%	
Financial	16%	14%	13%	
Neglect % acts of omission	28%	35%	45%	
Physical	38%	34%	27%	
Sexual	5%	5%	4%	

There has been a decline in the proportion of safeguarding enquiries involving physical abuse (-7%). Alongside this, neglect and acts of omission, has increased by 10%.

Safeguarding by ethnicity

This table outlines the ethnicity of those people affected by the safeguarding concerns raised, where there ethnicity is known.

	White	Mixed/ Multiple Groups	Asian/Asian British	Black or Black British	Chinese	Other Ethnic Group
2012/13	96.15%	0.53%	1.06%	1.44%	0.38%	0.43%
2013/14	96.25%	0.50%	1.21%	1.55%	0.15%	0.34%

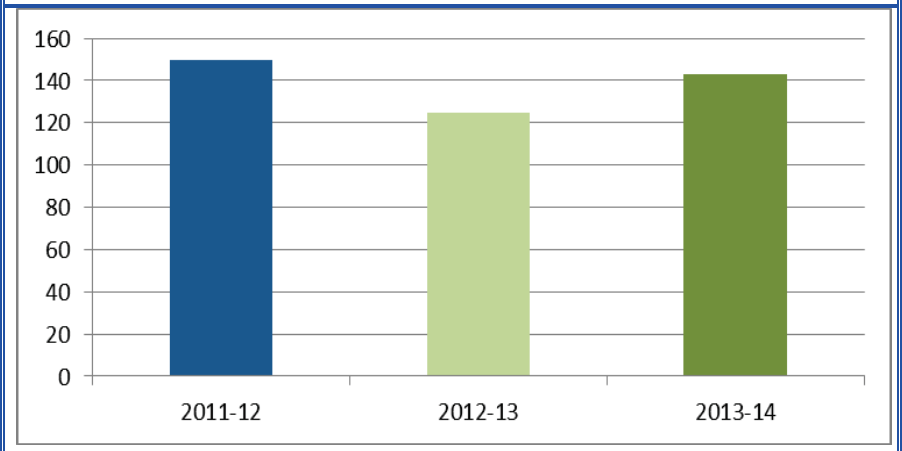
During 2013/14, 3.75% of people supported within the safeguarding adults procedures were from minority ethnic communities. According to the 2011 Census, **9.15%** of Oxfordshire's residents come from non-white backgrounds. This discrepancy is largely explained by the difference between age groups. Whereas the proportion of adults under 65 from non-white backgrounds is **9.44%** the proportion of adults over 65 from non-white backgrounds is **2.25%.**

Mental Capacity Act Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 provides a statutory framework to protect people who lack capacity to makes decisions for themselves. It sets out who can make decisions, in which situations they should do so, and how they should go about this. The House of Lords Select Committee's report on the implementation of the Mental Capacity Act 2005 highlighted that this piece of legislation was not working well. It was reported that this was because people do not know about the Act and where they do they do not understand it.

We will continue to commission and deliver a comprehensive training programme in relation to the Mental Capacity Act and DoLS The implementation of the Act is a priority for the board and a safeguarding adults sub-group has been set up to monitor the governance of the Act during 2015-2016.

DoLS Authorisations

During 2013/14	Over the last 3 years
143 **DoLS Authorisations**	

The DOLS service is working to raise awareness of the change in the definition of deprivation of liberty and is increasing the number of trained Best Interests Assessors in Oxfordshire so more assessments can be completed in as timely way as possible.

Looking forward

The board's priorities for 2014-2015 were:

- **Priority 1**: Improve information sharing between partner agencies to strengthen joint working to safeguard adults from abuse/harm.
- **Priority 2:** Develop methods for engaging service users and carers to capture their views and experience.
- **Priority 3**: Ensure there is a strong multi-agency approach to prevent adult abuse/harm.
- **Priority 4**: Ensure there are robust processes and procedures in place to respond to national and local safeguarding developments by risk assessing the impact of developments and risk assess response.

The financial pressures on care and support services, whether provided or commissioned by health or social care, have not eased. The demographic pressures that are generating increased demand for care and support services have yet to peak. These pressures apply to all the statutory services and to the independent, voluntary and community sector agencies that are commissioned to provide services.

OSAB and the Chair's role is in holding members to account for their activity as it effects the wellbeing and safety of the adults at risk in Oxfordshire, both as individual agencies but also a partnership working together. The OSAB is committed to developing, owning and implementing its Business Plan and strategic vision.

The OSAB's vision is that all vulnerable adults live and work or are cared for and supported in an environment free from abuse and neglect. This will continue to be the Board's priority going forward.

The Care Bill 2014 will establish Safeguarding Adults Boards on a statutory footing, bringing it in line with the well-established statutory Local Safeguarding Children's Boards. This will be an incredibly positive step and the OSAB will strive to meet the challenge of raising its profile to match that of the Children's Board. The increased duties and responsibilities contained in the Care Bill have yet to be fully identified.

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Health and Wellbeing Board
16 July 2015
Children's Trust Briefing

This paper outlines the activity of the Children's Trust since the last update which was provided to the Health and Wellbeing Board in March 2015.

1. The Trust has met twice since the last update and discussed and fed into issues including:

    a. The **Child and Adolescent Mental Health Service (CAMHS) Review.** The Trust discussed a number of points relating to the recommendations from the review, including the importance of early intervention with primary school-aged children; an open approach to joined-up working; the need to improve transitions from CAMHS to adult mental health services; and the need for improvements in data collection, particularly for black and ethnic minority communities. An action plan to implement recommendations from the CAMHS review will be brought back to the Trust at a future meeting.
    b. The **Oxfordshire Alcohol and Drugs Strategy.** The Trust discussed the Strategy in relation to children and young people and focused on the importance of engaging with the district and city councils on areas such as community safety and licensing, and the weaknesses in current data because of a reliance on self-reporting and estimated figures. A Strategy working group focusing on children and young people will report back to the Trust on progress going forward.
    c. **Adolescents.** As a result of a workshop on adolescents in January, the Trust produced an action plan that aims to bring together work across different areas, so that a co-ordinated approach can be taken. Actions focus on improving services for adolescents by monitoring and influencing current practice across the partnership and sharing best practice, particularly for groups identified at the adolescent workshop where concerns are most acute. Progress on the action plan will continue to be monitored by the Trust.
    d. The **Female Genital Mutilation Strategy.** The Trust received an update on the implementation of the Strategy and was pleased with progress on training professionals, but highlighted the need for consistent training across organisations.

2. The new **Children and Young People's Plan 2015-2018** and associated performance measures were agreed at the Trust's June meeting, for recommendation to the Health and Wellbeing Board.

3. At its June meeting the Trust welcomed number of **new members.** Jane Holt, Head teacher of Charlbury Primary School, to represent Oxfordshire's schools and colleges, and two Healthwatch Ambassadors, Naomi Spriggs and Adrian Sell, to represent the views of parents and carers.

    Katie Read / Ben Threadgold
    June 2015

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Health and Wellbeing Board
16 July 2015
Older People's Joint Management Group Briefing

This paper outlines the activity of the Older People's Joint Management Group since the last update provided to the Health and Wellbeing Board in March 2015.

1. The Group has met twice since the last update, on 24 March 2015 and 4 June 2015 and had discussions on the following issues in addition to matters arising from the previous meetings.

