Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 21 February 2013 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Rose Stratford

Councillors:	Jenny Hannaby Jim Couchman	Anthony Gearing Gillian Sanders	Keith Strangwood Lawrie Stratford
District Councillors:	Martin Barrett Christopher Hood	Susanna Pressel Alison Thomson	
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes:

Date of next meeting: *25 April 2013*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk

Committee Officer - *Claire Phillips, Tel: (01865) 323967*
claire.phillips@oxfordshire.gov.uk

Peter G. Clark

Peter G. Clark
County Solicitor

February 2013

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 10)

To approve the minutes of the meeting held on 15 November 2012 and to note for information any matters arising from them.

4. Speaking to or Petitioning the Committee

5. Healthwatch Update

10.15

Oxfordshire County Council Engagement Manager Lisa Gregory will provide the committee with an update on the Healthwatch procurement exercise.

6. Clinical Commissioning Update (Pages 11 - 16)

10.25

Dr Mary Keenan, Medical Director of the Oxfordshire Clinical Commissioning Group, will present and update on the following items:

- The CCG Authorisation Process
- Clinical Commissioning Group Draft Operating Plan for 2013/14
- Outcome-based Commissioning
- Pooled Budgets
- Joint Consultations

7. Community Hospital Update (Pages 17 - 20)

10.45

A representative from the Primary Care Trust will present a progress update on the Townlands and Bicester Community Hospital Development Projects.

8. Chipping Norton Maternity Review (Pages 21 - 26)

10.55

Jane Herve, Paul Brennan and Andrew Stevens from Oxford University Hospitals NHS

Trust will present an update on the review of the Cotswold Maternity Unit.

There will also be a verbal update on the Horton Hospital.

9. Public Health (Pages 27 - 56)

11.45

Angela Baker, Consultant in Public Health, will update the committee on matters of relevance and interest to the committee. This will include an update on the Public Health Outcomes Framework and the new NHS planning documents.

10. LINk - Final Reports (Pages 57 - 96)

12.15

Adrian Chant and Sue Butterworth from LINk will update the committee on the final LINk project reports for the Maternity Services Review, Dentistry Survey and Mental Health Hearsay update.

11. Chairman's Report

12.40

The chairman will give a verbal update on meetings attended since the last formal meeting of the Health Scrutiny Committee in November.

12. Close of meeting

12.45

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 15 November 2012 commencing at 10.00 am and finishing at 1.40 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Rose Stratford (Deputy Chairman) Councillor Jenny Hannaby Councillor Jim Couchman Councillor Gill Sanders Councillor Lawrie Stratford District Councillor Martin Barrett Councillor Susanna Pressel District Councillor Alison Thomson Councillor Tim Hallchurch MBE Councillor David Nimmo-Smith
Co-opted Members:	Dr Keith Ruddle
Other Members in Attendance:	Councillor Hilary Hibbert Biles (for Agenda Item 6)

Officers:

Whole of meeting	Claire Phillips
Part of meeting	Jonathan McWilliam Angela Baker

Agenda Item	**Officer Attending**
6	Jane Herve Andrew Stevens Tony MacDonald
7, 8	Stephen Richards, OCCG
7	Ginny Hope, NHS Oxfordshire Dr Geoff Payne, Thames Valley Local Area Team, NHS Commissioning Board Dr Prit Buttar, Oxfordshire Local Medical Council Dr Paul Roblin, Local Medical Council, Thames Valley Angie Eachus, NHS Oxfordshire

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

65/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Gearing (Councillor Hallchurch substituting), Councillor Strangwood (Councillor Nimmo-Smith substituting). District Councillor Hood, Dr Harry Dickinson and Mrs A Wilkinson.

66/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Cllr Dr Skolar declared that when practising he had been the Chair of the LMC for his area in London.

67/12 MINUTES
(Agenda No. 3)

The minute were approved with the following amendment:
The first sentence of the second paragraph of item 61/12 should read: *"Alan Webb explained that the visit had focused on a defined list of Key lines of Enquiry which by the end of the day over 90% were rated green"*

Matters arising:
59/12 Health and Wellbeing Strategy
Cllr Pressel asked if the Committee's request that the strategy include priorities for providers should be an action point. The Director of Public Health, replied that all comments had been logged and will be taken into account when the strategy is refreshed for the next year.

A&E waiting times
The committee asked OUHT to provide them with updates on A&E waiting times and delayed transfers of care.

68/12 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

Dr Ken Williamson of Keep our NHS Public (Oxford) addressed the committee. He asked about statements by the OCCG that it was obliged to adopt tendering of services under the 'Any Qualified Provider' (AQP) framework. He said that government policy and the law are different, as a press release by the Health Minister to the Stroud group has shown, and that the NHS is not legally required to put services out to tender. He said that AQP and competitive tendering gives GPs no guarantee of control over the service or control of quality.

The committee asked Dr Williamson if there was any case law supporting this interpretation of the law. He said that it came from a press release issued by the

Minister. He will circulate the references and evidence to the committee. The committee will ask OCCG to respond under item 8.

69/12 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health, Jonathan McWilliam provided the committee with his regular report on matters of relevance and interest to the committee.

Obesity

The Director of Public Health was asked if the committee should write to the Government asking for tighter regulation of the food industry to combat obesity. The Director said that new food labelling rules are being introduced, providing the public with the information necessary to make sensible and informed decisions about their diet.

Tuberculosis

Angela Baker, Consultant in Public Health, NHS Oxfordshire presented an update (JHO5) on work to address Tuberculosis in Oxfordshire.

Tuberculosis is most prevalent amongst the homeless, drug or alcohol abusers, those with immunosuppressant conditions, and people from countries with a high level of the disease.
Cases in Oxfordshire are rare and stable.

There are three ways to combat it:

- Targeted screening
- Early detection
- Ensuring that patients complete the course of treatment

o This is especially important to reduce the risk of antibiotic resistance developing

In Oxfordshire, the following actions have been taken:

- Homeless Screenings
- Pharmacy campaigns
- Liaison with local language schools

The committee asked about the procedures for screening at ports of entry of visitors from high-risk areas. In the past, people were asked to complete a survey that was sent to the Health Protection Agency, but follow-up was difficult as people would move on from the UK address they gave. New regulations soon to come into force will require visitors from high-risk areas to provide a certificate of health or evidence of vaccination when they arrive.

The committee asked for an outline of how at-risk children are identified for vaccination. The decision on whether to vaccinate a baby is made if the parents are from high-risk countries or are either likely to visit one or have guests from them within the first six months of the child's life. Surveys, in various languages, are also given to parents during both the reception year of school and in year seven.

Control of the disease is passing to the Clinical Commissioning Group from April 2013, but public health will have a monitoring role.

The Director of Public Health emphasised that tuberculosis is very difficult to catch.

70/12 TEMPORARY SUSPENSION OF BIRTHS AT THE COTSWOLD MATERNITY UNIT, CHIPPING NORTON

(Agenda No. 6)

Public addresses were made by:
Cllr Hibbert-Biles
Kim Murray, Susannah King mothers
Sarah Boyd, user representative, Maternity Services Liaison Committee

Oxford University Hospitals Trust were represented by:
Jane Herve, head of the OUHT midwifery service,
Andrew Stevens, the director of planning,
Tony McDonald, General Manager, Children's and Women's Division
Cllr Hibbert-Biles requested that this item be held in camera, but the committee decided to remain in public session. Due to the nature of some of her concerns, Cllr Hibbert-Biles will write to the chairman privately.

Cllr Hibbert-Biles raised concerns about mothers being discharged two hours after giving birth, of accounts of poor treatment requiring transfers to Banbury, that the service had broken down after the departure of two senior midwives, and new-born babies were not receiving the early health checks they require. She wanted a full independent enquiry and asked the HOSC to request this of OUHT. The Royal College of Midwives should be involved in any enquiry to ensure objectivity.

Kim Murray, a mother, addressed the meeting with her experiences of the unit. She had experienced poor treatment by the management and poor service by one of the mid-wives. She is aware of similar incidents from other women

Susannah King, a user representative for the MSLC, detailed her experiences of poor management andlack of confidence in the current midwives. She wants an extensive and independent enquiry.

Sarah Boyd, the Midwifery Services Liaison co-ordinator, said she had surveyed local women for their experiences over the last year. 30 responses were received, some positive and some negative. Many reported the lack of an overnight service, inconsistency of staffing, a mother having to be let in by the cleaner, and mothers receiving poor attention from the midwives. However, the unit itself was highly valued.

Jane Herve, the head of the OUHT midwifery service, Andrew Stevens, the director of planning, and Tony McDonald, General Manager, Children's and Women's Divisionaddressed the meeting on behalf of OUHT.

The trust highly values the maternity unit and is absolutely committed to reopening it as soon as possible. There are issues surrounding the unit and its staff which cannot be discussed in public.

The unit was suspended in view of comments received, mostly about working practices rather than one single incident, and as a result of other evidence such as benchmarking the service against both the other three midwifery led units in the county and national targets. There were particular concerns about the high level of transfers which were far above the expected levels. There has been no evidence of poor clinical provision or adverse outcomes, however. Mothers can stay for up to 24 hours and it is not the Trust's policy to discharge women after two hours, although they can voluntarily discharge themselves if they wish.

OUHT are happy to take external advice on the review, including from the Royal College of Midwives. They are open to agreeing who should be involved with the Committee, and to having independent representation on the panel. The committee felt that three months was an excessive amount of time for the review. OUHT want a three month review to ensure thoroughness and that all key stakeholders are involved.

Dr Ruddle was concerned that keeping the unit closed for so long would raise questions about its viability, and that after re-opening it would take time for the unit to regain the confidence of the local population. Cllr Hannaby asked why external staff could not be used to keep the unit open during the review. OUHT said that using outside staff raises issues about keeping the service open overnight.

It was AGREED that OUHT would liaise with the Chairman about the independent involvement in the review and to report back to the HOSC with the findings of the review as soon as possible in 2013

71/12 PRIMARY CARE IN OXFORDSHIRE

(Agenda No. 7)

Stephen Richards, Chief Executive, OCCG
Ginny Hope, Head of Primary Care Contracted Services, NHS Oxfordshire
Dr Geoff Payne, Medical Director, Thames Valley Local Area Team, NHS Commissioning Board
Dr Prit Buttar, Chair, Oxfordshire Local Medical Council
Dr Paul Roblin, Chief Executive, Local Medical Council, Thames Valley
Angie Eachus, Programme Manager, Primary Care, NHS Oxfordshire

Primary Care

The Chairman introduced the discussion by explaining that about 90% of the public's contact with health services is through primary care, but this committee has not examined it before.

Ginny Hope gave the committee a short overview of Primary Care in Oxfordshire. The NHS is currently undergoing its most radical reorganisation in sixty years. There are new functions and new relationships that have to be developed. Under the new structure there will be a single performance model and single set of performance

data. There will be an increased role for local government through Health & Wellbeing Boards.

GPs
The chairman asked about the future of the various GP contracts currently in existence (GMS/PMS/APMS).
GP contracts will be negotiated at the national level, although APMS contracts will still continue. There will be reductions in the resources and funding available for GPs, although the exact figures are currently unknown. The committee will be informed once the amount becomes available.

Oxfordshire is considered a wealthy and healthy county, so will face greater funding pressures than elsewhere. The expectation is that most practices will lose several thousand pounds, but some will see six figure reductions. These losses will inevitably impact the services provided and staffing. However, whilst funding has shifted to secondary in recent years, the introduction of GP commissioning and the move to community-provided services (mirroring in a way the old out-patient clinics) means GPs have faced an increased workload. There is a requirement for a mix of clinical and managerial skills in the service, but variation in the quality of management across the county's 83 practices needs to be addressed.

Medicinces Usage Review
There are far more medicines available now than in the past. Regular reviews ensure patients are taking the right medicines for their conditions. This is particularly important for those taking a variety of medicines as combinations can cause issues. There are benefits to working with community pharmacies to ensure reviews cover over-the-counter medicines and any herbal supplements people might be taking.

Rural dispensing
The committee asked about rural dispensing.
29 practices in rural areas can also dispense medicines. There are still gaps in provision, although rural dispensing is tightly-regulated to reduce potential conflicts of interest and impacts on other dispensers. No practice is allowed to dispense if there is a pharmacy within a radius of 1.6km.

Service commissioning
Primary Care will be commissioned by the Local Area Teams of the NHS Commissioning Board. Whilst there is a single operating model, they take a cross-Thames Valley approach. The relationship between GP commissioning and the local area commissioning team is an important issue for OCCG.

Cllr Pressel asked if the traditional model of general practice can survive.
Cheaper ways of providing GP services need to be found. There is an increasing reliance on salaried staff and locums, as well as a higher turnover of staff, which can impact on continuity of care. This also reflects the trend in new entrants moving away from traditional 365 GP work. Concerns also exist that contracts for health centres like Deer Park in Witney are too easily dominated by big conglomerates and that local GP groups cannot compete. It was noted, however the commissioning boards cannot assist with bid preparation without risking legal challenge. The role of the

commissioner it was noted is to hold under performing primary care to account in the way that happens with underperforming schools.

There are national rules on how large a tender has to be, and the commissioners have a range of contracts they can choose to employ depending on the situation. However, a provider's previous service history cannot be taken into consideration when assessing tenders.

The committee asked if Banbury Health Centre is value for money.
It is run by local shareholders and is a dedicated local provider. Although the creation of the centre was imposed from above and it receives three times more funding per patient than other practices, it is open for longer and provides services to groups that have been difficult to reach in the past. Whilst it means that funding is being distributed disproportionately to the north of the county, the experience gained could be used to provide a similar service in Oxford. The committee were keen to see that learning is shared across the county.

The committee asked about arrangements for patients using services in other authorities. Patients living on the county's borders have often used GP services in other counties, and there are long-standing processes to handle this which will continue under the new regime.

Learning Disabilities Services
The committee expressed concern about access to services for those with learning disabilities. There were now 79 practices signed up for the LD healthcheck scheme, and that they were still being supported by liaison nurses. Around 2000 people have been identified as requiring services. The Health & Well-being Board has said that the service should be offered to all those who require it.
The Local Medical Council said that as they were discretionary services not all practices were offering the services themselves although all had access to a register of where they were available so can refer patients.

72/12 CLINICAL COMMISSIONING UPDATE

(Agenda No. 8)

Dr Stephen Richards, Chief Executive, OCCG

Keep our NHS Public
Stephen Richards repeated his commitment to meet with Keep our NHS Public. In response to Dr Williamson's address (item 4), they are only using Any Qualified Provider for adult autism, podiatry, and audiology services. The OCCG considers that there is room for growth in these areas. Ultrasound services were considered for AQP, but based on the central model would have been too expensive. They will report to the committee on the process.

Authorisation
OCCG are in the process of submitting five outstanding conditions to the NHS by December and expect to have authorisation in the new year.

Committee members expressed concerns about the complicated layers structuring involvement and engagement with the OCCG.

Dementia
OCCG applied for, and received, just under £500,000 of extra funding for dementia services along with partners.

73/12 OXFORDSHIRE LINK GROUP – INFORMATION SHARE
(Agenda No. 9)

Adrian Chant, Mary Judge and Sheila from LINk attended the meeting.

Chipping Norton Maternity Unit
LINK expressed an interest to be part of the review of the maternity unit at Chipping Norton (item 6)

Maternity Review
LINK have given presentations on maternity services to the Children's Scrutiny Committee and the shadow children's partnership. Key themes that have arisen are breast feeding, mental health during maternity, and the continuity of care. In answer to a question from the committee, it was noted that home birthing has also been mentioned. About 160 replies have been received so far. Their findings will feed into the commission's review.

District Nursing
The district nursing service is currently undergoing a reorganisation. Sheila said that it would have an effect on care homes as the service is very important to them. The Chairman will raise the matter with Oxford Health and request a report.

Mental Health
A follow-up meeting on the mental health review will take place on 6 December at the Old Fire Station, Oxford.

LINK have concerns that residents at care homes are being labelled by staff as suffering from dementia despite lacking an official diagnosis. They have asked the Committee to be aware of this.

ME
A survey of GPs suggested that they want more services for children and a single point of access in the county to direct people to, however it has been difficult to get a good response rate as many GPs expect to be paid for their time. The current pathway is not available on the PCT's intranet, so the OCCG should be asked to provide it once they take over.

74/12 CHAIRMAN'S REPORT
(Agenda No. 10)

The Chairman has attended meetings of OUHT & CCCG

75/12 CLOSE OF MEETING
(Agenda No. 11)

The meeting closed at 13.40

..... in the Chair

Date of signing .....

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Oxfordshire Clinical Commissioning Group

NHS

Update on the development of the Oxfordshire Clinical Commissioning Group

1. Introduction

The following paper gives an update on the progress of Oxfordshire Clinical Commissioning Group (OCCG) in the lead up to its authorisation as a statutory NHS body in April 2013.

2. The authorisation process

In December, OCCG was formally authorised to take on to take on commissioning responsibilities for Oxfordshire from 1 April 2013. As expected there are five conditions to our authorisation. Meetings are in hand to address these conditions between now and the end of March 2013:

- Two relate to the constitution, the specific wording not adequately reflecting the national model. OCCG began work early on the constitution, before the national model was published. OCCG has reviewed the constitution with member practices and a new model has been agreed which will satisfy these requirements.
- Three relate to the clear and credible plan. OCCG has currently completed its first draft of its Operating Plan for 2013/4. A summary is set out below. The OCCG shadow Governing Body has agreed that it is essential that we deliver a realistic clear and credible three year plan to achieve the transformation we wish to achieve with partners in the Health and Social Care system. Meetings to discuss this approach are in hand with the Thames Valley Area Team and the South Region of the NHS Commissioning Board.

3. CCG Draft Operating Plan for 2013/14

Overview

The first draft of the OCCG Operating Plan was submitted to the NHS Commissioning Board Area Team on 24 January and feedback is expected soon. A draft 'plan on a page' is available by using this link http://www.oxfordshireccg.nhs.uk/who-we-are/documents/Plan.pdf

Financial context

OCCG operates in a health system which historically has always been financially challenged. The Plan is required to show a 1% surplus, 2% "headroom" for in-year non recurrent spend and a contingency of 0.5%. This will be very challenging.

Whilst the Plan covers 2013/4, given the current financial position and the comparatively low level of financial allocation to Oxfordshire, it is looking at developing radical solutions and significant change in order to deliver sustainable, higher quality care. This is achievable over 3 years. The

risks attached to this are being discussed with the NHS Commissioning Board Area Team and with South Region.

Summary

The plan has been structured round the NHS Outcomes domains, in order to provide focus:
Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing quality of life for people with long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring that people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

The Operational Plan is also informed by the five 'offers' made by the NHS Commissioning Board:

1. NHS Services, seven days a week
2. More transparency, more choice
3. Listening to patients and increasing their participation
4. Better data, informed commissioning, driving improved outcomes
5. Higher standards, safer care.

The Plan recognises that for OCCG to strive for improvement across the five domains, new ways of working must be adopted. Key themes for OCCG will be

- A shift towards commissioning across whole service pathways for outcomes defined by the patient or service user themselves. The key enabler for this will be the Outcomes Based Commissioning projects (see below).
- Improving integrated care through joint working. In this area, OCCG is ahead of many areas in the country, for example, through the establishment of pooled budgets with Oxfordshire County Council.
- Moving care closer to him. The Abingdon EMU is a unique facility which has achieved significant results and similar models are planned for elsewhere in the country.
- Commissioning patient centred services – applying the principle of 'no decision about me without me' to commissioning as well as to the clinician/patient relationship.

Improving quality

The plan puts great emphasis on the importance of quality. OCCG intends to achieve the NHS Commissioning Board 'quality premium' by meeting the four national targets:

- Amenable mortality
- Reducing avoidable emergency admissions
- Improving patient experience
- Preventing healthcare associated infections.

In addition, three local indicators will be agreed with the Oxfordshire Health and Wellbeing Board (and then by the NHS Commissioning Board). A workshop is planned for February to discuss these. OCCG will also have to ensure continued compliance with the four national waiting times targets (18 weeks, 4 hour wait, cancer waits, 8 min ambulance response). If achieved in 2013-14, the quality premium will be worth a maximum of £3.25 million (£5 per head). Payment would not be received until 2014.

Key work streams and projects

The following projects and work streams described in the Operational Plan support the five domains described above.

Domain 1

- Reducing health inequalities. This work is being progressed by the OCCG Localities, with the support of intelligence from the Public Health Team
- Increasing access to preventative services. This looks at groups which have a low uptake of services and will rely on joint working with the Public Health Team within the remit of the Health and Well Being Board. It includes a programme of work to improve GP access to diagnostics and a number of localised work streams within each locality.
- Improving children and young people's services. This area includes improving mental health services for young adults beyond 18, particularly those with delayed cognitive development, reviewing the community-based child and adolescent mental health services and learning disability services and working with Helen and Douglas House Hospices on end of life care for children.
- Improving outcomes in maternity services. A work stream with in the Outcomes Based Commissioning programme.

Domain 2

- Mental health: developing outcome based commissioning; a review of the 'talking therapies' service, in the light of the development of an integrated psychological medicine service; the development of joint physical health reviews and care planning for people with severe mental illness; Improve access to housing, support and employment for people with severe mental illness, through collaborative working steered by the Mental Health Joint management group.
- Physical disabilities and long term conditions: reviewing the pathway for people with neurological long term conditions; developing pathway and provider protocols for people with complex and rare long term conditions; a new model for the diabetes pathway.

Domain 3

- Proactive support for older/frail/vulnerable people – a joint strategy with Oxfordshire County Council
- Building a community infrastructure by developing integrated community teams and developing new services to support people to stay independent in their own homes and reduce the number of avoidable admissions.
- Right place first time – this includes 111, single point of access and Choose Well.

Domain 4

- Patient experience feedback. OCCG already uses a range of mechanisms to capture patient views. This work will be developed over 2013/14, including ensuring providers are using the new national 'friends and family' test.
- Outpatient appointments. The work stream will include working to reduce unnecessary outpatient follow up appointments and improving the quality of services and experience of care.

Domain 5

- Safeguarding. OCCG will continue to work with partners to protect vulnerable adults and children. This will include ensuring safeguarding requirements are specified in all provider contracts and reviewing all serious incidents.

- Healthcare associated infections (HCAIs). OCCG will monitor provider plans to tackle HCAIs, undertake joint route cause analyses and incentivise primary care to continue reducing the use of high risk antimicrobial prescribing.
- Medicine Optimisation. OCCG will continue to work with partners to improve the use of medicines across the County
- Emergency Planning. OCCG will work to ensure that it meets its emergency planning obligations. This will include identifying an accountable emergency officer.

What happens next?
OCCG will continue to work with Practices and Localities to refine the Plan. The final draft of the Plan will be presented to the Governing Body on 28 March and submitted to the NHS Board Area Team on 5 April.

4. Issues relating to the Horton Hospital

As members of the Health Overview and Scrutiny Committee will be aware, the Oxford University Hospitals (OUH) has suspended emergency abdominal surgery at the Horton Hospital in Banbury. OCCG supports this action in terms of patient safety. We will continue work closely with the OUH on this issue and will lead the countywide consultation on the future services to be delivered at the Horton.

5. Outcomes-based commissioning

In March 2012, Oxfordshire Clinical Commissioning Group (OCCG) decided to change how it commissions some health and social care services in the future by moving towards paying for patient outcomes not activity. The new approach moves away from the system known as Payment by Results which simply rewards higher levels of activity, to focus on commissioning for outcomes that matter to patients and clinicians.

OCCG is working in the following three care areas to introduce outcome based commissioning contracts for 2013/14:

- Frail Elderly
- Maternity
- Mental Health

Choosing these three areas allows us to test this new approach on different contracts and different patient groups with varying needs. This is a significant step for the CCG and the service areas involved account for around one quarter of the total CCG spending on healthcare.

OCCG's aim is to secure improved outcomes and value for money for patients and the public by incentivising providers to achieve the outcomes that matter most both clinically and to patients rather than rewarding the volume of activity undertaken. We are working very closely with Oxfordshire County Council as joint commissioners for both mental health and services for older people. The work builds on the work on the joint commissioning strategy to consider how best do we commission services to deliver these priorities.

In October 2012 OCCG commissioned external expertise to provide additional capacity and skills in the field. During phase 1 of the programme, a set of recommendations was agreed on the segments of each service to be in scope, the population served and potential expected outcomes. These were then debated at a well-attended engagement workshop on 8th January which brought together clinicians, managers, policy makers and patient and voluntary sector representatives. The outcomes of Phase 1 were presented to the OCCG Governing Body and they have agreed to continue with this work. The next phase includes:

- Deeper engagement with patients, service users and providers to test and refine outcome and refine them for securing services
- More widespread discussion with providers
- Agreement of documentation and approach to commission services in the new way

6. Pooled budgets

The pooling of commissioning budgets between OCCG and OCC is an essential vehicle for the delivery of our joint commissioning strategies that deliver the required change that will help us move towards sustainable long term financial health.

OCCG and OCC are currently reviewing all the current pooled budget legal agreements. The intention is to have one overarching agreement that is robust in terms of financial and quality management, within the right governance, is flexible and will bring consistency of risk management between all the pooled budgets. As all the current arrangements finish at the end of this financial year they will have to be replaced by new one(S) in 2013/14. Work is underway to deliver to this timeframe however, there is commitment to come to an arrangement that all parties are comfortable with and should this not be reached within this time frame our plan is to replace the current arrangements with very similar ones and bring changes on line in year, when agreed formally by both parties.

The main focus of the work is in the Older People's pooled budget which, when in place, will be the main underpinning arrangement to implement the Older People's Joint Commissioning Budget 2013/16. The intended end state for the pooled budget will be to include budgets that cover the current health and social care services delivered to older people with the specific intention of ensuring greater integration of services. Due to the complexities of 'payment by results' the plan is to start with including all services which deliver primarily based in the community (either in bed based care or to people living at home) for the first year (the joint budget being circa £187million) and then in the second year include the budgets that fund older people's care provided in the acute hospitals. The current proposal is for the risk share to be proportionate to the income provided to the pool by each party. Plans are in place to move toward this arrangement by the end of this financial year.

7. Joint Consultations

The following consultations are taking place

- **OCCG Equality Delivery System – 4 Dec – 31 March**
  Responsibility for equality and diversity will shift from NHS Oxfordshire (the Primary Care Trust) to the Oxfordshire Clinical Commissioning Group (OCCG) by April 2013. OCCG is committed to meeting its duties under the Equality Act (2010) by having due regard in all they do to help eliminate unlawful

discrimination, advance equality of opportunity and to foster good relations across all protected groups.

- **Autism Strategy (jointly with OCC) – 2nd Jan – 15 Feb**
  Autism is a lifelong developmental and neurological disability. People with autism experience difficulty with social communication, social interaction, social imagination, sensory issues and other difficulties. This strategy has been developed with the help of members of the Oxfordshire Autism Partnership Board, (members include people with autism, carers, commissioners, providers and partners), who have discussed unmet needs and desirable service improvements. The strategy addresses these issues and builds on some improvements which have been made in services and support for people with autism in Oxfordshire in recent years.

- **Older People's Strategy (jointly with OCC) – 30 Nov – 4 Feb**
  The Oxfordshire Older People's Joint Commissioning Strategy is the plan to encourage people to stay healthy as they age and support older people who need help and care. It has been put together by the NHS, County and District Councils, organisations that work with older people and older people themselves.

- **Carers' Strategy (jointly with OCC) – 10 Dec – 1 Feb**
  Many people in Oxfordshire provide unpaid care by helping to look after friends or family members who are frail, ill or disabled. Oxfordshire County Council (OCC), the Oxfordshire Clinical Commissioning Group (OCCG) and their partners, including Carers UK, have been working to better understand the local carer population and to review local support for carers by developing a refreshed and revised Joint Oxfordshire Carers' Strategy for 2013-2016. This replaces a previous strategy and takes account of the new model of carers' support.

8. Francis enquiry

OCCG is considering in detail the findings and recommendations of the Public Enquiry into Mid Staffordshire NHS Foundation Trust and will work with the NHS Commissioning Board area team to develop plans as to how its recommendations can be put into action. Patient safety and the quality of all of our services are our top priorities. We will continue to work closely with all of the providers of health care for our patients to ensure that safety is maintained and quality improved. We also work with them to ensure that there is an open and transparent process for raising issues, investigating problems, putting things right and learning lessons. It is essential that the lapses of care outlined in this report are not allowed to happen again and we will do all in our power to ensure that this is the case for our patients.

Buckinghamshire and Oxfordshire Cluster

TOWNLANDS AND BICESTER COMMUNITY HOSPITALS PROJECTS

PROGRESS UPDATE FOR HOSC – FEBRUARY 2013

1. Background

The procurement of new community hospitals to be located on the current hospital sites in Bicester and Townlands in Henley has been ongoing for the past eighteen months and is reaching the final stages. The facilities will replace outdated accommodation on both sites and provide new purpose built accommodation providing:

Bicester	Townlands
12 inpatient beds – subacute level 2	18 inpatient beds – subacute level 2
Outpatient accommodation	12 inpatient beds palliative Care
Minor injuries unit	Minor Injuries unit
Imaging	Outpatient accommodation
Ambulance base	Physiotherapy
Physiotherapy	Imaging, Dental, SALT

The schemes have received all the necessary approvals in order to allow the PCT to proceed to a financial close. Bicester had Full Business Case approval from the SHA in November 2012 and full planning was granted in September 2012. Townlands received SHA approval for the full business case in August 2012 and full planning permission was granted in November 2012.

All target dates in the timetable have been achieved and the current delay has been the result of the changing structure to NHS organisations as explained below

2. Context

The current NHS reforms mean that on 1 April premises belonging to Primary Care Trusts (PCT), which are statutory bodies, will transfer to NHS Property Services Ltd (NHS PSL), a commercial ltd company wholly owned by the Department of Health. This is a national policy issue that applies to all PCT premises contracts therefore applies to a number of transactions in the market.

This transfer currently affects the views of the projects funder as to the level of the risk associated with the new organisation, NHS PSL.

Both projects have achieved all the required approvals including planning permission and full business case sign off. Once the contracts have been signed, it is anticipated that the clinical

work streams will commence work to develop the commissioning strategy for each facility, to support intentions for the localities.

Work with the providers (sub-tenants) in the buildings is on-going to agree leases, decant programmes and operational policies. This includes Oxford Health Foundation Trust (OHFT), Royal Berkshire Foundation Trust (RBFT), Oxford Universities Hospital Trust (OUH), South Central Ambulance Service (SCAS) and Sue Ryder.

Both projects are now entering a delay period given the programmes indicated construction to commence in January 2013. This is due to the funding issue.

3. Funder General Delay Issue both projects

Aviva is the senior debt funder on both projects. Aviva has been seeking some comfort from the Department of Health regarding the covenant strength of Property Services Ltd, the organisation to which the properties will be transferred post 1st April 2013.

The discussions between Aviva and Department of Health have been ongoing for some months without significant progress being made and this issue has produced a delay to the original procurement programme and the ability of the PCT to reach financial close.

The PCT were notified on the 1st February that these discussions are now making good progress and Aviva are now comfortable with a proposal from Department of Health to provide a letter of comfort. Hence they have issued a letter to the bidders confirming that their original term sheet (funding agreement and interest rates) will still stand until 31st March 2013. In effect this means the cost of the projects does not increase if they reach financial close prior to 31st March. They have not issued any detail regarding term sheet post 1st April and this point remains to be resolved by the bidders. This represents a significant step forward and the PCT is now working to achieve financial close as soon as possible.

4. Latest position on each scheme

4a Bicester Community Hospital Project

The preferred bidder, Kajima, has proposed a Financial close date of 28th February. The PCT team are confident that this can be achieved because most issues have been resolved and information required to reach financial close has been received. Kajima have been proactive and continued to work during the slight delay. A programme is being agreed to ensure that both teams provide the necessary resource to achieve Financial close.

One main focus is to agree Heads of Terms with subtenants (OHFT and SCAS) before the close date and these discussions are ongoing.

4b Townlands Community Hospital project

The Townlands scheme is more complex with a three part development and therefore will require longer to close. The preferred bidders for this scheme are Amber care solutions. The PCT adviser team and Amber estimate that it will take 8 weeks to reach financial close on this project. This would mean a close early to mid April 2013. The PCT team are currently assessing what, if any impact this will have on the project costs and sign off by Property Services Ltd. A programme to Financial close is being produced so that a date can be agreed between all parties.

Discussions regarding the Care Home element of the scheme with Oxfordshire County Council have also been responsible for some delays on this project but this is now progressing and a meeting has been arranged for 15th February to close out all remaining legal issues.

One main focus is to agree Heads of Terms with subtenants (OHFT, Sue Ryder RBHT and OHT) before the close date and these discussions are ongoing and should not pose a major risk to completion.

5. Conclusions

Excellent progress has been made on these important scheme and all the necessary approvals are in place. The funding issue has caused a major delay but the resolution of this should now enable the schemes to proceed to financial close. As part of the overall operational handover arrangements the PCT will work with the new NHS architecture to complete these schemes. There remain a funding risk is the scheme do not close by 31st March but given the progress made recently with the funder and the Department of Health the Trust is confident this does not represent a high risk to the projects.

Matthew Tait
Chief Executive
7 February 2013

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Oxford University Hospitals NHS
NHS Trust

Paper Number

Health Overview and Scrutiny Committee meeting: 21 February 2013

Title	**Progress report on the review of the Cotswold Maternity Unit**

Status	A paper for noting by members of HOSC outlining the review of the Cotswold Maternity Unit (CMU) and the proposed way forward.
History	Follow up report following the presentation at the HOSC meeting on 15 November 2012.