2. The Older People's Joint Management Group monitors activity, performance and spending from the pooled budget to meet the six priorities of **the Older People's Joint Commissioning Strategy,** which are:

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

3. Key messages in relation to the priorities and activity include

    - The Council has placed more people in care homes than the target but admissions direct from own home decreased by one third this year;
    - Spending on care at home increased due to 8% increase in the average cost of a home care package even though the number of people supported at home remained the same;
    - Early inspection results suggest that quality of care at care homes in Oxfordshire requires some improvement to meet the requirements of tougher CQC inspection regime;
    - The key areas off target remained the same:
        - High levels of delayed transfers of care, particularly relating to people needing on-going health care and reablement;
        - The number of emergency admissions to hospital;
        - The low level of people being referred to reablement from community settings - not from hospital.
    - The Joint Management Group approved the overall year end position for the Older People's and Equipment Pool with an underspend of £0.758m against a total budget of £182.099m.

4. The Group discussed the changes to **Carers' Support Plans and Financial Assistance.** The paper explained that from 1 April 2015, the council has been using a new carers assessment to assess carers (people who support and care for family, neighbours and friends) needs and the impact of caring on their wellbeing. The assessment results in a carer receiving information about local support groups, practical support such as respite care, or a payment if the carer has eligible needs. This payment will replace the carers' grants. A review of the new process and the number of carers who come forward for assessment and the support provided to them will be reported back to the Group in September 2015.

5. The Joint Management Group approved the recommendation a for a new '**dementia support service**' to replace the existing information and advice and practical support services. The new service will provide a standardised post-diagnostic support for everybody who has dementia and who are not in care homes (approximately 2,000 people) by providing a single point of contact. This will ensure person- centred and flexible support to people according to their needs.

6. The JMG agreed the changes to the measures and targets of the **Joint Health and Wellbeing Strategy for 2015/16** relevant to older people to be submitted to the Health and Wellbeing Board on 1 July 2015. The discussion focused on the current and proposed measures and targets for the Priority 6 and 7 of the Joint Strategy.

7. **The Older People's Partnership Board** representatives fed into the discussions and raised specific questions on dementia services, discharges from hospital late in the night, provision of equipment, workforce issues and quality of care.

Fulya Markham
Policy & Partnership Officer

25 June 2015

An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
July 2015

The Health Improvement Board has held 2 meetings since the last report to the Health and Wellbeing Board.

1. Health Improvement Board meeting, April 2015

At its meeting in April 2015 the Board received detailed reports on performance on three areas of work – immunisation of children, successful completion of treatment for drugs misuse and the prevention of homelessness / uptake of housing related support across the county. The Board members were able to use this detailed insight to agree priorities for the year ahead, building on the progress achieved in the last year but also highlighting areas where more attention is still needed.

An update on Oral Health Promotion explained which services are available in the County and outlined plans for the year ahead. Detailed information on oral health needs was not available due to the way information is collected, but in general it was concluded that where there are communities with poor outcomes on other health issues, they may be likely to have poor oral health too.

A report on a successful year of Public Health work at the Oxford University Hospitals Trust was presented and was well received. The Here for Health drop-in clinic was shown to be a great success in attracting staff, patients and family members for practical advice and support in adopting healthier lifestyles. The Vice Chairman agreed to write to the Chief Executive of OUHT to stress the importance of recruiting a Public Health Consultant to lead this important work in the Trust.

Councillor Mark Booty was thanked for his Chairmanship of the Health Improvement Board and everyone wished him well as he stood down from his Councillor duties at the election. Aziza Shaffique and Paul McGough were thanked for their great work as Public Involvement Network representatives.

2. Health Improvement Board meeting, July 2015

The July meeting of the Health Improvement Board took place at Oxford Town Hall.

The agenda included a paper on the partnership work which supports young people who are in need of housing related support. This was an informative presentation and it was agreed that the work to commission housing related support for young people should come under the governance of the Health Improvement Board. An outcome measure has been proposed for inclusion in the Joint Health and Wellbeing Strategy to monitor this work. It was agreed that more consultation should take place before this outcome measure is agreed and this work will be carried out as soon as possible so that the outcomes can be included in the Joint Health and Wellbeing Strategy.

The annual report of the Public Health Protection Forum was presented and it highlighted the current situation with regard to outbreaks of infectious disease, immunisation and screening uptake and trends in the prevalence of sexually transmitted infections. It was agreed that the issue of Air Quality would be discussed at a future meeting of the Board.

This meeting saw several changes to membership and was the first meeting for the new Healthwatch Ambassadors who will share the role. Councillor Ed Turner has is now the Chairman of this Board, with Councillor Anna Badcock as Vice Chairman. There are also new representatives from Cherwell, West Oxfordshire and Vale of White Horse District Councils. The membership of the Board is now:

Chairman – City Councillor Ed Turner	Oxford City Council
Vice Chairman - Councillor Anna Badcock	South Oxfordshire District Council
***Board Members**:*	
Ian Davies	Cherwell & South Northants District Council
Cllr John Donaldson	Cherwell District Council
Laura Epton and Emma Henrion	Healthwatch Ambassador (job share)
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Dr Jonathan McWilliam	Director of Public Health
Cllr James F. Mills	West Oxfordshire District Council
Dr Paul Park	Oxfordshire Clinical Commissioning Group
Cllr Monica Lovatt	Vale of White Horse District Council
Jackie Wilderspin	Public Health Specialist
Val Johnson	In attendance as officer supporting District Councils

Jackie Wilderspin, July 2015

Oxfordshire

Children & Young People's Plan

2015 - 2018

Contents

Foreword

Welcome to the new Oxfordshire Children and Young People's Plan

In the last year the Children's Trust's membership has been refreshed and reinforced. This puts us in an even stronger position to promote the value and importance of children and young people in the county. We are committed to realising our vision for Oxfordshire to be the best place in England for children and young people to grow up.

This Plan has been developed through discussion with our partners and through public consultation about what the priorities should be for services for children, young people and families in Oxfordshire over the next three years. Our responsibility as a Trust is now to play our part in delivering this Plan by highlighting the importance of these priorities to all partners across the county, monitoring the performance of agencies in delivering services that support the Plan, and working to solve problems and find solutions collaboratively.

It is crucial in times of limited budgets and increased demands on services that the Trust continues to enable partnership working. Only together will we meet these challenges and tackle our Plan's priorities such as improving children's mental health, improving educational attainment especially of vulnerable learners, and preventing neglect and child sexual exploitation.

We know that there have been some significant successes in achieving better outcomes for children in Oxfordshire and that a majority of children, young people and families in Oxfordshire are healthy, safe and thriving at both home and school. Many of the services we commission and provide meet children and young people's needs very well and we must work to ensure that these services continue to evolve and adapt to meet the changing needs of our children, young people and families.

As Chairman and Vice-Chairman of the Children's Trust we look forward to making this new Plan a reality and working with every child and young person to develop the skills, confidence and opportunities they need to achieve their full potential.