Board Lead(s)	Sir Jonathan Michael, Chief Executive			
Key purpose	Strategy	**Assurance**	Policy	Performance

Progress report on the review of the Cotswold Maternity Unit (CMU)

Introduction

1. At the HOSC meeting held on 15 November 2012 members of the Oxford University Hospitals NHS Trust were given the opportunity to explain the decision to temporarily suspend births at the Cotswold Maternity Unit, Chipping Norton. A number of issues had been raised and these concerns had been identified through internal monitoring processes, the staff and via the Maternity Services Liaison Committee. The issues mainly related to working practices within the unit and not to one single incident. Higher than expected transfer rates and falling numbers of births had been noted and it was felt this may indicate an underlying problem.

2. The decision was taken to suspend the births, while maintaining the other components of the service, during the time the review was undertaken; the rationale for this decision was to enable the Trust to properly support the staff and mothers during this review. It was acknowledged that it would be a difficult time for all concerned and it was important not to add extra pressure on the staff in the unit which may then impact on the outcomes for women and their babies.

Review process

3. The scope of the review included (but was not necessarily restricted to) the following purposes:

   3.1 Evaluate the current governance arrangements to ensure that staff working in the unit comply at all times with those arrangements.

   3.2 Provide assurance to the Trust that clinical practice in the Cotswold Maternity Unit is in line with Directorate and National guidance, as well as Trust policies. This should include examination of: case notes, incident forms, previous complaints and claims, and records of transfers in labour and the early postnatal period.

   3.3 Examine the risk management performance of the unit with particular attention to:

      a. Identification of high-risk patients throughout pregnancy;

      b. Compliance with antenatal guidelines, including whether appropriate and timely referrals have been made to a consultant for an opinion or on-going care;

      c. Management of labour to include care plans, recognition of risk (both mother and baby), and compliance with guidelines regarding transfer to consultant-led care;

      d. Postnatal care including appropriate transfer/discharge of mother and baby.

   3.4 Examine systems for risk management, including incident reporting and investigation, risk assessment, and implementation and monitoring of action plans.

   3.5 Advise on professional supervision including statutory supervision of midwives.

   3.6 Conduct interviews with staff to understand any concerns relating to clinical practice, transfer rates and the reduction in the total number of births.

3.7 Conduct interviews with key stakeholders and the local population to ensure their involvement and, importantly, understand their issues in relation to the Cotswold Maternity Unit.

3.8 Identify barriers to good practice where problems are identified.

3.9 Reinforce and publicise good practice.

3.10 Investigate the culture of the unit, as well as any underlying problems with relationships amongst staff and the impact on the unit's effectiveness.

3.11 Advise on the appropriate service model for the provision of safe, high-quality, effective and accessible midwifery-led care at the Cotswold Maternity Unit.

4. The OUHT was explicit at the outset of the review that the intention was to reopen the unit once any recommendations highlighted through the review had been implemented and provided assurance to HOSC at the previous meeting as to this commitment. We would wish to reiterate that again in this progress report.

Process

5. In order to fully address the scope of the review and the purposes detailed above, a robust structure of interviews, meetings, case reviews and questionnaires were put in place. Given the concerns raised by some individuals about the need for an external rather than an internal review a degree of independence was built into every level of the review. Independence included:

- At HOSC's recommendation all the staff based in the CMU were offered the opportunity to have an external person present during their interview; all declined and were happy to meet to discuss their own personal and professional experiences and views.
- An external facilitator and Chair of MSLC met with the local community at a series of events.
- The PCT Lead and the Head of Midwifery met with the local General Practitioners and Health Visitors.
- Supervisors of Midwives with no involvement in the CMU conducted the case reviews.
- Questionnaires sent to a randomly selected group of women who have received care at the CMU to gain their views.

6. It was important to ensure the review encompassed an appropriate timescale to determine practice, cultural issues and any changes that have been implemented; the decision was taken to focus on the last 4 years. (2008 -2012)

7. The steps taken and the independent elements are as follows:

Specific review	Number	Actual completed	Independent element
Meetings with staff	51	36	Staff working in CMU offered the opportunity to have an external person present.
Questionnaires sent to women	200	94	Random selection of notes

Letters received re the review	4		2 from local women 1 from an observer 1 other
Case note reviews	200	200 (100%)	Random selection of cases. Reviews completed by Supervisors of Midwives not involved in CMU.
Review of transfers	46	46	
Review of home births	4	2	Consultant Midwives contact with each woman planning to give birth at home.
Questionnaires to GP's	16 (8 – Banbury area & 8 –CN GP's	4	All GP practices in Banbury area.
Meeting with local GP's and Health Visitor	1	1	PCT Lead
Public meetings	6 sessions x 120 places	6 sessions held and 52 people attended	External facilitator and Chair of MSLC
NCT and MSLC			Feedback received.

Emerging themes

8. Whilst acknowledging further analysis and review is required, the review has identified the following themes:

    - Local women and their families are supportive of the Cotswold Maternity unit and want it to be available for the full range of services.
    - An analysis of recent transfers has shown that these were entirely appropriate and done to ensure the safety of the mother and baby. It appears that some staff have recently been more cautious when working in the CMU because of the prevailing culture of the unit; this is related to the fact that the team was not operating in a unified and cohesive basis.
    - The need to agree and implement an effective discharge policy.
    - The need for midwives and local General Practitioners to work closely together to support each other in the care of pregnant women and to collaborate in the on-going development of the unit.
    - The need agree staffing ratios and the appropriate skill mix to provide the service at the CMU.
    - A number of concerns have been raised by staff who have been on the periphery of the units at Chipping Norton; these relate to the culture and the difficulties this has caused between groups of staff. This will be addressed in the main report.

- The need to review the working arrangements to ensure continuity and provision of midwifery care.
- The importance of promoting the service by working closely with the local community, GPs and other key stakeholders to build up support for the CMU and thus encourage and support women who want to birth in the standalone midwifery unit.

Next steps

9. Given the level of information obtained as part of the review it is important to ensure time is given to an effective analysis of the data and provide robust evidence to underpin the recommendations about the future of the unit. This will include a detailed analysis of the individual staff meetings and completed questionnaires from the women and GPs, and evaluation of the audit of the 200 case notes. It is imperative that the detail is analysed in such a way to address the purposes of the review and to fully address any concerns or deviations from practice.

10. The need to ensure that the outcome of the review is robust and comprehensive must be balanced with the desire of the local community and the Trust to reopen the unit at the earliest appropriate time. A timetable has, therefore, been agreed to ensure the final report is completed by the end of February 2013 for consideration by the Trust Board on 13 March 2013.

Timescales

Work plan	**Timescale**
Analysis of all data collected.	Mid February 2013
Report writing	Complete end February 2013
Agree action plan	13 March 2013
Open Cotswold Maternity Unit	To be agreed

Conclusion

11. HOSC is asked to note this progress report and the emerging themes.

Jane Hervé,
Head of Midwifery

Andrew Stevens
Director of Planning and Information

11 February 2013

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Public Health Outcomes Framework
Briefing Paper
December 2012

Background

The new Public Health Outcomes Framework (PHOF) sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy will enable the use of the most reliable information available to understand the nature of health inequalities both within areas and between areas.

A set of supporting public health indicators will help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can be currently realistically measured, are grouped into four 'domains':

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality

In November 2012, a baseline assessment was released which allows us to compare and benchmark ourselves against the national picture.

Overview

Generally, the overall picture for Oxfordshire shows that we are doing very well with only a few indicators which need more consideration. Oxfordshire is a healthy place to live, which generally has good services and high quality of living.

This compendium covers a range of topics which belong to a range of partners across many organisations within Oxfordshire. The indicators included in the "scorecard" are separated out in the four domains above.

Each indicator is displayed in three ways, by spine chart, as a tartan rug and finally as summary charts. Each provides the same information but in a format that shows different aspects of the data.

Some areas which need exploring in more depth.

It should be noted that in some instances the data used is old. However, there is no room for complacency, for some areas, we need to do better and in some areas where we are average, we need to aspire to being good. This briefing is intended to be a position statement of "where we are", it does not attempt to provide solutions to the problems.

Specific Indicators explored

1.06 – Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation

Indicator 1.6i - % of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family.

Indicator 1.6ii - % of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting

	2010/2011	2011/12
Indicator 6i	81.4%	82.0%
Indicator 6ii		45.9%

The data suggests in 2010/11 81.4% of people with learning disabilities lived with their families or independently alone, by March 2012 this had increased to 82%. The regional (South East) average is 70% and the national average is 69.9%.

For those with Mental Ill health, in 2010/11, the data suggests that only 1.3% lived in appropriate accommodation. The 2011/12 data shows that 45.9% of people live in appropriate accommodation. This is higher than the regional average (43%) but lower than the national rate of 57.8%. The baseline data needs further exploration, but this could be an artifact of poor recording, it would be unlikely that a 44.6% improvement in performance would be achievable in one year.

This indicator uses 2010/11 data, 2011/12 data shows us that by the end of March 2012, our position was improving.

Lead Organisation/Director – John Jackson, Oxfordshire County Council

1.10 – Killed/seriously injured on Roads

Indicator - Number of people reported killed or seriously injured on the roads, all ages, per 100,0000 resident population.

	2009/2011 Oxon	2009/2011 National
Indicator 10	56.3	48.1

As this has been aggregated into a three year rolling statistics, we do not as yet have comparative data for 2010/12, however looking at the annual data would suggest that 2010 was a particularly high year which will affect the 3 year average. This will impact on next year's data as well. The national average is 42.2.

2009	30 deaths	315 serious injuries
2010	41 deaths	354 serious injuries
2011	26 deaths	329 serious injuries

The data suggests that in Oxfordshire, there are significantly higher number of people who are killed or seriously injured on our roads but local monitoring shows this is decreasing.

This indicator uses 2009/11 data, 2010/12 provisional data will be available in February 2013
Lead Organisation/Director – Dave Etheridge, Oxfordshire County Council

2.15 – Drug Treatment

Indicator – Number of drug users that left drug treatment successfully (free of dependency) who do not re-present to treatment again within 6 months as a proportion of the local number in treatment

The data suggests Oxfordshire has just under 10% of drug users successfully completed treatment. The national average is 12.3% and the best results are 33.6%.

This indicator uses National Drug Treatment Monitoring data as at March 2010, the data shows that we are low compared to the national and regional trends. This is due to a number of compacting factors

the numbers are small and therefore one person could make the difference between high and low ratings.
as a new target, the baseline gives us something to focus on,
this new target measures 6 month success rate, new Oxfordshire services, as part of the National Payment by results pilots, measure 12 month recovery.
All patients were discharged from the old service and re registered with the new service which has also affected the data.

This indicator is the responsibility of Public Health in Local Authority.

2.17 - Recorded Diabetes

Indicator – Number of Quality Outcome Framework (QOF) recorded cases of diabetes per 100 patients registered with GP Practices (17 years and over)

The data suggests that we have significantly lower number of people, diagnosed with diabetes, than expected, using predictive modelling. This may be because we have a healthy population or it may be because diagnosis of Diabetes is being missed. Between April 2011 and March 2012 we have seen the roll out of NHS Health Checks programmes, this has identified an extra 38 patients with diabetes.

	National rate	Regional Rate	Oxon rate
2009/10	5.3	4.7	4.2
2010/11	5.5	4.9	4.4
2011/12	5.8	5.1	4.5

This indicator uses Quality Outcomes Framework (QOF) data as at March 2010, interim data shows us that we are still low but are following national and regional trends

This indicator is the responsibility of the NHS CB.

2.20 - Cancer Cervical Screening

Indicator – The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period

	National rate	Regional Rate	Oxon rate
2010/11	78.6%	79.7%	78.1%
2011/12	78.6%	79.8%	78.3%

The data suggests that whilst average, we would aspire to be significantly better than average and have work to do to increase coverage.

This indicator uses 2010 data, 2011/12 data shows us that cervical screening coverage in Oxfordshire is 78.3%, below the national and regional rates

This indicator is the responsibility of the Public Health England who are responsible for ensuring screening programmes are delivered, whilst Public Health in Local Authority have a responsibility to monitor the programme ensuring effective coverage.

2.22 – NHS Health checks

Indicator – Percentage of eligible population aged 40 – 74 offered an NHS Health Check in the financial year.

This indicator is currently under development. The data shown is for PCT level data as at March 2011/12. As schemes have been developed in different ways across the country the data is not comparable. From April 2013, this indicator will be reported at Local Authority level. Local data shows that in 11/12 12,432 people were offered a health check – 13.7% of the eligible population over a 5 year period, slightly lower than Englands average of 13.9%

This indicator is the responsibility of Public Health in Local Authority

2.24 – Falls

Indicator 2.24i – Age sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population.

Indicator 2.24ii – Age sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 to 79 per 100,000 population.

Indicator 2.24iii – Age sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 80 and over per 100,000 population.

The data suggests that we appear to have a more falls than other populations. This may be due to several reasons, we may record falls better than other areas, a greater awareness of falls or our population could be falling more often than others do. Our falls service is extensive, and there are several projects underway to support the work they do, for example, a nursing home project which reaches staff to recognise those residents most at risk from falling.

This indicator uses 2010/11 data, local data suggests that the number of falls are decreasing

	Hip fracture	Fracture per 1000 beds
Year 2003	81	
Year 2005	111	2.6
Year 2007	91	2.07
Year 2009	84	
Year 2011	82	1.8

This indicator is the responsibility of the Oxfordshire County Council

3.02 – Chlamydia

Indicator – Crude rate of Chlamydia diagnoses per 100,000 adults aged 15 - 24

The data suggests that we are significantly lower than average, this is a difficult indicator to assess as high infection in a population is bad, yet may also show a well-targeted service. Much work has been undertaken to increase, firstly, the number of screens undertaken and secondly targeting screens at those most at risk from Chlamydia. It should be noted that the data provided is crude data, therefore does not take into account the different sex/age structures of populations.

This indicator uses 2010 data although this has been produced retrospectively as the indicator is new. Quarter 2 data for 2012/13 shows an increased diagnosis rate.

	National	Regional	Oxon PCT
Imputed Data for 2010	2220		1396
Quarter 2 2012/13	1850	1353	1548

This indicator will be the responsibility of Public Health in Local Authority.

33.03 – Flu for "at risk" populations

Indicator – Flu Vaccination coverage (at risk individuals from age 6 months to under 65, excluding pregnant women)

The data suggests that whilst average, we would aspire to be significantly better than average

This indicator uses 2010/2011 data, 2011/12 data shows us that Oxfordshire's flu vaccination coverage in people under 65 at risk had improved on the previous year, although we will still fall short of the national 75% target.

Year	OPCT	South Central	England
2010/11	50.3%	51%	47.4%
2011/12	51.1%	52.6%	51.1%
2012/13(to date)	50.2%	51.4%	50.4%

This indicator is the responsibility of the PHE who are responsible for ensuring immunisation programmes are delivered, whilst Public Health in Local Authority have a responsibility to monitor the programme ensuring effective coverage.

3.05 – Treatment Completion for TB

Indicator – The percentage of people completing treatment for tuberculosis within 12 months prior to 31st December, of all those whose case was notified the previous year.

Indicator – TB Incidence per 100,000 population

The data suggests that we have high completion rates (98.3%) and low TB incidence (9.5). This is good news.

This indicator uses 2011 data, which is the latest available data.

This indicator is the responsibility of the Oxfordshire Clinical Commissioning Group who are responsible for delivering secondary care treatments, whilst NHS Commissioning Board are responsible for ensuring that primary care services are available. Public Health in Local Authority have a responsibility to monitor the programme ensuring effective coverage.

4.12 – Preventable Sight loss certificates

Indicator – Crude rate of sight loss certifications per 100,000 population

The data suggests that whilst we have average levels of sight loss, we have lower than average sight loss certifications, the reason for this is not clear from the data available. There are four indicators in this set all which use different Office of National Statistics Mid-year population estimates age groups, this could mean that we are not comparing like with like. However to assure ourselves, an audit of sight loss certification would indicate if everyone eligible for certification is offered the opportunity to apply because certification and registration are voluntary. The indicator uses 2010/11 data. Interim data is not available.

This indicator is the responsibility of the PHE who are responsible for ensuring immunisation programmes are delivered, whilst Public Health in Local Authority have a responsibility to monitor the programme ensuring effective coverage.

Appendix 1 – Public Health Outcome Framework Score Card for Oxfordshire

Oxfordshire

Introduction

The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

This profile currently presents data for the first set of indicators at England and upper tier local authority levels, collated by the public health observatories in England.

The profile allows you to:

- Compare your local authority against other authorities in the region
- Benchmark your local authority against the England average

Public Health Outcomes Framework baseline data will be revised and corrected in accordance with the *general DH statistical policy on revisions and corrections*.

Contents

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DH Department of Health

Spine Charts

Improving the wider determinants of health		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
1.01	Children in poverty	12.7	21.1	7.4		45.9
1.03	Pupil absence	5.64	5.79	4.84		7.12
1.04	First time entrants to the youth justice system	465	928	333		2,310
1.05	16-18 year olds not in education employment or training	6.10	6.10	1.60		11.80
1.06i	Adults with learning disabilities who live in stable and appropriate accommodation	81.4	59.0	19.3		84.2
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	1.3	66.8	1.3		92.8
1.10	Killed and seriously injured casualties on England's roads	56.3	42.2	18.1		82.4
1.12ii	Violent crime (including sexual violence) - violence offences	13.5	14.6	6.3		34.6
1.13i	Re-offending levels - percentage of offenders who re-offend	25.7	26.8	17.3		36.3
1.13ii	Re-offending levels - average number of re-offences per offender	0.7	0.8	0.4		1.2
1.14i	The percentage of the population affected by noise - Number of complaints about noise	5.8	7.8	1.3		66.7
1.15i	Statutory homelessness - homelessness acceptances	0.98	2.03	0.13		10.36
1.15ii	Statutory homelessness - households in temporary accommodation	0.9	2.2	0.0		33.6
1.16	Utilisation of outdoor space for exercise/health reasons	15.1	14.0	2.2		29.1

How to interpret the spine charts

Health improvement		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
2.01	Low birth weight of term babies	2.4	2.8	1.8		7.8
2.02i	Breastfeeding - Breastfeeding initiation	78.2	73.7	38.4		92.9
2.02ii	Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	59.5	46.0	19.2		83.1
2.03	Smoking status at time of delivery	7.95	13.52	2.95		33.23
2.04	Under 18 conceptions	22.0	35.4	6.2		64.7
2.06i	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	20.0	22.6	14.9		28.5
2.06ii	Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	28.9	33.4	24.6		41.9
2.08	Emotional well-being of looked after children	15.5	13.9	10.1		22.8
2.14	Smoking prevalence - adults (over 18s)	18.8	20.7	14.0		31.0
2.15	Successful completion of drug treatment	9.3	12.3	5.1		33.6
2.17	Recorded diabetes	4.4	5.5	3.4		7.7
2.20i	Cancer screening coverage - breast cancer	80.0	76.9	51.4		85.0
2.20ii	Cancer screening coverage - cervical cancer	75.6	75.5	58.8		82.5
2.21vii	Access to non-cancer screening programmes - diabetic retinopathy	80.5	79.2	20.2		97.0
2.22i	Take up of NHS Health Check Programme by those eligible - health check offered	13.7	13.9	0.0		91.1
2.22ii	Take up of NHS Health Check programme by those eligible - health check take up	48.8	51.6	8.6		100.0
2.23i	Self-reported well-being - satisfied with life	21.9	24.3	14.6		30.5
2.23ii	Self-reported well-being - worthwhile	20.8	20.1	12.8		25.4
2.23iii	Self-reported well-being - happy yesterday	29.8	29.0	19.2		36.6
2.23iv	Self-reported well-being - anxious yesterday	43.2	40.1	34.4		48.3
2.24i	Injuries due to falls in people aged 65 and over (Persons)	1,793	1,642	923		3,127
2.24i	Injuries due to falls in people aged 65 and over (Males)	1,411	1,269	610		2,647
2.24i	Injuries due to falls in people aged 65 and over (Females)	2,175	2,014	1,237		3,694
2.24ii	Injuries due to falls in people aged 65 and over - aged 65-79	1,026	959	487		1,822
2.24iii	Injuries due to falls in people aged 65 and over - aged 80+	5,245	4,711	2,831		9,097

How to interpret the spine charts

Oxfordshire

Health protection		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
3.01	Fraction of mortality attributable to particulate air pollution	5.6	5.6	3.6		8.3
3.02	Chlamydia diagnoses (15-24 year olds)	1,396	2,220	1,065		5,219
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	99.8	-	33.3		100.0
3.03i	Population vaccination coverage - Hepatitis B (2 years old)		-	2.4		100.0
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)	97.4	94.2	82.5		98.2
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	97.7	96.0	87.3		98.9
3.03iv	Population vaccination coverage - MenC	96.0	93.4	81.0		97.5
3.03v	Population vaccination coverage - PCV	96.5	93.6	80.5		97.8
3.03vi	Population vaccination coverage - Hib / MenC booster	94.9	91.6	74.1		97.6
3.03vii	Population vaccination coverage - PCV booster	94.4	89.3	70.0		98.2
3.03viii	Population vaccination coverage - MMR for one dose (2 years old)	93.3	89.1	75.4		96.8
3.03ix	Population vaccination coverage - MMR for one dose (5 years old)	96.0	91.9	80.7		97.8
3.03x	Population vaccination coverage - MMR for two doses (5 years old)	92.4	84.2	61.0		95.1
3.03xii	Population vaccination coverage - HPV	90.7	84.2	56.4		95.1
3.03xiii	Population vaccination coverage - PPV	74.0	70.5	46.8		76.0
3.03xiv	Population vaccination coverage - Flu (aged 65+)	74.9	72.8	67.2		78.7
3.03xv	Population vaccination coverage - Flu (at risk individuals)	47.4	50.4	35.3		61.5
3.05i	Treatment completion for TB	98.3	84.3	55.6		98.3
3.05ii	Treatment completion for TB - TB incidence	9.5	15.4	1.1		137.0
3.06	Public sector organisations with a board approved sustainable development management plan	57.1	74.3	20.0		100.0

How to interpret the spine charts

Healthcare public health and preventing premature mortality		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
4.03	Mortality from causes considered preventable (provisional)	118.5	146.1	100.7		264.2
4.04i	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) (Provisional)	46.1	62.0	40.3		116.0
4.04ii	Under 75 mortality rate from cardiovascular diseases that is considered preventable(including heart disease and stroke) (Provisional)	28.3	40.6	23.0		75.1
4.05i	Under 75 mortality rate from cancer (Provisional)	99.2	106.7	82.5		152.0
4.05ii	Under 75 mortality rate from cancer that is considered preventable (Provisional)	53.2	61.9	45.2		98.1
4.06i	Under 75 mortality rate from liver disease (Provisional)	9.9	14.4	8.7		39.3
4.06ii	Under 75 mortality rate from liver disease that is considered preventable (Provisional)	8.7	12.7	7.5		37.0
4.07i	Under 75 mortality rate from respiratory diseases (Provisional)	19.3	23.4	13.7		62.0
4.07ii	Under 75 mortality rate from respiratory diseases that is considered preventable (Provisional)	8.6	11.6	5.3		28.6
4.10	Suicide rate	7.8	7.9	4.3		13.9
4.11	Emergency readmissions within 30 days of discharge from hospital (persons)	11.4	11.8	8.1		13.8
4.11	Emergency readmissions within 30 days of discharge from hospital (males)	12.3	12.1	8.6		14.8
4.11	Emergency readmissions within 30 days of discharge from hospital (females)	10.7	11.4	7.2		13.2
4.12i	Preventable sight loss - age related macular degeneration (AMD)	92.7	109.4	10.0		224.4
4.12ii	Preventable sight loss - glaucoma	10.5	11.8	0.0		36.9
4.12iii	Preventable sight loss - diabetic eye disease	2.5	3.6	0.0		12.9
4.12iv	Preventable sight loss - sight loss certifications	37.3	43.1	2.9		85.7
4.14i	Hip fractures in people aged 65 and over	467	452	341		641
4.14ii	Hip fractures in people aged 65 and over - aged 65-79	237.1	224.2	120.6		330.5
4.14iii	Hip fractures in people aged 65 and over - aged 80+	1,501	1,476	973		2,267

How to interpret the spine charts

Tartan Rugs

Improving the wider determinants of health

Indicators for tracking progress against wider factors that affect health and wellbeing.

Indicator		Period	England	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
1.01	Children in poverty	2010	21.1	12.4	20.7	10.8	18.7	12.8	22.0	18.5	21.8	20.8	**12.7**	25.6	22.2	22.7	26.8	10.6	11.6	13.8	10.1	7.4
1.03	Pupil absence	2010/11	5.79	5.22	5.95	5.62	6.10	5.41	6.54	5.90	5.61	5.56	**5.64**	6.26	5.48	6.19	6.40	5.40	5.06	5.51	5.24	5.13
1.04	First time entrants to the youth justice system	2010	928	404	1,029	450	1,256	1,036	1,471	1,062	1,130	1,018	**465**	803	892	714	919	639	693	1,072	333	364
1.05	16-18 year olds not in education employment or training	2011	6.10	5.60	7.90	4.10	5.90	5.30	5.20	6.80	6.70	5.80	**6.10**	7.20	8.70	5.20	7.40	4.20	4.40	5.30	4.50	4.30
1.06i	Adults with learning disabilities who live in stable and appropriate accommodation	2010/11	59.0	82.4	60.6	72.5	55.6	69.5	61.3	66.4	60.2	76.1	**81.4**	71.2	67.7	75.0	67.0	49.5	68.7	70.5	60.5	67.7
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2010/11	66.8	75.3	67.8	1.5	66.0	25.9	44.6	68.4	65.9	72.8	**1.3**	50.7	56.1	44.6	14.8	72.3	45.5	72.6	52.2	36.9
1.10	Killed and seriously injured casualties on England's roads	2009-11	42.2	22.3	59.0	45.2	64.2	52.6	59.6	39.5	25.5	34.2	**56.3**	53.3	30.9	31.3	52.3	49.5	43.3	53.3	39.9	27.0
1.12ii	Violent crime (including sexual violence) - violence offences	2010/11	14.6	13.8	19.0	12.9	11.4	13.6	18.0	11.7	13.4	23.4	**13.5**	25.1	26.9	27.5	27.9	12.5	14.0	11.0	16.3	6.9
1.13i	Re-offending levels - percentage of offenders who re-offend	2010	26.8	24.0	24.5	23.8	23.6	24.1	27.4	25.1	26.0	25.1	**25.7**	30.5	30.3	28.3	28.7	22.9	25.9	23.1	21.5	24.5
1.13ii	Re-offending levels - average number of re-offences per offender	2010	0.8	0.6	0.8	0.6	0.7	0.7	0.8	0.7	0.8	0.7	**0.7**	1.0	1.0	0.8	0.9	0.7	0.8	0.7	0.7	0.6
1.14i	The percentage of the population affected by noise - Number of complaints about noise	2010/11	7.8	3.6	15.3	3.8	6.5	5.0	5.2	6.4	10.8	10.4	**5.8**	7.0	5.2	4.8	10.4	5.2	6.9	5.1	3.8	3.3
1.15i	Statutory homelessness - homelessness acceptances	2010/11	2.03	0.62	3.70	1.17	1.19	0.85	1.29	1.73	1.40	1.88	**0.98**	4.78	0.65	1.33	1.76	0.42	0.28	1.58	0.40	0.13
1.15ii	Statutory homelessness - households in temporary accommodation	2010/11	2.2	0.4	4.4	0.5	0.7	1.1	2.4	0.8	1.0	1.5	**0.9**	0.8	1.0	1.8	1.4	0.5	0.4	1.6	0.4	0.2
1.16	Utilisation of outdoor space for exercise/health reasons	Mar 2009 - Feb 2012	14.0	-	18.2	20.5	19.0	20.5	25.7	13.4	6.6	22.1	**15.1**	20.6	2.2	8.9	-	8.9	8.1	15.5	-	-

When no preferred polarity: Lower | Similar | Higher | Not compared

Health improvement

Indicators for tracking progress against helping people to live healthy lifestyles and make healthy choices.

Indicator		Period	England	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
2.01	Low birth weight of term babies	2010	2.8	2.5	2.8	2.8	2.0	1.9	1.8	2.2	2.2	3.5	**2.4**	2.0	3.4	4.0	3.2	2.2	1.9	2.6	2.1	2.4
2.02i	Breastfeeding - Breastfeeding initiation	2010/11	73.7	81.0	85.5	80.1	79.2	79.9	81.1	-	67.9	75.4	**78.2**	75.4	77.9	81.0	74.6	81.2	77.9	-	81.0	77.9
2.02ii	Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2010/11	46.0	-	70.5	57.8	48.0	45.5	44.6	-	37.9	55.9	**59.5**	44.4	55.4	-	42.9	-	55.4	48.8	-	55.4
2.03	Smoking status at time of delivery	2010/11	13.52	9.56	7.72	7.52	16.63	12.61	22.07	16.81	19.81	12.11	**7.95**	17.72	7.08	9.56	16.26	7.48	7.08	-	9.56	7.08
2.04	Under 18 conceptions	2010	35.4	18.2	36.9	20.2	31.3	25.2	34.2	35.3	46.0	29.9	**22.0**	43.3	40.9	36.8	49.2	20.8	19.4	26.4	16.6	13.1
2.06i	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2010/11	22.6	18.4	21.5	20.1	20.4	19.0	23.1	22.9	24.2	23.2	**20.0**	24.3	26.2	21.1	23.7	19.0	19.7	20.3	15.3	18.2
2.06ii	Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2010/11	33.4	31.3	28.9	29.5	31.3	29.4	31.9	33.3	33.3	34.4	**28.9**	34.4	34.6	38.0	31.9	26.8	31.4	29.8	26.0	26.8
2.08	Emotional well-being of looked after children	2010/11	13.9	11.8	15.7	13.2	15.4	13.9	12.2	15.5	15.5	14.4	**15.5**	14.5	17.5	14.2	22.8	14.5	15.8	-	13.3	14.0
2.14	Smoking prevalence - adults (over 18s)	2010/11	20.7	17.6	24.7	15.9	21.2	17.2	18.0	21.3	22.2	22.9	**18.8**	26.4	21.6	19.9	20.8	14.0	16.3	18.3	18.5	15.8
2.15	Successful completion of drug treatment	2010	12.3	18.1	9.5	16.7	15.4	11.9	16.4	24.4	13.7	11.8	**9.3**	10.2	5.2	9.0	11.3	17.7	8.7	9.1	15.8	11.0
2.17	Recorded diabetes	2010	5.5	4.7	3.8	4.9	5.4	5.1	5.7	5.6	6.3	4.7	**4.4**	4.9	4.3	7.5	4.9	4.6	4.0	5.4	4.5	4.0
2.20i	Cancer screening coverage - breast cancer	2010	76.9	79.9	71.0	82.6	67.9	79.9	81.3	79.6	79.7	78.5	**80.0**	72.2	73.6	74.5	72.0	76.6	82.2	78.9	80.3	82.7
2.20ii	Cancer screening coverage - cervical cancer	2010	75.5	79.6	73.5	78.5	77.3	78.5	76.0	78.5	77.2	76.0	**75.6**	71.5	75.3	69.8	72.3	77.0	81.3	77.7	77.7	80.4
2.21vii	Access to non-cancer screening programmes - diabetic retinopathy	2010/11	79.2	68.7	85.4	78.0	76.9	74.2	77.6	88.5	92.6	75.9	**80.5**	79.7	70.6	68.7	70.6	78.3	70.6	83.5	68.7	70.6
2.22i	Take up of NHS Health Check Programme by those eligible - health check offered	2011/12	13.9	1.2	15.9	13.8	9.5	18.6	1.6	7.0	21.4	0.0	**13.7**	21.3	12.3	1.2	14.6	1.0	12.3	7.8	1.2	12.3
2.22ii	Take up of NHS Health Check programme by those eligible - health check take up	2011/12	51.6	91.9	48.9	31.2	43.5	31.3	100.0	32.8	36.3	-	**48.8**	10.5	57.8	91.9	69.5	98.7	57.8	37.2	91.9	57.8
2.23i	Self-reported well-being - satisfied with life	2011/12	24.3	23.7	18.7	20.9	24.8	20.3	22.4	21.3	26.9	23.8	**21.9**	24.5	22.9	27.2	24.4	20.0	20.5	20.2	19.5	18.4
2.23ii	Self-reported well-being - worthwhile	2011/12	20.1	20.5	16.2	17.3	20.7	16.4	17.7	15.7	20.6	22.2	**20.8**	24.2	23.3	24.7	22.6	16.7	15.0	15.3	16.7	15.3
2.23iii	Self-reported well-being - happy yesterday	2011/12	29.0	30.1	27.5	27.0	27.5	25.2	27.9	26.4	26.8	29.7	**29.8**	31.3	30.0	27.0	29.5	27.5	23.0	26.1	28.1	28.6
2.23iv	Self-reported well-being - anxious yesterday	2011/12	40.1	38.8	40.5	38.4	38.2	36.0	34.4	37.8	40.8	39.8	**43.2**	37.0	37.3	44.4	38.0	40.9	37.4	38.0	42.7	39.7
2.24i	Injuries due to falls in people aged 65 and over (Persons)	2010/11	1,642	1,300	2,104	1,290	1,582	1,545	1,077	1,680	1,822	1,874	**1,793**	1,995	1,014	1,764	1,900	1,587	1,099	1,601	1,771	923
2.24i	Injuries due to falls in people aged 65 and over (Males)	2010/11	1,269	861	1,707	922	1,106	1,210	855	1,272	1,322	1,356	**1,411**	1,499	742	1,340	1,414	1,242	860	1,182	1,371	610
2.24i	Injuries due to falls in people aged 65 and over (Females)	2010/11	2,014	1,738	2,501	1,658	2,058	1,880	1,300	2,088	2,323	2,392	**2,175**	2,492	1,285	2,187	2,386	1,932	1,338	2,020	2,172	1,237
2.24ii	Injuries due to falls in people aged 65 and over - aged 65-79	2010/11	959	754	1,307	773	859	863	614	884	939	1,008	**1,026**	1,157	581	1,171	1,238	845	635	861	1,083	487
2.24iii	Injuries due to falls in people aged 65 and over - aged 80+	2010/11	4,711	3,755	5,690	3,615	4,837	4,614	3,161	5,260	5,796	5,769	**5,245**	5,769	2,962	4,429	4,877	4,927	3,187	4,931	4,867	2,888

Oxfordshire

Health protection

Indicators for tracking progress against protecting the population's health from major incidents and other threats.