Cllr Melinda Tilley

Chairman of the Children's Trust and Oxfordshire County Council's Cabinet member for Children, Education and Families

Dr Matthew Gaw

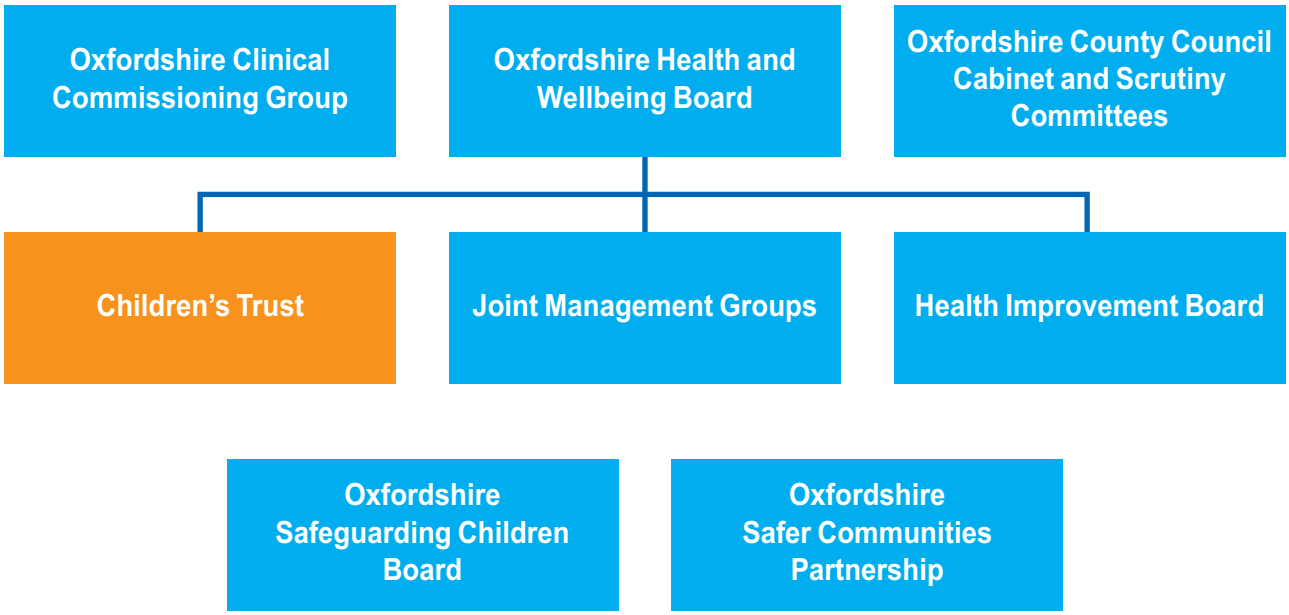
Vice-Chairman of the Children's Trust and GP

Introduction

The Children and Young People's Plan drives the work of the Children's Trust and is jointly authored by all of the Trust's members. It is based on evidence from the Oxfordshire Children's Needs Analysis 2014 and from the Joint Strategic Needs Assessment 2015.

The Children's Trust is a group of stakeholders who have an interest in the health and wellbeing of children and young people in Oxfordshire. It includes representatives from the county council, city and district councils, Thames Valley Police, the NHS, schools, the voluntary sector, and parents.

Our relationship with other partnership boards



The Oxfordshire Health and Wellbeing Board is responsible for improving the health and wellbeing of the people of Oxfordshire through partnership working.

The Children's Trust influences and supports the Oxfordshire Health and Wellbeing Board in its aim to improve outcomes for children, young people, and their families.

The Trust informs and complements the work of other partnerships in the county, in particular: the Health Improvement Board; the Oxfordshire Safeguarding Children Board; the Oxfordshire Safer Communities Partnership; and the Oxfordshire Skills Board. These Boards also have an interest in making sure Oxfordshire is the best place in England for children and young people to grow up.

Our vision

We want Oxfordshire to be the best place in England for children and young people to grow up in, by working with every child and young person to develop the skills, confidence and opportunities they need to achieve their full potential.

We want Oxfordshire to be a 'thriving Oxfordshire'. This means a place where people can work to achieve a decent life for themselves and their family, a place alive with vibrant, active communities, and a place where people can enjoy the rewards of a growing economy and feel safe.

To achieve this, the Trust is focussed on four priorities:

1. Ensuring children have a healthy start in life and stay healthy into adulthood
2. Narrowing the gap for our most disadvantaged and vulnerable groups
3. Keeping children and young people safe
4. Raising achievement for all children and young people

Our approach to achieving this vision

When developing and implementing this Plan, we will focus on:

- Social disadvantage – where disadvantaged and vulnerable groups are targeted
- Helping communities and individuals to help themselves – where we find ways to support people, allowing them to be as independent as possible
- Locality working – where locality approaches are used when they are the best way to make improvements

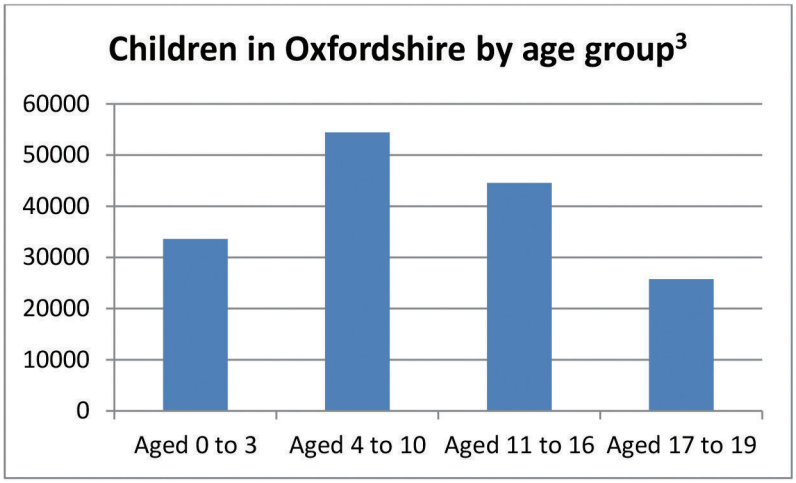
In developing this Plan, the Children's Trust has identified a number of principles that will shape our priorities:

Principle	This means…
Having a 'family' approach	… children and young people are not viewed in isolation and, whenever appropriate, action is taken to address issues that affect the whole family.
Encouraging early intervention	…wherever possible, issues are identified and interventions are made early in order to avoid more acute problems developing down the line.
Getting input from children and young people	…our work reflects the concerns and meets the needs of children and young people. We are always listening.
Promoting working in partnership	…planning and implementation of services is joined up wherever outcomes can be improved.
Smoothing the transition between children's and adult services	…ensuring a coherent and simplified experience for young people moving into adulthood.
Having cost effective services	…where budgets are spent wisely and efficiently.

Children and young people in Oxfordshire

There are 138,000[1] people under the age of 18 in Oxfordshire. They represent 21% of the county's population. The graph below shows how they are distributed by age range.

The birth rate in Oxfordshire is 1.77[2]. This is its highest level since 1973, but the Office for National Statistics anticipates that national fertility rates will remain stable between now and the mid-2030s.



82%[4] of our children and young people are from white British ethnic backgrounds. There are differences across the county though, and in Oxford City 42% of children are non-white British. The largest minority ethnic group in the county is Asian/Asian British at 6.22%, with most coming from Indian or Pakistani backgrounds. This rises to 17.41% in Oxford City. Ethnic diversity is higher amongst young people than in the population in general.

Most children live in households where there are two parents but 18.7%[5] of all households with dependent children have single parents.

Approximately 12.2% of children aged 15 and under live in income-deprived households. This is well below the national average of 21.8%. However, there are wide local variations with Oxford City reaching 22.9% and West Oxfordshire at 8%[6].