Indicator		Period	England	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
3.01	Fraction of mortality attributable to particulate air pollution	2010	5.6	5.6	5.4	5.6	4.8	5.3	4.6	5.6	6.1	5.8	**5.6**	5.9	5.9	6.8	6.2	5.7	5.5	5.0	5.9	5.7
3.02	Chlamydia diagnoses (15-24 year olds)	2010	2,220	1,305	1,856	1,245	1,776	1,862	1,873	1,562	2,173	2,278	**1,396**	2,631	2,190	1,902	1,968	1,087	1,451	1,432	1,120	1,065
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	2010/11	-	100.0	-	87.8	-	-	-	88.5	81.3	100.0	**99.8**	-	97.1	100.0	91.7	100.0	97.1	-	100.0	97.1
3.03i	Population vaccination coverage - Hepatitis B (2 years old)	2010/11	-	84.0	-	-	-	-	-	29.7	40.0	100.0	**-**	-	75.8	84.0	100.0	75.9	75.8	-	84.0	75.8
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2010/11	94.2	95.2	91.2	97.2	94.0	95.4	92.1	94.7	95.6	95.3	**97.4**	94.5	95.2	95.2	94.7	90.3	95.2	94.7	95.2	95.2
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2010/11	96.0	96.5	93.7	98.4	95.7	96.8	95.2	97.1	98.1	96.5	**97.7**	97.3	96.3	96.5	96.5	91.3	96.3	96.5	96.5	96.3
3.03iv	Population vaccination coverage - MenC	2010/11	93.4	94.6	90.2	96.7	93.5	95.1	90.8	94.2	95.2	94.7	**96.0**	94.2	93.9	94.6	93.8	89.4	93.9	94.3	94.6	93.9
3.03v	Population vaccination coverage - PCV	2010/11	93.6	94.7	90.3	97.0	93.4	95.1	92.3	94.5	95.4	94.6	**96.5**	94.5	94.7	94.7	94.1	89.6	94.7	94.0	94.7	94.7
3.03vi	Population vaccination coverage - Hib / MenC booster	2010/11	91.6	90.9	89.3	93.0	92.5	93.6	90.1	93.0	94.9	92.5	**94.9**	93.2	91.1	90.9	90.9	83.9	91.1	94.6	90.9	91.1
3.03vii	Population vaccination coverage - PCV booster	2010/11	89.3	89.7	86.5	94.4	89.7	90.4	87.0	91.6	93.0	90.0	**94.4**	88.6	89.4	89.7	89.5	80.9	89.4	91.3	89.7	89.4
3.03viii	Population vaccination coverage - MMR for one dose (2 years old)	2010/11	89.1	90.5	85.9	92.4	88.1	90.9	87.6	91.6	93.3	91.2	**93.3**	89.4	91.1	90.5	91.5	82.3	91.1	91.4	90.5	91.1
3.03ix	Population vaccination coverage - MMR for one dose (5 years old)	2010/11	91.9	91.0	88.8	93.4	92.6	92.8	92.0	92.9	93.4	94.4	**96.0**	93.8	94.8	91.0	93.7	80.7	94.8	92.8	91.0	94.8
3.03x	Population vaccination coverage - MMR for two doses (5 years old)	2010/11	84.2	83.4	76.8	87.3	83.1	86.6	80.5	87.2	89.3	87.1	**92.4**	83.8	85.4	83.4	86.7	70.1	85.4	85.2	83.4	85.4
3.03xii	Population vaccination coverage - HPV	2010/11	84.2	78.0	84.9	86.0	86.3	75.7	90.0	76.7	77.7	86.0	**90.7**	84.8	86.9	78.0	71.1	81.3	86.9	86.8	78.0	86.9
3.03xiii	Population vaccination coverage - PPV	2010/11	70.5	72.5	68.7	72.3	70.8	75.5	75.9	67.5	73.0	75.4	**74.0**	72.0	75.8	72.5	73.1	68.7	75.8	70.3	72.5	75.8
3.03xiv	Population vaccination coverage - Flu (aged 65+)	2010/11	72.8	72.7	68.9	73.9	71.4	73.4	70.3	72.8	73.3	71.0	**74.9**	74.4	75.0	72.7	74.2	68.4	75.0	71.6	72.7	75.0
3.03xv	Population vaccination coverage - Flu (at risk individuals)	2010/11	50.4	52.2	48.8	48.3	50.2	52.7	51.5	47.2	51.8	51.6	**47.4**	51.7	51.4	52.2	53.5	45.6	51.4	48.8	52.2	51.4
3.05i	Treatment completion for TB	2011	84.3	-	82.6	93.8	78.9	76.8	-	75.5	84.2	96.2	**98.3**	87.0	91.5	93.0	79.2	79.2	-	79.6	-	-
3.05ii	Treatment completion for TB - TB incidence	2009-11	15.4	8.9	10.7	8.6	4.7	5.5	2.8	7.6	8.7	13.1	**9.5**	11.7	35.7	55.2	15.6	8.0	5.2	7.3	7.3	7.4
3.06	Public sector organisations with a board approved sustainable development management plan	2010/11	74.3	100.0	83.3	80.0	85.7	87.5	100.0	87.5	100.0	80.0	**57.1**	75.0	100.0	100.0	100.0	66.7	100.0	88.9	100.0	100.0

When no preferred polarity: Lower | Similar | Higher | Not compared

Healthcare public health and preventing premature mortality

Indicators for tracking progress against reducing numbers of people living with preventable ill health and people dying prematurely.

Indicator		Period	England	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
4.03	Mortality from causes considered preventable (provisional)	2009-11	146.1	128.7	172.0	113.0	135.2	116.1	133.4	138.3	159.5	148.7	**118.5**	179.9	154.3	168.4	172.2	109.3	118.5	122.3	115.2	100.7
4.04i	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) (Provisional)	2009-11	62.0	47.4	57.8	48.1	51.3	44.5	61.6	58.8	65.6	64.3	**46.1**	72.3	71.3	81.0	66.6	44.7	46.5	48.5	54.0	40.3
4.04ii	Under 75 mortality rate from cardiovascular diseases that is considered preventable(including heart disease and stroke) (Provisional)	2009-11	40.6	30.8	35.4	30.2	31.3	28.9	37.5	39.8	47.0	44.3	**28.3**	47.4	48.1	56.0	43.4	27.6	29.3	30.9	32.1	27.2
4.05i	Under 75 mortality rate from cancer (Provisional)	2009-11	106.7	107.2	115.6	91.2	102.3	94.4	99.4	103.2	120.8	106.6	**99.2**	120.1	100.8	110.7	119.3	90.3	95.7	98.3	93.2	90.6
4.05ii	Under 75 mortality rate from cancer that is considered preventable (Provisional)	2009-11	61.9	60.0	69.1	49.2	58.9	52.3	54.9	59.4	71.6	60.7	**53.2**	72.7	57.8	60.1	74.8	50.2	55.3	55.7	54.4	46.8
4.06i	Under 75 mortality rate from liver disease (Provisional)	2009-11	14.4	12.8	20.4	9.5	12.7	9.1	11.3	11.5	14.5	11.0	**9.9**	18.5	14.1	18.7	17.4	10.0	8.8	11.3	10.7	8.9
4.06ii	Under 75 mortality rate from liver disease that is considered preventable (Provisional)	2009-11	12.7	10.9	17.6	8.8	10.8	8.2	10.3	9.6	10.4	9.7	**8.7**	16.8	11.5	16.1	16.1	9.3	8.7	10.5	9.2	8.0
4.07i	Under 75 mortality rate from respiratory diseases (Provisional)	2009-11	23.4	18.2	25.7	16.5	17.4	17.7	20.2	22.4	25.5	26.7	**19.3**	28.5	22.3	29.9	27.3	17.4	15.7	18.1	14.7	14.6
4.07ii	Under 75 mortality rate from respiratory diseases that is considered preventable (Provisional)	2009-11	11.6	10.1	15.3	6.9	9.0	8.9	7.7	11.6	14.2	12.0	**8.6**	16.9	11.8	17.0	16.7	7.7	7.2	8.6	5.8	5.7
4.10	Suicide rate	2009-11	7.9	8.0	11.1	7.6	10.4	8.1	11.8	7.4	5.9	7.0	**7.8**	8.6	5.9	7.0	9.7	8.1	7.0	6.4	5.8	5.3
4.11	Emergency readmissions within 30 days of discharge from hospital (persons)	2010/11	11.8	10.8	13.2	11.8	11.5	11.0	9.7	11.6	12.3	12.3	**11.4**	12.5	10.4	13.2	12.2	11.8	10.1	11.1	11.8	10.4
4.11	Emergency readmissions within 30 days of discharge from hospital (males)	2010/11	12.1	10.7	13.2	12.4	11.8	11.2	10.3	12.2	13.2	13.0	**12.3**	13.0	11.4	14.4	12.4	12.2	10.8	11.7	11.5	10.3
4.11	Emergency readmissions within 30 days of discharge from hospital (females)	2010/11	11.4	10.8	13.2	11.3	11.1	10.8	9.2	11.2	11.4	11.7	**10.7**	12.1	9.4	12.1	11.9	11.3	9.6	10.5	12.0	10.4
4.12i	Preventable sight loss - age related macular degeneration (AMD)	2010/11	109.4	118.8	152.2	140.3	128.1	153.0	115.1	93.6	47.0	145.7	**92.7**	212.1	110.7	106.6	214.6	116.4	137.9	140.9	109.4	123.4
4.12ii	Preventable sight loss - glaucoma	2010/11	11.8	11.1	12.2	7.4	13.5	13.8	16.7	10.5	5.7	18.4	**10.5**	9.4	12.0	13.5	21.4	11.4	-	17.6	12.4	7.5
4.12iii	Preventable sight loss - diabetic eye disease	2010/11	3.6	-	2.2	3.6	3.8	4.0	6.4	2.6	6.9	8.5	**2.5**	2.8	5.3	12.9	5.2	3.6	4.6	2.7	8.0	8.6
4.12iv	Preventable sight loss - sight loss certifications	2010/11	43.1	34.3	49.9	43.0	62.3	59.7	64.8	37.5	19.5	54.7	**37.3**	54.6	34.4	46.5	59.2	41.1	35.1	55.6	40.4	39.8
4.14i	Hip fractures in people aged 65 and over	2010/11	452	436	450	439	431	436	420	477	487	544	**467**	469	415	341	375	494	413	432	501	406
4.14ii	Hip fractures in people aged 65 and over - aged 65-79	2010/11	224.2	242.7	239.2	198.1	207.4	207.0	184.5	223.2	214.4	249.0	**237.1**	256.1	205.5	198.7	185.3	245.4	226.3	185.0	298.1	192.4
4.14iii	Hip fractures in people aged 65 and over - aged 80+	2010/11	1,476	1,306	1,398	1,521	1,437	1,468	1,480	1,619	1,711	1,869	**1,501**	1,426	1,359	980	1,229	1,614	1,253	1,543	1,415	1,365

When no preferred polarity: Lower | Similar | Higher | Not compared

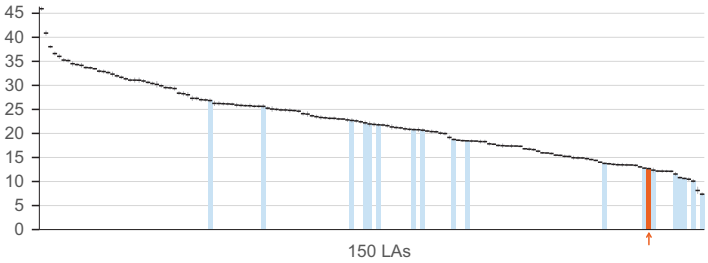
Summary Charts

Key
- Oxfordshire
- Other local authorities in the South East

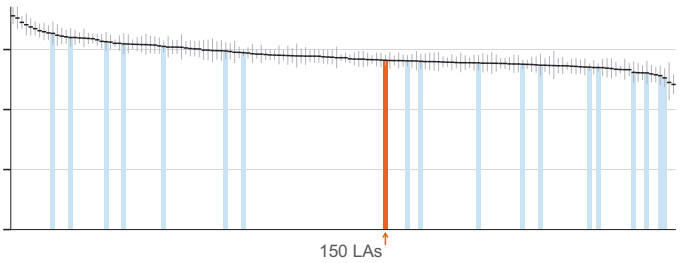
Improving the wider determinants of health

Indicators for tracking progress against wider factors that affect health and wellbeing.

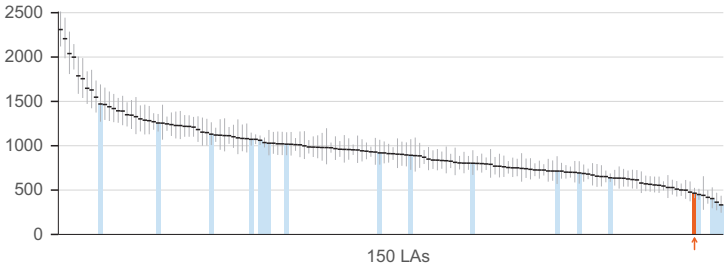
1.01. Children in poverty



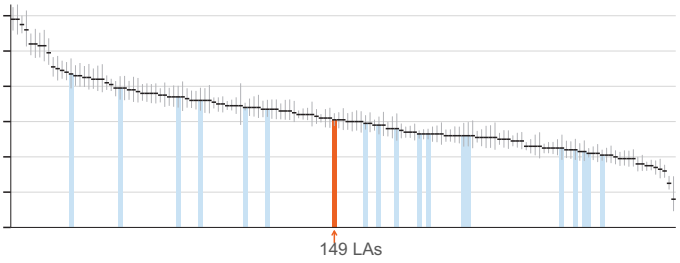
1.03. Pupil absence



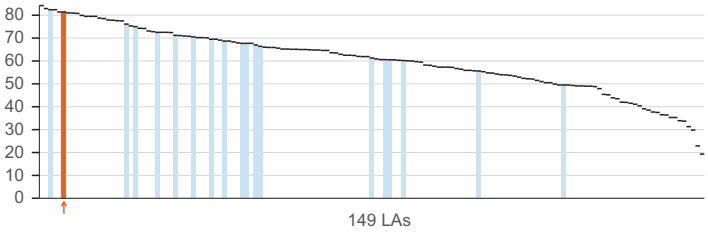
1.04. First time entrants to the youth justice system



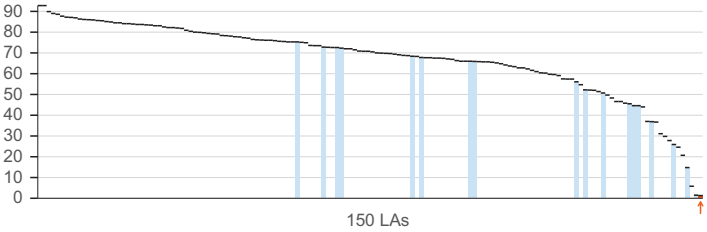
1.05. 16-18 year olds not in education employment or training



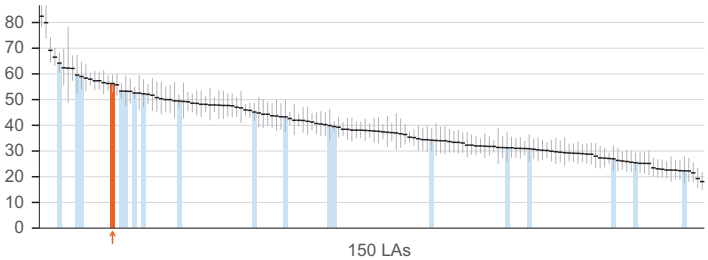
1.06i. Adults with learning disabilities who live in stable and appropriate accommodation



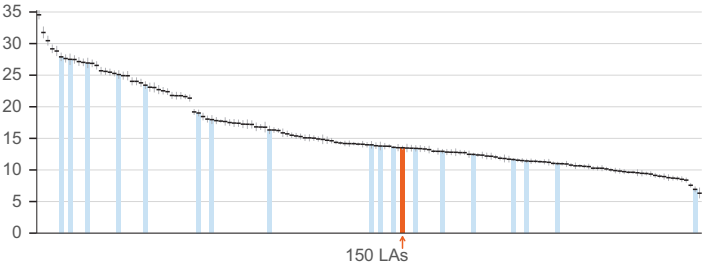
1.06ii. Adults in contact with secondary mental health services who live in stable and appropriate accommodation



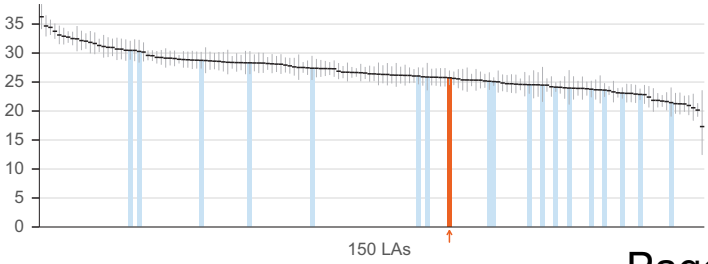
1.10. Killed and seriously injured casualties on England's roads



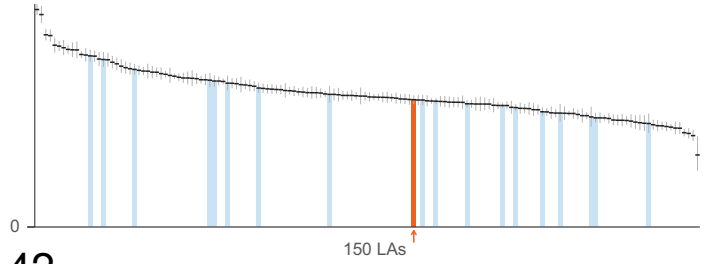
1.12ii. Violent crime (including sexual violence) - violence offences



1.13i. Re-offending levels - percentage of offenders who re-offend



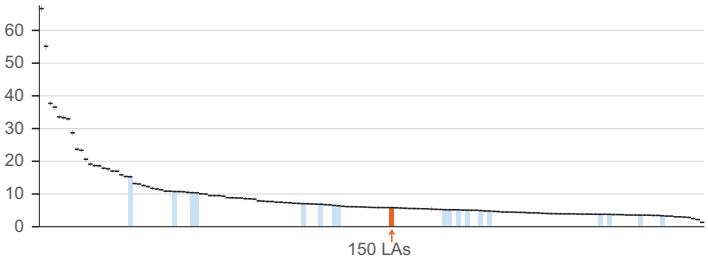
1.13ii. Re-offending levels - average number of re-offences per offender



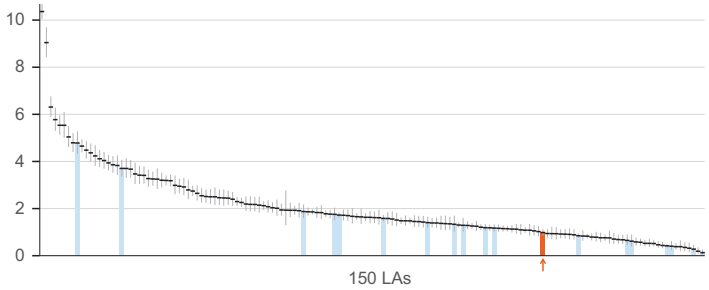
Improving the wider determinants of health continued

Indicators for tracking progress against wider factors that affect health and wellbeing.

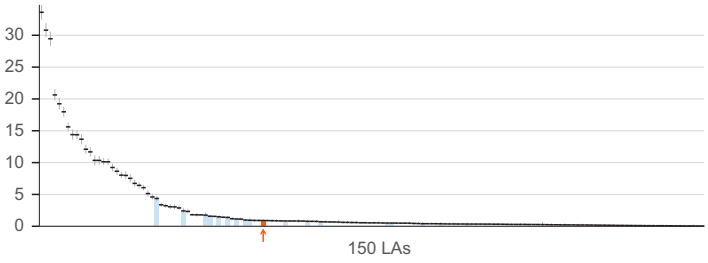
1.14i. The percentage of the population affected by noise - Number of complaints about noise



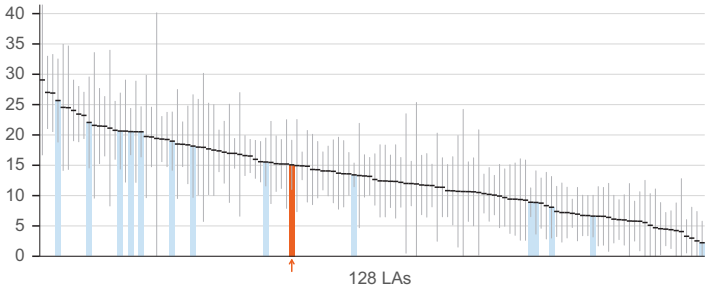
1.15i. Statutory homelessness - homelessness acceptances



1.15ii. Statutory homelessness - households in temporary accommodation



1.16. Utilisation of outdoor space for exercise/health reasons

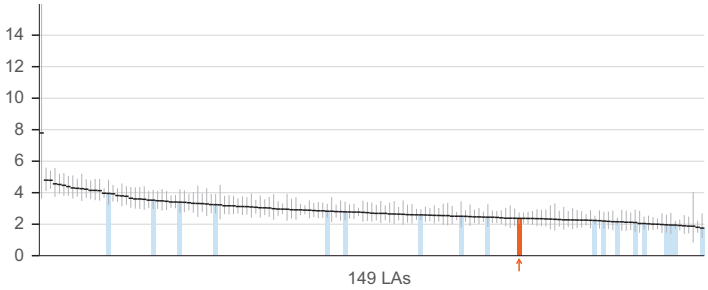


Oxfordshire

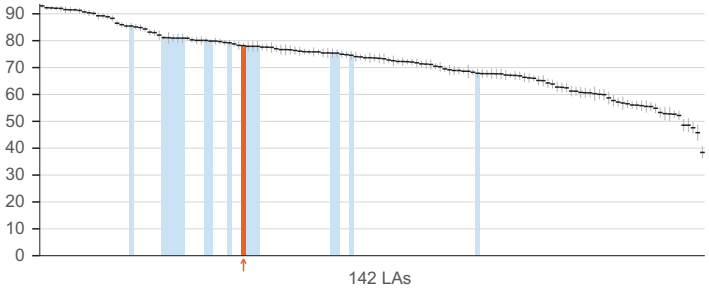
Health improvement

Indicators for tracking progress against helping people to live healthy lifestyles and make healthy choices.

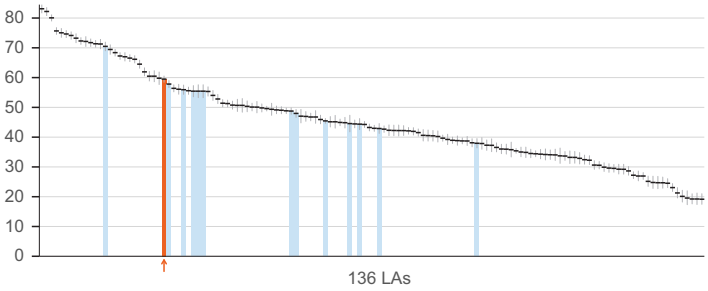
2.01. Low birth weight of term babies



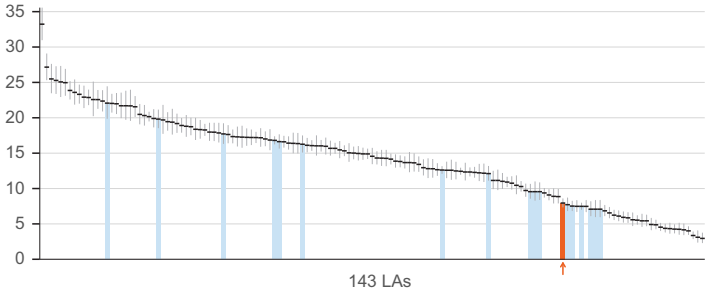
2.02i. Breastfeeding - Breastfeeding initiation



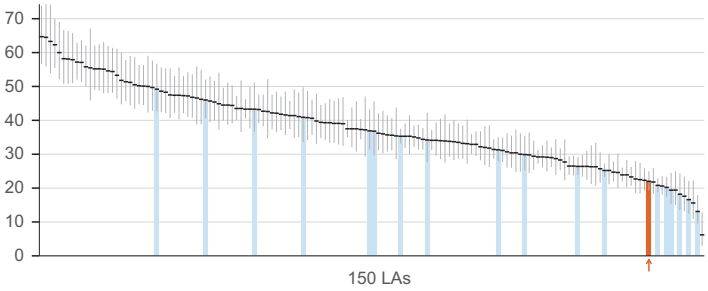
2.02ii. Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth



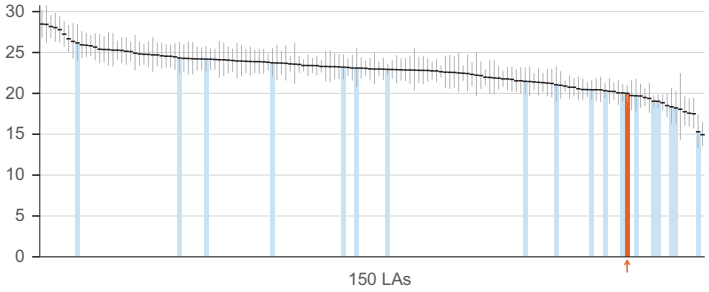
2.03. Smoking status at time of delivery



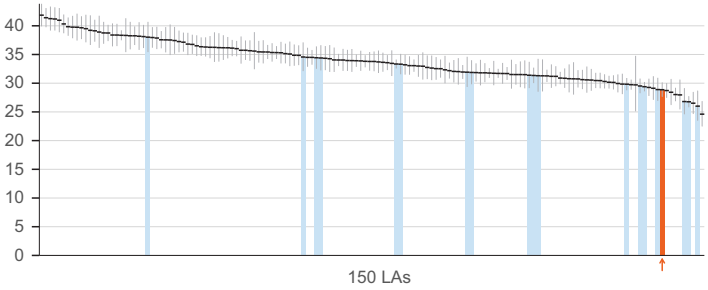
2.04. Under 18 conceptions



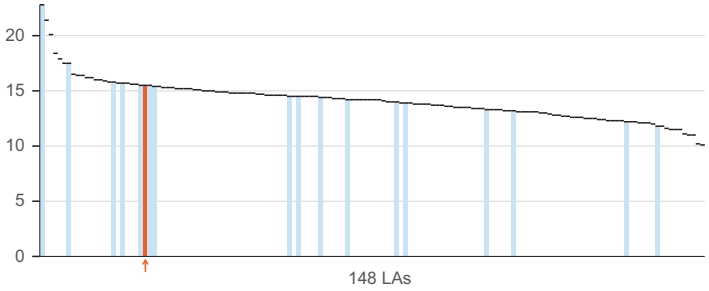
2.06i. Excess weight in 4-5 and 10-11 year olds - 4-5 year olds



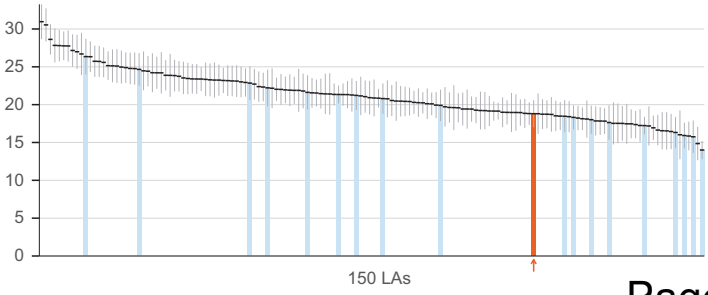
2.06ii. Excess weight in 4-5 and 10-11 year olds - 10-11 year olds



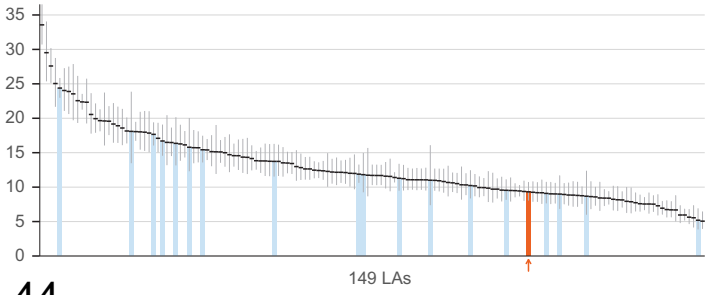
2.08. Emotional well-being of looked after children



2.14. Smoking prevalence - adults (over 18s)



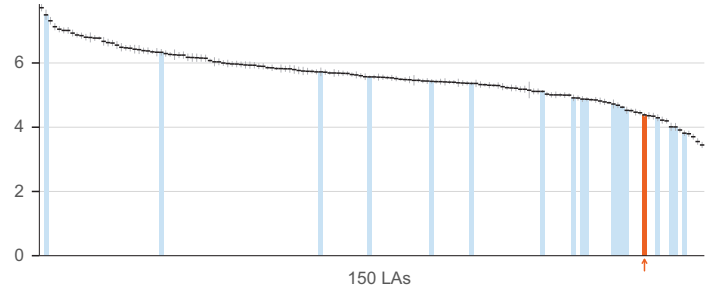
2.15. Successful completion of drug treatment



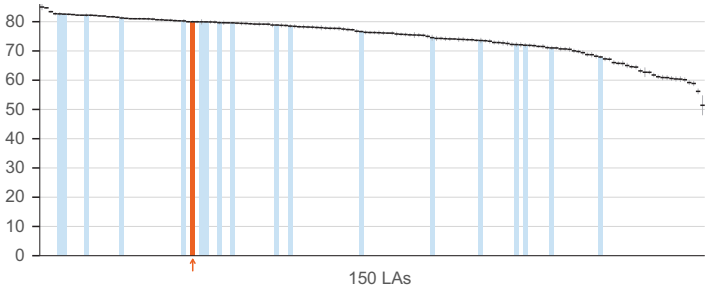
Health improvement continued

Indicators for tracking progress against helping people to live healthy lifestyles and make healthy choices.

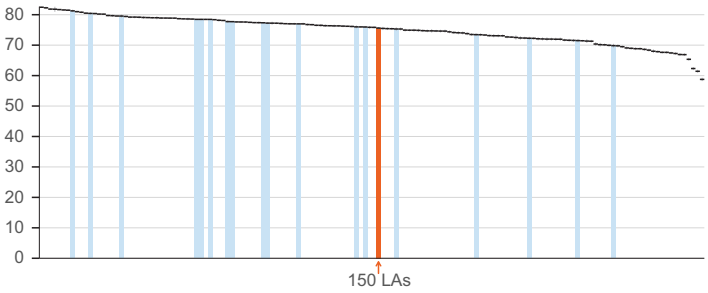
2.17. Recorded diabetes



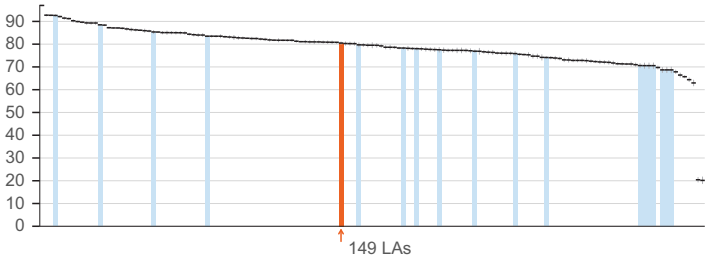
2.20i. Cancer screening coverage - breast cancer



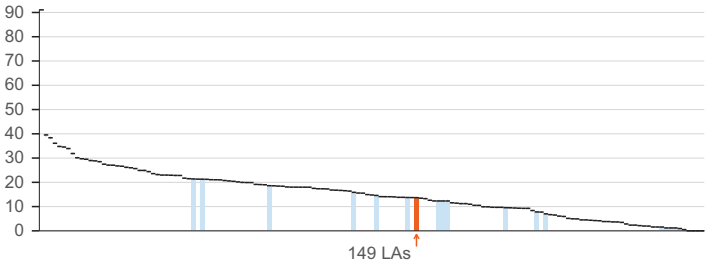
2.20ii. Cancer screening coverage - cervical cancer



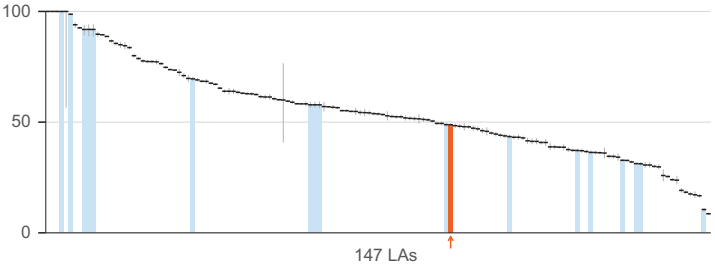
2.21vii. Access to non-cancer screening programmes - diabetic retinopathy