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[1] Census 2011

[2] Based on ONS Mid-2013 Population Estimate. The Birth Rate is the total number of births per 1,000 of a population in a year.

[3] ONS Mid-2013 Population Estimate

[4] Census 2011

[5] Census 2011

[6] IMD 2010 data published by DCLG

Progress across the county

Healthy Start

More women see a midwife or maternity health care professional within the first 13 weeks of pregnancy than in previous years.

95% of children aged two to two and a half years old received a Health Visitor review during 2013/14.

The county achieves high coverage rates for the majority of childhood immunisations.

Emergency admissions to hospital of young children with infections have decreased.

Narrowing the gap

Teenage pregnancies are at their lowest figure since records began and lower than the national average.

810 families are on track to be turned around as part of the Troubled Families programme. Oxfordshire is an early starter for Phase 2 of the programme, supporting a further 434 families.

Persistent absence rates from school have improved.

Keeping Safe

Children's social care services are rated as "good" by OFSTED.

More than 3,500 staff across Oxfordshire have received child protection training since 2012.

21 extra dedicated child protection social workers were recruited in 2013/14.

The Kingfisher team, which works with children vulnerable to child sexual exploitation, has won a number of national awards.

The Multi-Agency Safeguarding Hub – home to a multi-agency team which identifies risks to vulnerable adults and children - opened in October 2014.

Raising achievement

More pupils now attend 'good' and 'outstanding' schools than ever before.

Reading at Key Stage 1 continues to improve.

In 2014, 59.4% of pupils achieved five or more A*-GCSEs, including English and Maths – higher than the national average.

In July 2014, 4.4% of young people aged 16-19 years in Oxfordshire were classed as being 'Not in Employment, Education or Training' (NEET), the lowest rate for a number of years.

The successful Oxfordshire Reading Campaign has been extended for another year.

2,600 16-24 year olds started apprenticeships in 2012/13.

Priority one: Ensuring children have a healthy start in life and stay healthy into adulthood

Aim: All children should have access to the wide range of services universally available to protect and promote health. When health problems do occur they should have access to safe and high quality local health services that aim to help them recover as soon as possible.

There is increasing evidence that outcomes across health, education and social care are determined from very early on in life. A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life.

By ensuring that children have a healthy start in life, and that this continues into adulthood, we are helping services move towards the prevention of ill health and helping to reduce unnecessary demand for services in the future.

What we know about getting a healthy start in life[7]

Pregnancy and the first few months

Low birth weight increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. Low birth weight is normally associated with ethnicity but can indicate lifestyle issues of the mother and/or issues with maternity services. Rates in Oxfordshire are higher than the South East average, but below England as a whole.

In 2013/14, 9.3% of mothers in Oxfordshire were recorded as smokers at the time of delivery which is lower than the equivalent proportion in England, 12%.

Breast milk provides the ideal nutrition for infants. Increases in breastfeeding are expected to reduce illness in young children and have health benefits for the infant and the mother. The county's breastfeeding initiation rate is higher than the national figure, as is the breastfeeding rate at six to eight weeks.

Maternal Postnatal Depression affects around 13% of mothers. Compared to children of non-depressed mothers, the children of mothers with Postnatal Depression are more likely to have learning, behavioural and attachment problems.

[7] Much of the 'what we know' information in this Plan is taken from the Oxfordshire Children's Needs Analysis (version 3.3, June 2014) and the Joint Strategic Needs Analysis Annual Summary report 2015.

Teenage mothers are more likely to suffer from Postnatal Depression, and to smoke during pregnancy. They are less likely to breastfeed, and likely to struggle to complete their education and find it difficult to gain employment. The under-18 conception rate in Oxfordshire is significantly lower than the national one and is decreasing broadly in line with the trend for England.

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. In Oxfordshire levels of immunisation for childhood diseases continue to increase.

Into childhood

There are significant health consequences of childhood obesity, including Type 2 diabetes, and it makes conditions such as asthma worse. It can also lead to psychological problems such as social isolation, low self-esteem, and bullying. The percentages of children overweight or obese are lower in Oxfordshire than overall in England or the South East, but there are still a significant number of children in the county who are obese. Nationally, there is a strong positive relationship between deprivation and obesity prevalence for children, and obesity rates are significantly higher for children in ethnic groups including Asian or Asian British, Black or Black British, and Mixed ethnicity.

There is good scientific evidence that being physically active can help us lead healthier lives, whatever our age. In Oxfordshire in 2013 about 90% of children aged between five and 16 spent at least two hours a week doing sport or physical activity at school. This is in line with the national figures.

Engagement in culture, as well as sport, has a positive effect on wellbeing, and a higher frequency of engagement is generally associated with a higher level of wellbeing. Similarly there are also direct benefits of green space to both physical and mental health and wellbeing. Oxfordshire is the most rural county in the South East and 52% of Oxford City's area is open space (not including the colleges).

Hospital admissions caused by unintentional and deliberate injuries in children in the county have declined, and unplanned hospitalisation for asthma, diabetes and epilepsy are at levels below the England average. The number of emergency admissions for children with lower respiratory tract infections is significantly lower than the England average.

Tooth decay in children is a preventable disease. Rates of tooth decay are higher than South East rates in Oxford, Cherwell and West Oxfordshire.

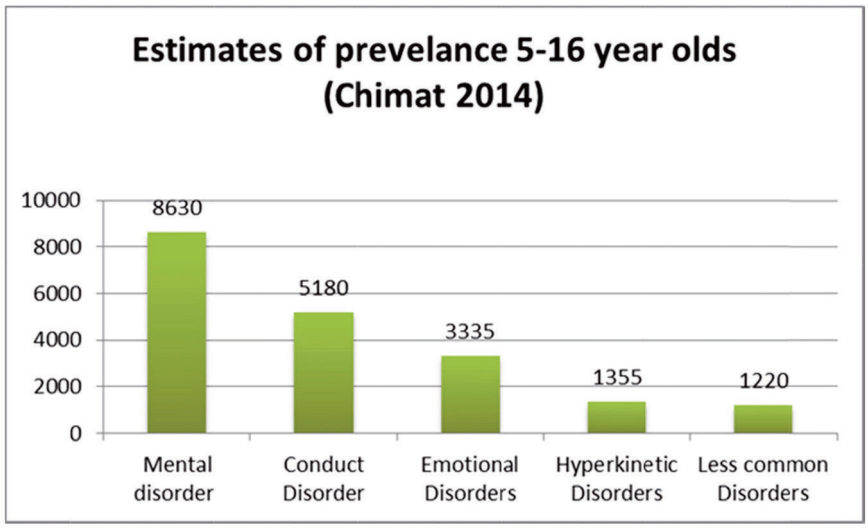
1% of children are thought to have Autistic Spectrum Condition (ASC) (including Asperger's Syndrome). This equates to 1,300 children and young people in the county. In Oxfordshire, the incidence of diagnosed ASC is almost twice the national figure.

Bad housing conditions – including homelessness, temporary accommodation, overcrowding, insecurity, and housing in poor physical condition – are a risk to health. A 2006 study by Shelter found that experience of multiple housing problems increases children's risk of ill-health and disability by up to 25% during childhood and early adulthood.

Moving towards adulthood

One in 10 children and young people aged 5 to16 suffer from a diagnosable mental health disorder – that is around three in every class at school. About half of these (5.8%) have a conduct disorder, whilst others have an emotional disorder (anxiety, depression) and Attention Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16 to 24 age group.

Around a quarter of the 11,000 referrals for Oxford Health mental health services in 2013/14 were for Child and Adolescent Mental Health Services (24%).



Young people with mental health difficulties are also likely to have lower attainment than their peers, higher rates of absenteeism from school and higher risk of falling into the NEET (Not in Education, Employment or Training) category.

Analysis of national surveys suggests that peak onset of mental ill health is between eight to 15 years and half of lifetime mental ill health starts by age 14.

Self-harming in young people is not uncommon. Estimates indicate that approximately 2,600 14 to 17 year olds self-harm to some degree in the county. Urban self-harm rates are substantially higher than rural rates. Autistic people have significantly higher levels of self-harm and suicide than their mainstream peers.

The National Youth Survey results show that a large minority of young people in their early teens take part in heavy ‘binge’ drinking. A quarter of 13 and 14 year old students admit they have recently drunk five or more alcoholic drinks in a single session, rising to more than half of all 15 and 16 year olds.

In three of the districts (Cherwell, South Oxfordshire and West Oxfordshire) there has been a declining trend in under 18 alcohol-specific hospital admissions over the four years from 2008/9 to 2012/13. In Oxford and Vale of White Horse numbers have remained fairly stable over the period.

Nationally, fewer young people are smoking but in 2013 8% of 15 year olds surveyed on behalf of the Health and Social Care Information Centre said they smoked regularly. Smoking affects lung growth and can lead to lung function decline which may cause an increased risk of lung disease later in life. 75% of young people who smoke say they want to give up.

Public Health England estimates that the rate of hospital admissions due to substance misuse among 15 to 24 year-olds in Oxfordshire was 56.9 per 100,000 people between 2010 and 2013. The England average was 75.2.

Nationally, young people experience the highest Sexually Transmitted Infection (STI) rates, and Chlamydia is the most commonly diagnosed infection. Chlamydia diagnoses are high in Oxford, but other parts of the county are well below the England rate.

Mental health was a consistent theme in our consultation. Young people value having impartial, emotional support and parents/carers felt that the mental health of the whole family was important to the wellbeing of young people.

Areas of focus for the Trust

- **Mental Health, including:**
  - Maternal and peri-natal (the period immediately before and after birth)
  - Self-harm and suicide
  - Wellbeing, confidence, and body image
- **Substance misuse (including drugs, alcohol and tobacco), including:**
  - Education and prevention
  - Treatments for substance misuse, including those for parents

In considering our areas of focus we acknowledge the work being done by the Health Improvement Board, which also recognises the importance of a healthy early start in life in promoting the health and wellbeing of the county. The Health Improvement Board will lead on the following issues:

- Promoting breastfeeding
- Halting the increase in childhood obesity, including monitoring the Healthy Weight Strategy and Action Plan and the work of the Oxfordshire Sports Partnership
- Preventing infectious disease through immunisation
- The Stop Smoking Service and the percentage of woman smoking in pregnancy.

The Children's Trust will seek information on the progress made by the Health Improvement Board, and will discuss these issues if there are particular areas of concern.

In addition, the Oxfordshire Community Safety Partnership is engaged in related work to divert young people away from crime and anti-social behaviour including Mental Health and the Alcohol and Drug Strategy. As the Trust's focus is on children and young people, we will coordinate with the work of the Partnership to avoid duplication and ensure children and young people are properly considered in its work.

Outcomes for ensuring children have a healthy start in life and stay healthy into adulthood

We want to make sure things are moving in the right direction within our areas of focus, so we will measure progress wherever we can. To do this, we have a set of measurable outcomes that we want Oxfordshire to aim for.

There is a subgroup of the Oxfordshire Safeguarding Children Board called the Performance Audit and Quality Assurance (PAQA) group which does this monitoring for us and they will raise areas of concern to the Children's Trust if progress is not on track.

These measures don't cover every single one of our areas of focus. Even so, we will ensure that we check on progress for each one of the areas over the next three years.

Area of focus	Measure
Mental Health, including: • Maternal and peri-natal (the period immediately before and after birth) • Self-harm • Suicide • Wellbeing, confidence, and body image	Waiting times for first appointment with Child and Adolescent Mental Health Services (CAMHS). 75% of children will receive their first appointment within 8 weeks of referral by the end 2016/17.
Substance misuse (including drugs, alcohol and tobacco), including: • Education and prevention • Treatments for substance misuse, including those for parents	Support all secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.
Plus monitoring relevant Health Improvement Board measures, including:	
Area of focus	**Measure**
Promoting breastfeeding	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%.
Halting the increase in childhood obesity	Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2014 this was 16.9%) No district population should record more than 19%.
Preventing infectious disease through immunisation	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 and no Clinical Commissioning Group locality should perform below 94%. At least 95% children receive dose 2 of MMR vaccination by age 5 and no Clinical Commissioning Group locality should perform below 94%.

Priority two: Narrowing the gap for our most disadvantaged and vulnerable groups

Aim: Children, young people and families will benefit from effective early and targeted support when they face significant challenges and have greater access to high quality services to prevent gaps developing and to break the cycle of deprivation and of low expectation.

Oxfordshire is overall a very 'healthy and wealthy' place but there are significant differences in outcomes across health, education and social care for some specific groups and in some specific areas of the county.

We know that outcomes for children and families from vulnerable groups and disadvantaged communities can be worse than for their peers and these are variable across the county.

What we know about our disadvantaged and vulnerable groups

Poverty and deprivation

Child Poverty is defined as growing up in a household with low income. Certain groups of people face a much higher risk of living in poverty than others, including lone parents, parents and/or children with disabilities and households where only one adult works.

The most deprived areas of the county are mainly in the urban centres of Oxford and Banbury. However, there are also rural areas that have relatively high levels of deprivation on the geographic barriers index, which assesses the average road distance to important services such as hospitals and schools.

The most deprived communities have the poorest mental and physical health and wellbeing. Children from the poorest 20% of households are three-times more likely to have mental health problems than children from the wealthiest 20%. Parental unemployment is also associated with a two- to three-times greater risk of emotional or behavioural problems in childhood. Nationally, among children in reception and year 6, the prevalence of obesity in the 10% most deprived groups is approximately double that in the 10% least deprived.

Vulnerable groups

Young Carers

At the time of the 2011 Census 1,300 children aged 0-15 years provided some unpaid care in Oxfordshire. Young carers are more likely to have mental health problems, poorer school attendance than average, and are more likely to: be eligible for Free School Meals; be identified as having Special Educational Needs; and have poor educational attainment. In 2013 they were seven times more likely to be Not in Education, Employment or Training (NEET).

Looked After Children

Looked after children – children in the care of social services - experience significantly worse mental health than their peers, and a high proportion experience poor health, and poor educational and social outcomes after leaving care. In Oxfordshire, 6.7% of looked after children have a substance misuse problem, almost double the South East and England average of 3.5%. The emotional and behavioural health of children who have been looked after continuously for 12 months or more in the county is classified as borderline but leaning towards 'cause for concern'.

Disabled children

The mean percentage of disabled children in English local authorities has been estimated to be between 3% and 5.4%. If applied to the population of Oxfordshire this would equate to between 3,946 and 7,102 children experiencing some form of disability.