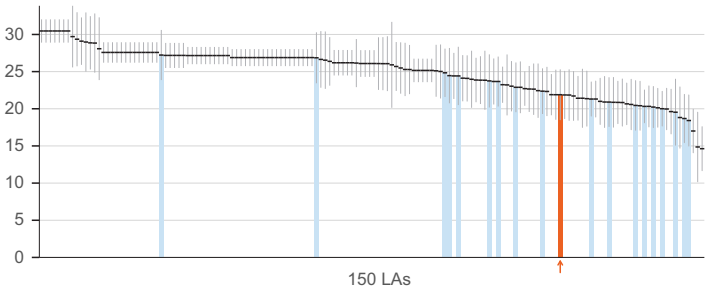
2.22i. Take up of NHS Health Check Programme by those eligible - health check offered



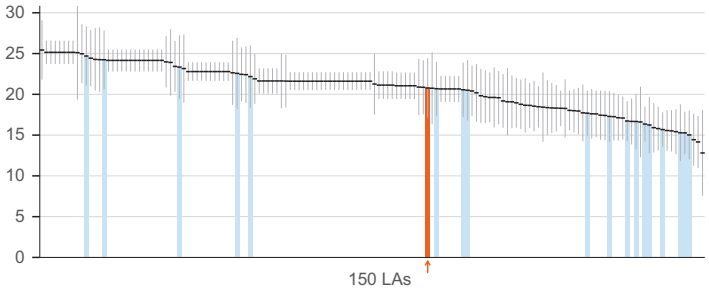
2.22ii. Take up of NHS Health Check programme by those eligible - health check take up



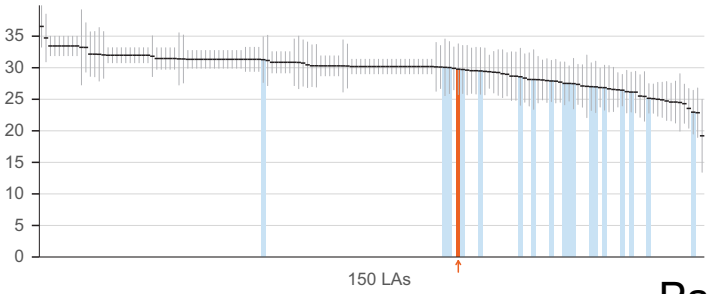
2.23i. Self-reported well-being - satisfied with life



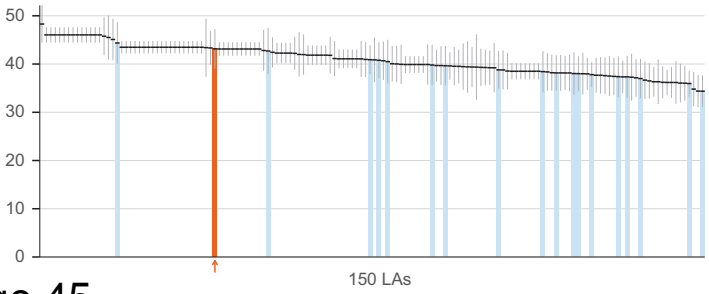
2.23ii. Self-reported well-being - worthwhile



2.23iii. Self-reported well-being - happy yesterday



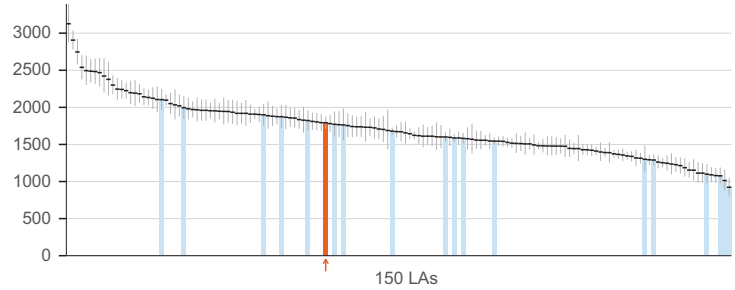
2.23iv. Self-reported well-being - anxious yesterday



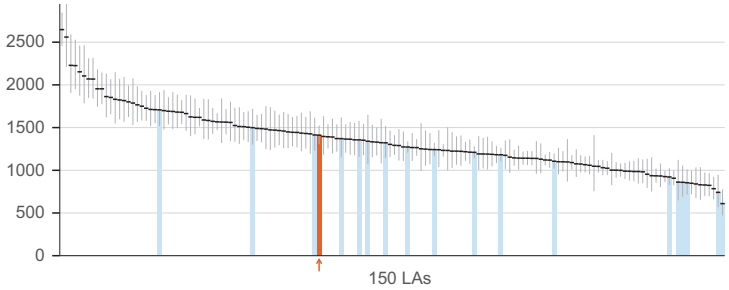
Health improvement continued

Indicators for tracking progress against helping people to live healthy lifestyles and make healthy choices.

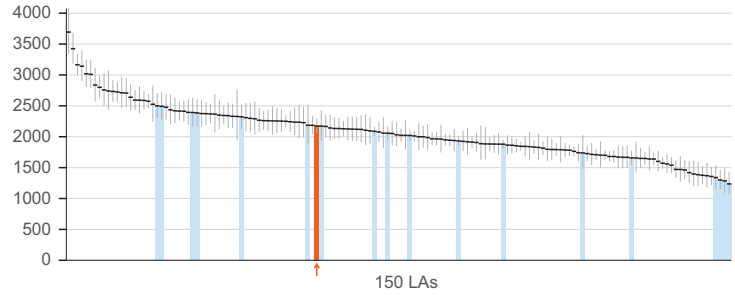
2.24i. Injuries due to falls in people aged 65 and over (Persons)



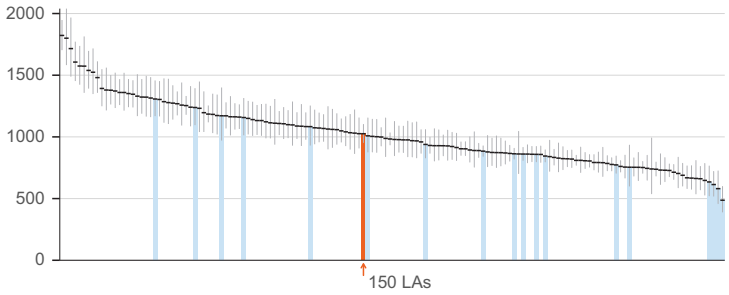
2.24i. Injuries due to falls in people aged 65 and over (Males)



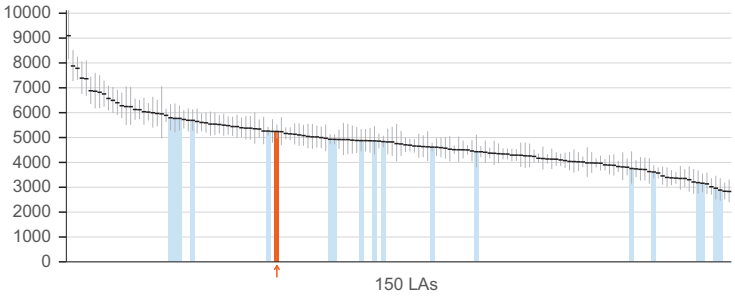
2.24i. Injuries due to falls in people aged 65 and over (Females)



2.24ii. Injuries due to falls in people aged 65 and over - aged 65-79



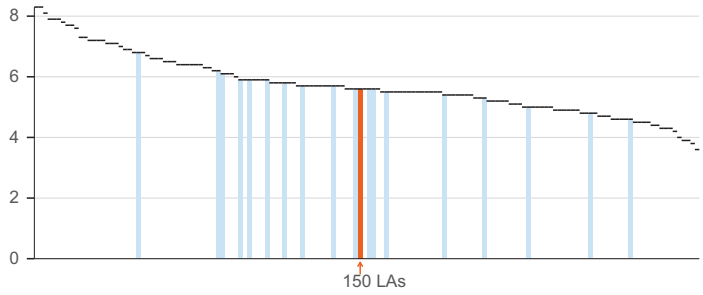
2.24iii. Injuries due to falls in people aged 65 and over - aged 80+



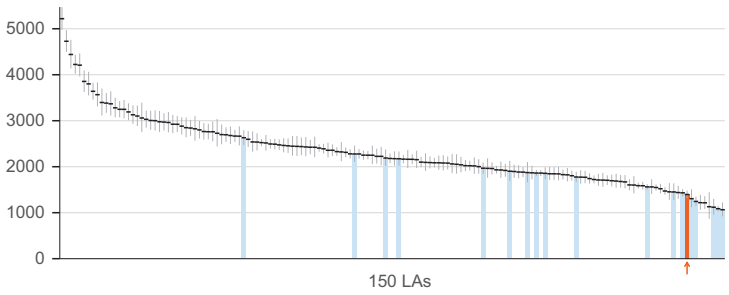
Health protection

Indicators for tracking progress against protecting the population's health from major incidents and other threats.

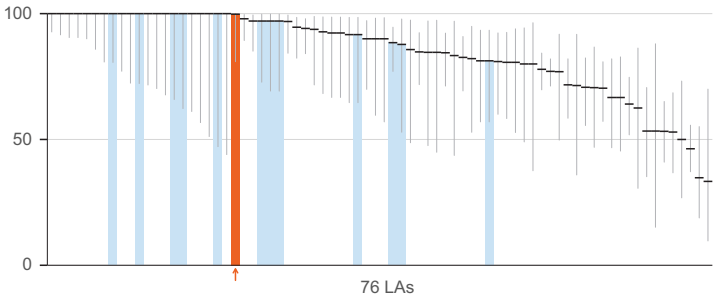
3.01. Fraction of mortality attributable to particulate air pollution



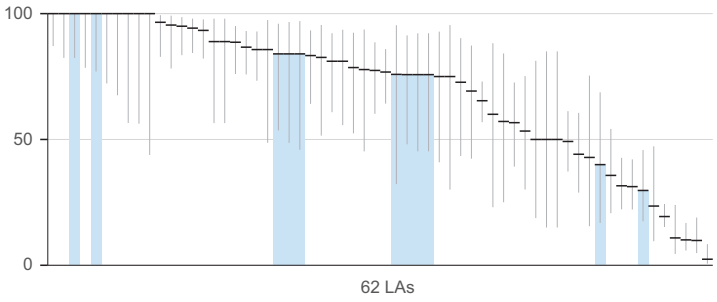
3.02. Chlamydia diagnoses (15-24 year olds)



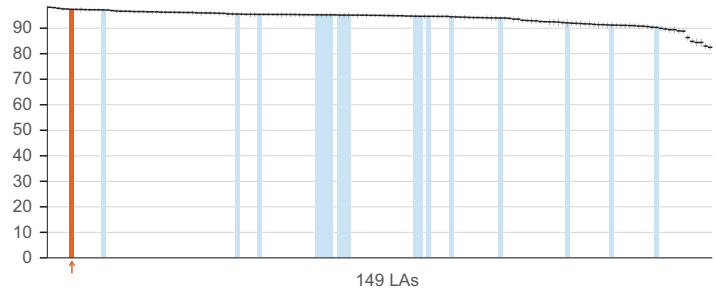
3.03i. Population vaccination coverage - Hepatitis B (1 year old)



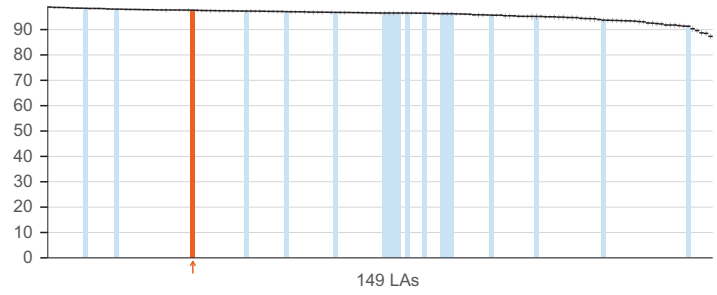
3.03i. Population vaccination coverage - Hepatitis B (2 years old)



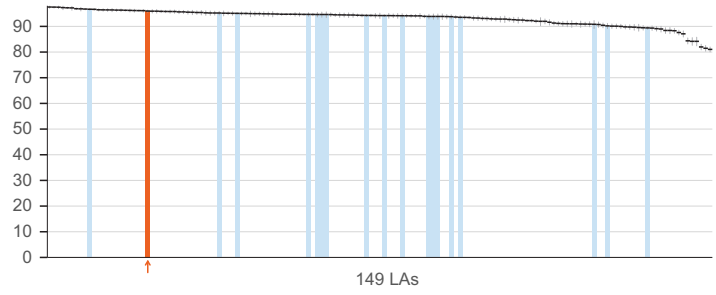
3.03iii. Population vaccination coverage - Dtap / IPV / Hib (1 year old)



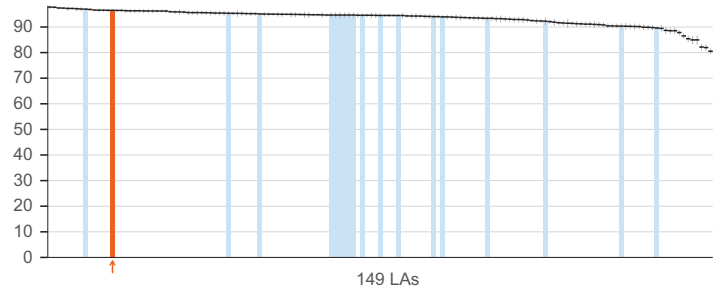
3.03iii. Population vaccination coverage - Dtap / IPV / Hib (2 years old)



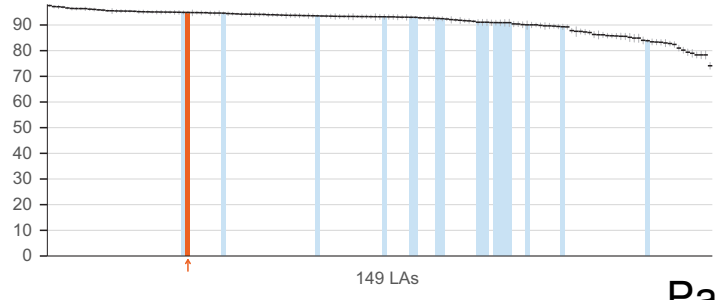
3.03iv. Population vaccination coverage - MenC



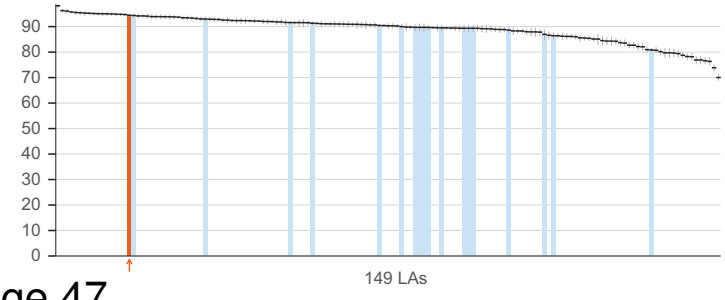
3.03v. Population vaccination coverage - PCV



3.03vi. Population vaccination coverage - Hib / MenC booster



3.03vii. Population vaccination coverage - PCV booster

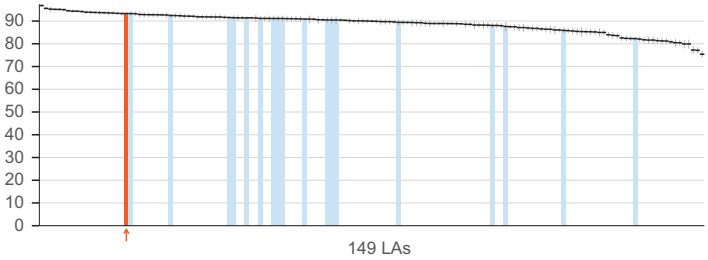


Oxfordshire

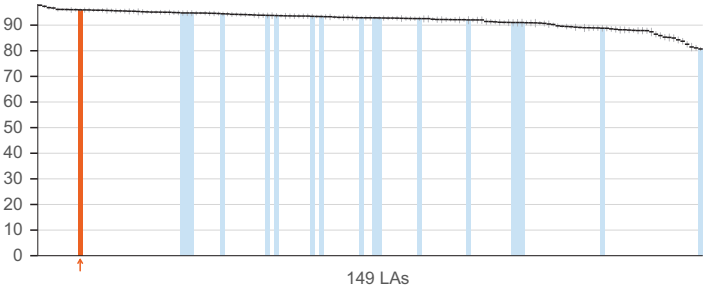
Health protection continued

Indicators for tracking progress against protecting the population's health from major incidents and other threats.