Estimates from 2010 suggest that around 3,600 children in the county had a learning disability. In 2014 around 2,300 (2.1% of) pupils in Oxfordshire schools had statements of Special Educational Needs (SEN). This proportion has remained broadly similar in the years since 2007. Oxfordshire's rate of SEN-statemented pupils was a little lower than in the South East (2.9%) and England overall (2.8%). In the same year around 16,700 (15.7% of) pupils in Oxfordshire schools were recorded as having SEN but not having statements. Again, this proportion remained broadly similar in the years since 2007, but was slightly above the rates for the South East and England overall (15.1% for both).

Learning disabilities are most common in young boys. Children from poorer families are also more likely to have a learning disability. Moderate and severe learning difficulties are more common among Traveller and Gypsy/Romany children. Profound multiple learning difficulties are more common among Pakistani and Bangladeshi children.

An Anti-Bullying Alliance survey in 2014 found that 70% of the teachers polled heard children using disability terms abusively. Primary school pupils with Special Educational Needs are twice as likely as other children to suffer from persistent bullying. Over 90% of parents of children with Aspergers have reported their child has been bullied in the previous year.

Young Offenders

First-time youth offending rates are lower in Oxfordshire than England, and custody rates are also relatively low. However, 95% of young offenders who are imprisoned have a mental health disorder, and young people in prison are 18 times more likely to take their own lives than others of the same age. 84% of young offenders aged 11 to 17 are boys and over a half of all offences in this group was committed by 16 and 17 year olds.

Thriving families

It is estimated there are 810 families in the county who meet at least two of the national criteria which are tracked as part of the 'Thriving Families' programme. The criteria include:

- Children not attending school regularly or behaving well in school
- Parents in receipt of age-related working benefits
- Anti-social behaviour/ offending within the family

As of 31 August 2014, Oxfordshire has turned around 725 out of 810 families identified.

Equality and discrimination were mentioned by young people regularly throughout the review of this Plan, in particular discrimination regarding young people who are in the care system, or who are "different" such as gay people and goths.

Areas of focus for the Trust

- **Services in deprived areas, including:**
  - The Breaking the Cycle of Deprivation programme – which targets the wards in Oxford City with worst outcomes across a range of indicators
  - The Brighter Futures in Banbury programme
- **Looked after children, including:**
  - Oxfordshire's Placement Strategy – for children in and on the edge of care – which aims, for example, to keep children with their families wherever possible, and increase in-house fostering for harder to place children
- **Care Leavers**
- **Young carers**
- **Disabled children**

The Health Improvement Board also looks at issues relating to this priority, including:

- Controlling the number of households in temporary accommodation
- Preventing households from becoming homeless
- Fuel poverty

The Oxfordshire Safer Communities Partnership supports activity to protect vulnerable children and prevent youth offending, as well as achieve better outcomes for young victims of crime.

We also know that the Education Strategy 2015-18 will have improving provision and raising standards for vulnerable learners as a priority.

The Children's Trust will seek information on the progress made by the Health Improvement Board and the Oxfordshire Safer Communities Partnership and will monitor the Education Strategy, and will discuss these issues if there are particular areas of concern, or where a coordinated interagency approach is needed.

Outcomes for narrowing the gap for our most disadvantaged and vulnerable groups

Area of focus	Measure
Services in deprived areas, including: • The Breaking the Cycle of Deprivation programme – which targets the wards in Oxford City with worst outcomes across a range of indicators • The Brighter Futures in Banbury programme	Reducing inequalities as measured by Public Health measure 1.01i – Children in poverty (all dependent children under 20) – such that the gap between the wards with most poverty and least poverty is reduced.
Looked after children, including: • Oxfordshire's Placement Strategy – for children in and on the edge of care – which aims, for example, to keep children with their families wherever possible, and increase in-house fostering for harder to place children	Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 50.
Care Leavers	Reduce the level of care leavers 'Not in Employment, Education or Training' (NEETs) from 50% (measured at 19th, 20th and 21st birthday of care leaver).
Young carers	Increase the number of young carers identified and worked with by 20% from 1,825 at 1st April 2015 to 2,190.
Disabled children	Reduce the number of children with SEN who have at least one fixed term exclusion in the academic year (down from 5.1% in the academic year 2013/14). Increase the proportion of children with a disability and are eligible for Free School Meals who are accessing short breaks services from 24% in 2014/15.

Plus monitoring relevant Health Improvement Board measures, including:	
Controlling the number of households in temporary accommodation	The number of households in temporary accommodation as at 31 March 2016 should be no greater than the level reported in March 2015.
Preventing households from becoming homeless	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. Increase the number of households in Oxfordshire who have received significant increases in 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.
Plus monitoring relevant Oxfordshire Safer Communities Partnership measures, including:	
Prevent youth offending	Reduce the number of first time entrants to the Youth Justice Service from 208 in the calendar year 2014. Reduce the rate of custodial sentencing per 1,000 of the 10-17 year old population.

Priority three: Keeping children and young people safe

Aim: All children and young people to grow up in a safe, healthy and supportive environment and have good access to services at the right time.

Keeping all children and young people safe must be a priority for everyone in Oxfordshire. Children need to feel safe and secure if they are to reach their full potential in life.

Keeping children safe is everyone's business and many different agencies work together to achieve it.

We want children who need help to receive it as quickly and easily as possible.

What we know about keeping children and young people safe

Child sexual exploitation

Child sexual exploitation - a type of sexual abuse in which children, both boys and girls, are sexually exploited for money, power or status - has been an emerging national issue of concern over recent years. Operation Bullfinch is a joint operation by police and social workers within Oxfordshire, which has resulted in the successful prosecution and conviction of seven men for a range of serious sexual offences, and continues to bring prosecutions. The Kingfisher team – a multi-agency team made up of social workers, police and health professionals - has the responsibility of reviewing all suspected child sexual exploitation cases.

Factors linked to heightened risk of child sexual exploitation include children going missing, children with a history of abuse and children in care. During the first half of 2014/15 over 400 children went missing in Oxfordshire, with around 15% of those going missing on more than two occasions.

Domestic abuse

There were 4,820 incidents of domestic abuse reported to the police in 2012/13 in Oxfordshire where there were children in the household. Many incidents will affect more than one child and domestic abuse is under reported to the police, so this is only a partial picture of the number of children affected. Children and young people who are exposed to domestic violence, experience emotional, mental and social damage that can affect their developmental growth.

Teenage relationship abuse is also a concern, and a 2009 national survey by the NSPCC showed that: a quarter of girls and 18% of boys reported some form of physical partner violence; nearly three-quarters of girls and half of boys reported some form of emotional partner violence; and one in three girls and 16% of boys reported some form of sexual partner violence.

Young people said that advice about healthy relationships, friendships, contraception and bullying were issues on which they would like to have consistent advice and guidance.

Female Genital Mutilation (FGM)

It is estimated that in England and Wales nearly 66,000 women have experienced FGM and over 20,000 girls under the age of fifteen are at high risk of FGM. The most recent research was a statistical study conducted by FORWARD in 2007 to estimate the prevalence of FGM in England and Wales. The highest estimated percentages of FGM incidences were in London but with prevalence of over 2% in some cities including Oxford. Due to the impact that FGM has on the health, safety and wellbeing of girls and women, it was identified as a priority by the Thames Valley Police and Crime Commissioner.

Bullying

Statistics on bullying collated from government reports and research by the NSPCC show that almost half (46%) of children and young people say they have been bullied at school at some point in their lives and 38% of young people have been affected by cyber-bullying.

The Oxfordshire Pilot Bullying Survey 2013/14 found that 17% of pupils have been bullied every month or more frequently, 14% every week or more frequently, and 11% most days or more frequently. In line with national trends, the survey also showed that those young people who are “different” from the majority in terms of race, religion, sexuality or experience of long term illness are likely to experience increased frequency of bullying and feeling unsafe.

68% of bullying takes place at school. Bullying in the community is also an issue with 22% saying they have been bullied out of school.

A Department for Education study in 2010 showed that there is a link between bullying and attainment as well as bullying and the likelihood of being ‘Not in Employment, Education or Training’ (NEET). Bullying can have a powerful impact on young people’s future prospects.

Our consultation showed that young people as well as parents/carers are concerned that bullying, particularly online, is rife and that young people need to be further educated to prevent them from becoming victims.

Risky behaviour among adolescents

As we saw in priority one, a large minority of teenagers are engaged in risky behaviour including substance use (including smoking, alcohol consumption, and illicit drug use), engagement in criminal activity, and sexual risky behaviour. A Centre for Understanding Behavioural Change report in 2013 showed that participation in risky behaviour starts at a young age, risky behaviour amongst young people is very persistent and participation in one type of risky behaviour is predictive of later participation in other forms of risky behaviour.

The report also describes risk factors associated with the likelihood of engaging in risky behaviour. For example, substance misuse is more likely to occur among young people who are female, live in a rural area and have experiences of being bullied. And criminal activity is more likely to be associated with young people who are male, play truant or have been suspended and believe they are treated unfairly by their teachers.

Vulnerable parents

It is estimated that parental drug misuse affects between 2,340 and 3,510 children in Oxfordshire. In addition the national figure for children living with alcohol misusing parents is 1.3 million, four times the number of children living with parental drug misuse.

The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; incomplete immunisation and inadequate health care; a wide range of emotional, behavioural and other psychological problems; early addiction problems and offending behaviour; and poor educational attainment. These can range greatly in severity and may often be subtle and difficult to detect.

Looked After Children

As of March 2014 there were 465 children in care (or 'looked after children') in Oxfordshire. The majority (68%) of looked after children are in a foster placement.

Nearly 50% of looked after children are looked after because of abuse or neglect. Neglect is the ongoing failure to meet a child's basic needs. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. The NSPCC estimates that one in 10 children in the UK have suffered neglect. Family dysfunction is the next most common reason for a child going into care at 17%.

The number of children subject to a child protection plan[8] in Oxfordshire is rising year on year – the figure has risen by 129% since March 2007. The increase was much higher in Oxfordshire than in England overall (73% over the same period).

[8]A child protection plan offers support and services to the family to ensure the child is safe from harm and remains that way. Child protection plans remain in force until the child is no longer considered at risk, moves out of the local authority area or reaches the age of 18.

Protection from abuse, neglect and child sexual exploitation was mentioned numerous times in our consultation. Young people are concerned about the vulnerability of children in Oxfordshire.

Areas of focus for the Trust

- **Neglect**
- **Risky behaviours among adolescents**
- **Bullying**
- **Domestic Abuse**
  Including abuse within teenage relationships
- **Progress of the Multi-Agency Safeguarding Hub**
  a multi-agency team which identifies risks to vulnerable adults and children
- **Female Genital Mutilation (FGM)**
- **Child sexual exploitation (CSE)**

In considering our areas of focus we acknowledge the work being done by the Oxfordshire Safeguarding Children Board (OSCB). Its remit is to secure effective inter-agency arrangements to safeguard and promote the welfare of children and young people. The OSCB has a CSE strategy and action plan which is managed through a dedicated child sexual exploitation sub-group with wide partnership representation.

The Chair of the OSCB is a member of the Trust and will report on progress of the Board's work as required. The OSCB and the Children's Trust have a working protocol that makes clear their respective functions, inter-relationships and roles and responsibilities.

Naturally, the Oxfordshire Safer Communities Partnership is also heavily involved in this area of work, including supporting victims of domestic abuse as well as training practitioners across Oxfordshire, reducing the risk of vulnerability to radicalisation and supporting community safety concerns that are being led elsewhere, such as the Oxfordshire Safeguarding Children Board's child sexual exploitation strategy and the FGM strategy.

The Children's Trust will seek information on the progress made by the Oxfordshire Safeguarding Children Board and the Oxfordshire Safer Communities Partnership and will also aim to focus on areas that support and supplement their work, not duplicate it.

Outcomes for keeping children and young people safe

Area of focus	Measure
Neglect	Set a baseline for and then increase the amount of times the Independent Chair overseeing a child protection plan is satisfied that the objectives of the plans are being progressed by the Core Group. (The Core Group is the group of partners - which can include schools, health, police and social workers etc. - who carry out the work required by the child protection plan). Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan. Increase the proportion of neglect cases where the neglect toolkit is used. (The neglect toolkit is a checklist that professionals use to identify whether a child is being neglected and whether to refer them to children's services.)
Risky behaviours among adolescents; including abuse within teenage relationships	Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (Public Health measure number 2.07ii).
Bullying	More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying.
Plus monitoring relevant Oxfordshire Safer Communities Partnership measures, including:	
Domestic Abuse	Reduce the assessed level of risk for high risk domestic abuse victims managed through the MARAC (Multi-Agency Referral Risk Assessment Conference).

Priority four: Raising achievement for all children and young people

Aim: To see every single child being successful and reaching their potential, thriving in an outstanding learning environment throughout their education, wherever they live across the county, and to see the gap reduced between the lowest and the highest achievers. We aim for every single school and setting to be rated at least as 'good' and to be moving towards 'outstanding'.

Central to our vision is the aim that every child and young person develops skills and is given opportunities to achieve their full potential. Through raising achievement, children and young people are more likely to get the best start in life and be set up to play an active and positive part in the community as adults.

What we know about raising achievement

Early years

During their early years, babies and young children experience phenomenal growth in brain development, and in their understanding of themselves and the world around them. Children who attend higher quality preschool provision tend to do better throughout primary school, particularly in reading.

In 2014 in Oxfordshire 60% of pupils achieved a good level of development at the age of five, equal to the England average.

Attainment

In 2014, 78% of pupils in Oxfordshire achieved level 4 or above in reading, writing and maths at Key Stage 2 (year 6). This represents a drop below the England average (79%) for the first time in a number of years.

In 2014, 59.4% of pupils at schools in Oxfordshire achieved 5 or more A*-C grades at GCSE (Key Stage 4), including English and maths. This was above the England average of 56.8%.

The number of young people starting apprenticeships in the county increased from 1,610 in 2005/06 to 4,530 in 2012/13.

Children eligible for Free School Meals

There are large gaps in attainment between pupils known to be eligible for Free School Meals and their peers in Oxfordshire. 58% of pupils known to be eligible for Free School Meals achieved level 4 or above in reading, writing and maths at Key Stage 2 (year 6). 72% of these pupils leave school without five GCSEs at A*-C.

Children with Special Educational Needs

The attainment gap is even greater for children with Special Educational Needs, with 35% achieving level 4 or above in reading, writing and maths at Key Stage 2 (year 6). 86% of these pupils leave school without five GCSEs at A*-C.