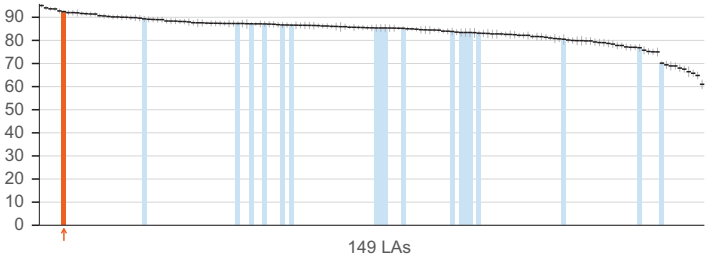
3.03viii. Population vaccination coverage - MMR for one dose (2 years old)



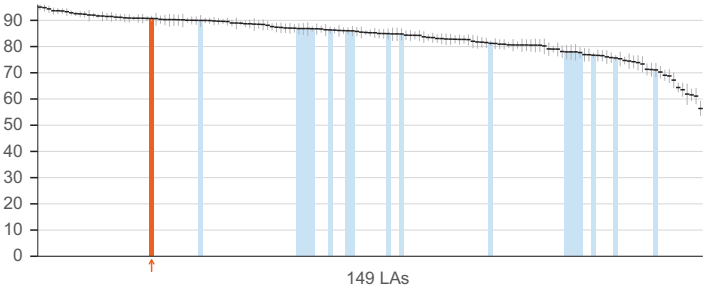
3.03ix. Population vaccination coverage - MMR for one dose (5 years old)



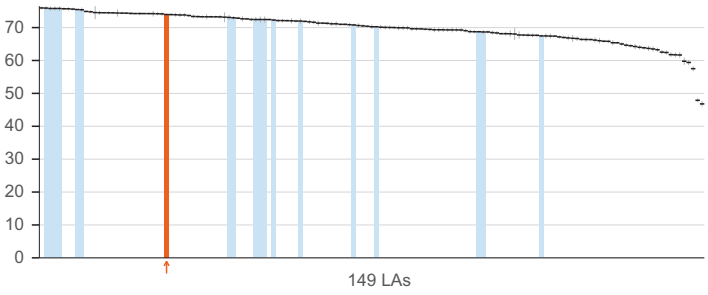
3.03x. Population vaccination coverage - MMR for two doses (5 years old)



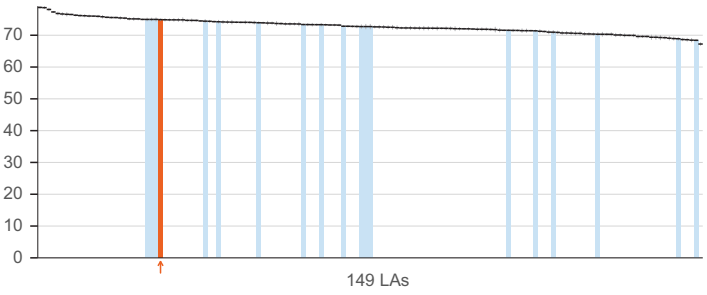
3.03xii. Population vaccination coverage - HPV



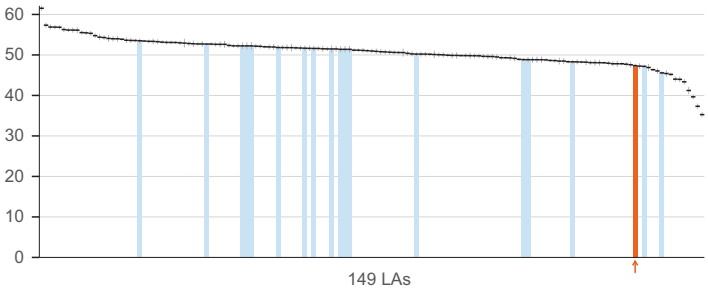
3.03xiii. Population vaccination coverage - PPV



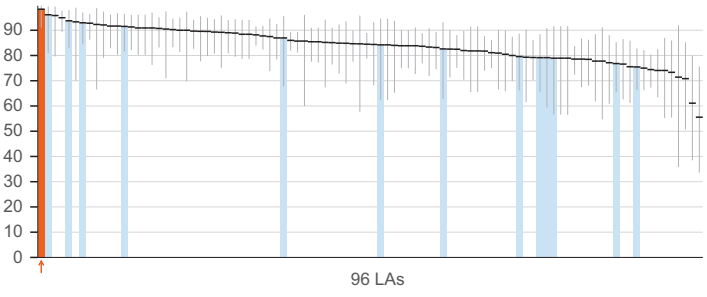
3.03xiv. Population vaccination coverage - Flu (aged 65+)



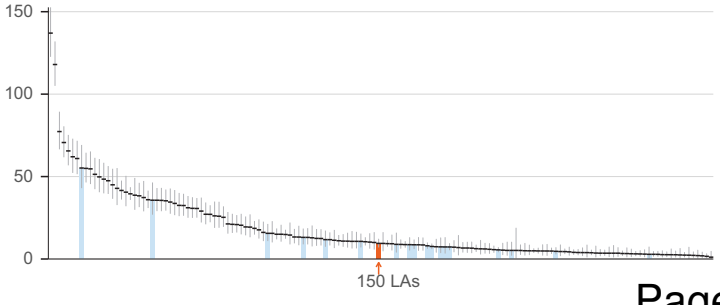
3.03xv. Population vaccination coverage - Flu (at risk individuals)



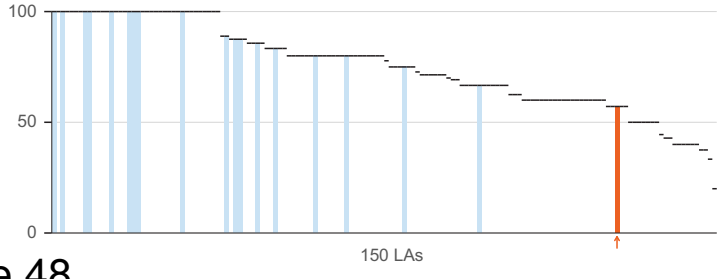
3.05i. Treatment completion for TB



3.05ii. Treatment completion for TB - TB incidence



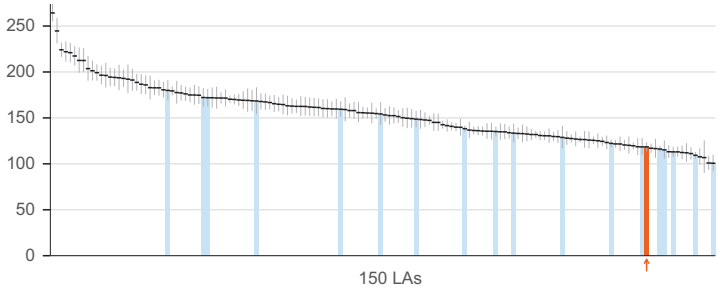
3.06. Public sector organisations with a board approved sustainable development management plan



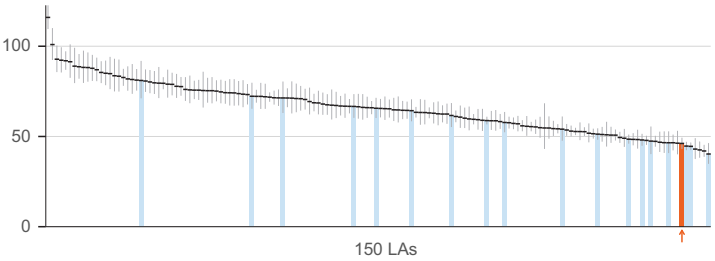
Healthcare public health and preventing premature mortality

Indicators for tracking progress against reducing numbers of people living with preventable ill health and people dying prematurely.

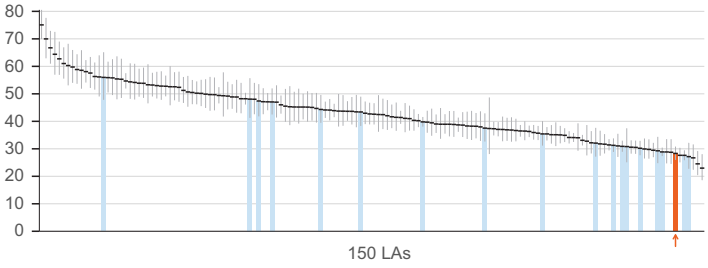
4.03. Mortality from causes considered preventable (provisional)



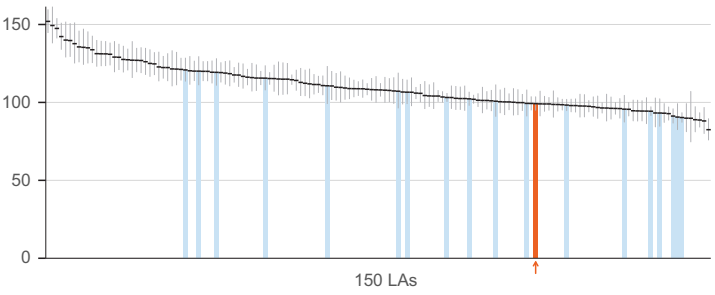
4.04i. Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) (Provisional)



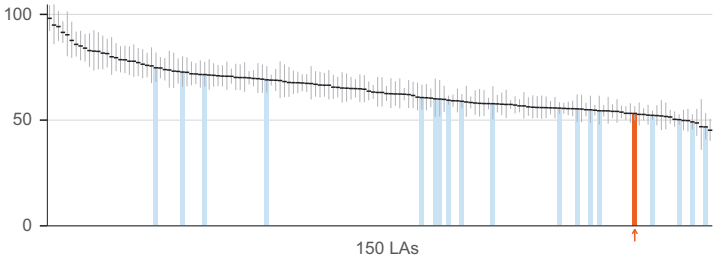
4.04ii. Under 75 mortality rate from cardiovascular diseases that is considered preventable(including heart disease and stroke) (Provisional)



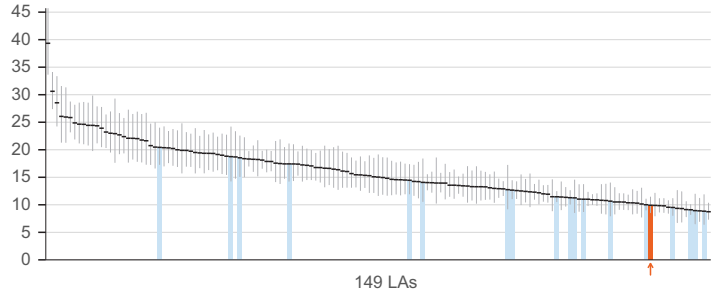
4.05i. Under 75 mortality rate from cancer (Provisional)



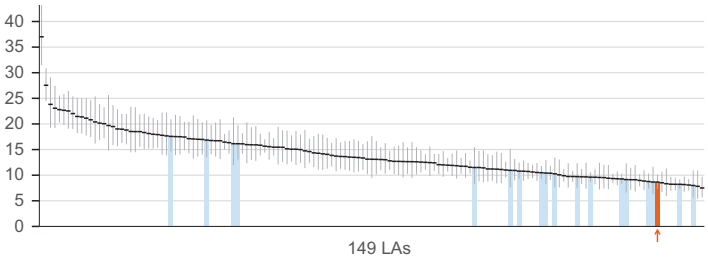
4.05ii. Under 75 mortality rate from cancer that is considered preventable (Provisional)



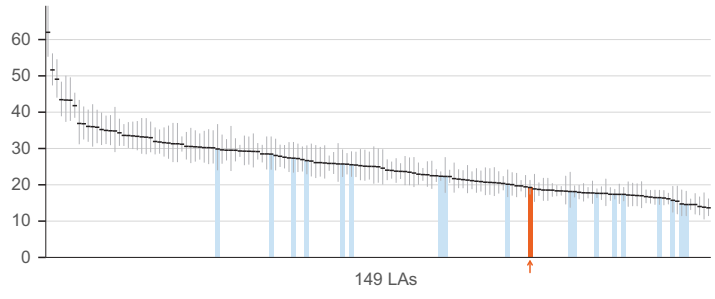
4.06i. Under 75 mortality rate from liver disease (Provisional)



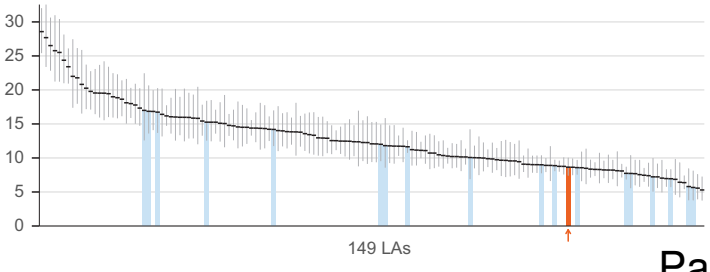
4.06ii. Under 75 mortality rate from liver disease that is considered preventable (Provisional)



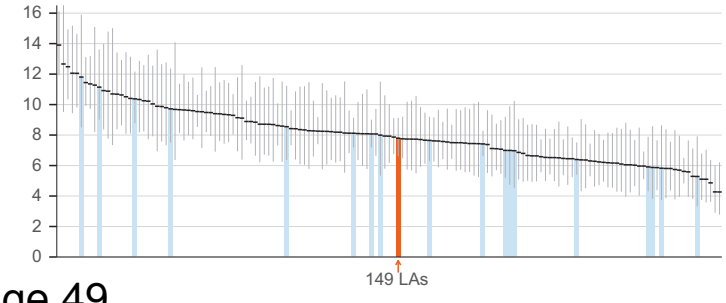
4.07i. Under 75 mortality rate from respiratory diseases (Provisional)



4.07ii. Under 75 mortality rate from respiratory diseases that is considered preventable (Provisional)



4.10. Suicide rate

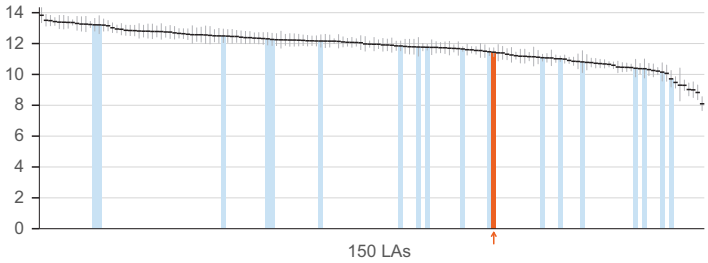


Oxfordshire

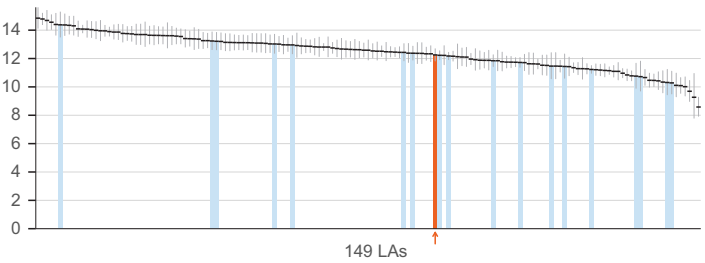
Healthcare public health and preventing premature mortality continued

Indicators for tracking progress against reducing numbers of people living with preventable ill health and people dying prematurely.

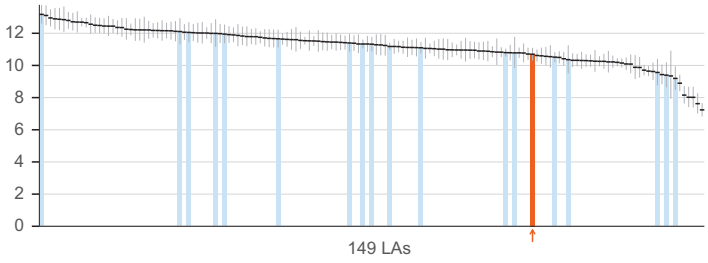
4.11. Emergency readmissions within 30 days of discharge from hospital (persons)



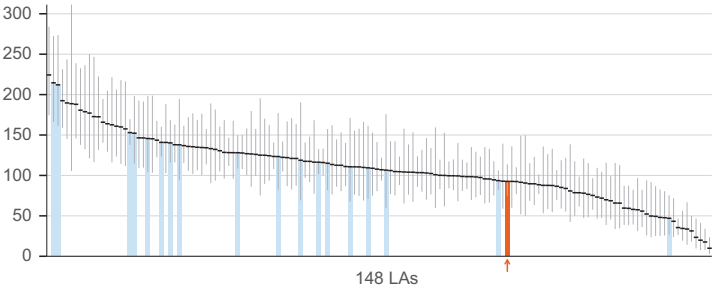
4.11. Emergency readmissions within 30 days of discharge from hospital (males)



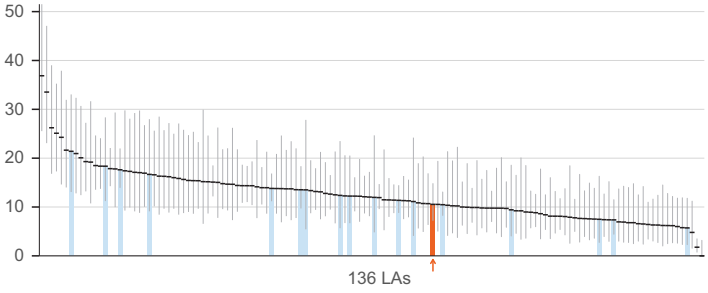
4.11. Emergency readmissions within 30 days of discharge from hospital (females)