Young people recognise that not everyone will achieve high academic standards and would like those young people to be encouraged and helped to gain confidence in their strengths and abilities to reach their own potential.

Parents/carers felt that a narrow focus on attainment in exams did not always work in the best interest of a young person and a child's wellbeing can suffer as a result.

Attendance

There is clear evidence of a link between poor attendance at school and low levels of achievement. Of pupils who miss more than 50% of school, only 3% manage to achieve five A* to C GCSEs. Children with low attendance in the early years are more likely to come from the poorest backgrounds.

Evidence shows that pupils who are persistently absent in secondary schools have had poor attendance levels in primary school. In primary schools rates of persistent absence in Oxfordshire are below the national average, but in secondary schools rates are slightly above the national average.

Pupils with Special Educational Needs miss more school through absence compared to those without Special Educational Needs. Looked after children are three times more likely to be persistently absent from school. Persistent absentee rates among Free School Meals pupils are 2.5 times that seen in non- Free School Meals pupils.

At the end of July 2014, 4.4% of young people aged 16-19 years in Oxfordshire were classed as being 'Not in Employment, Education or Training' (NEET). This is the lowest rate for a number of years.

Exclusions

Fixed period exclusions have fallen after peaking in 2010/11 and remain below both the South East and England average.

Quality of provision, including special schools

The number of academies in the county continues to grow, and it is expected that 50% of Oxfordshire pupils will likely to be attending academies by the end of 2015.

More pupils now attend 'good' and 'outstanding' schools than ever before; for example, in 2014, 79% of primary schools were judged good or outstanding, a 20% improvement on 2012. As of March 2015, 83% of special schools in the county were also judged as good or outstanding.

Ensuring that all young people regardless of their abilities or circumstances are able to have the same opportunities as everyone else was mentioned as important by young people in our consultation.

Areas of focus for the Trust

In considering our areas of focus we recognise the on-going work to develop the Education Strategy for 2015-18 as well as the work of the Oxfordshire Skills Board.

The new Education Strategy will build on the ambitions of the previous strategy which included:

- **Early Years, including:**
  - Foundation stage outcomes (for children aged 5)
  - The quality of childcare settings
  - Levels of attainment and quality across all primary and secondary schools
- **Closing the attainment gap, including:**
  - Children eligible for Free School Meals
  - Special schools
  - Children with Special Educational Needs

The Oxfordshire Skills Board, which works closely with the Oxfordshire Local Enterprise Partnership, is charged with understanding and communicating the needs of employers and providers in Oxfordshire relating to business development, employment and skills issues. Its priorities include:

- Creating seamless services to support young people through their learning – from school and into training, further education, employment or business
- Up-skilling and improving the chances of young people marginalised or disadvantaged from work
- Increasing the number of apprenticeship opportunities

The Children's Trust will seek information on the progress made on the Education Strategy, and on the priorities of the Oxfordshire Skills Board, and will discuss issues if there are particular areas of concern.

The Oxfordshire Growth Board is also monitoring developments around: the apprenticeship programme; Information Advice and Guidance to drive better employability skills in young people; and increasing the number of people entering training in Science, Technology, Engineering and Manufacturing (STEM) subjects. The Trust will coordinate with this monitoring work wherever possible to limit duplication.

Outcomes for raising achievement for all children and young people

Area of focus	Measure
Early years, foundation stage outcomes.	62% of children in early years and foundation stage reach a good level of development.
Closing the attainment gap, including: • Children eligible for Free School Meals • Special schools • Children with Special Educational Needs	Improve the Free School Meals attainment gap at all key stages and aim to be in line with the national average by 2015 a) KS2: 19% points b) KS4: 27% points Ensure that the proportion of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average.

Plus monitoring relevant Oxfordshire Skills Board measures, including:	
Area of focus	**Measure**
Up-skilling and improving the chances of young people.	Work place experiences and accredited employability skills training will be widely available to young people. By 2020, 35% of businesses in Oxfordshire will be working with schools and colleges to support young people in their transition into work (up from 12%).
Increasing the number of apprenticeship opportunities.	By 2020, an additional 1,150 apprenticeship places for 16-24 year olds will be created (up from 2,600 in 2012/13).

How the Children's Trust will use this Plan

This Plan will drive the work of the Children's Trust until 2018. However, the Plan will remain under review and will be refreshed annually, if required, to ensure that the areas of focus of the Trust remain relevant and remain the most pressing issues facing children and young people in the county.

The Trust meets six times a year to monitor and feed into the partnership work that is taking place around the issues outlined in this Plan. Through this work it will influence and support the Health and Wellbeing Board in its aim to improve outcomes for children and young people, and their families.

Published July 2015

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Communications received by the Chairman October 2015 – February 2015
Report to the Health and Wellbeing Board, March 2015

The Chairman of Health and Wellbeing Board receives correspondence from a range of partners and stakeholders. The Board agreed a process by which this correspondence can be responded to or directed to the most appropriate individual, organisation or group for action. The table below summarises activity from March to June 2015

Date received	Communication topic	Action taken
5.3.15	Foetal Alcohol Syndrome – information on the local availability of training, support and advice	The information was forwarded to Commissioners of Drugs and Alcohol Treatment services in the Public Health Directorate.
11.3.15	Copy of correspondence with the CCG on compliance of OUHT with NICE Clinical Guidelines on Heavy Menstrual Bleeding and NICE Interventional Procedures Guidance on Uterine Artery (Fibroid) Embolisation.	This matter was dealt with by the CCG.
26.3.15	From Age UK Oxfordshire – Excess Winter Deaths. Asking for NICE recommendations to be adopted locally	A response was sent welcoming the NICE guidance and outlining work already being undertaken by the Affordable Warmth Network which meets many of the recommendations made by NICE.
12.4.15	Chronic Fatigue Syndrome – an enquiry on whether the County Council still had access to Grantfinder and whether a voluntary organisation could have access to help their fundraising effort	A response was sent informing the correspondent that the County Council no longer holds a license for Grantfinder, but that the organisation could access this tool through OCVA
13.4.15	Invitation to nominate people for the Bevan Prize, recognising individuals and organisations that have made an outstanding contribution to health and wellbeing in the UK	The information was forwarded to partners.
9.4.15	Macmillan Cancer - invitation to participate in research amongst senior stakeholders with involvement in these services, across the UK.	Invitation forwarded to Adult Social Care senior officers.
27.4.15	Campaign to End Loneliness invitation to participate in an on-	Survey completed

	line survey	
30.4.15	Letter from Andrew Smith MP on behalf of a constituent on the topic of Motor Neurone Disease and services to aid communication for patients.	Response sent based on information received from NHS England Specialist Commissioners for a previous correspondent on this topic.
30.4.15	End Fuel Poverty Coalition – highlighting the NICE guidelines on Excess Winter deaths	A response was sent referring to the Joint Strategic Needs Assessment annual report and the work of the Affordable Warmth Network
1.5.15	St Mungo's – requesting feedback on the Homeless Health Matters campaign	Response sent outlining the work overseen by the Health Improvement Board on housing and homelessness issues .
29.6.15	Oxford Community Social network – a proposal to offer and coordinate volunteering opportunities in Oxfordshire using social media	Response is being prepared by relevant officers at the time that this paper is being submitted.

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk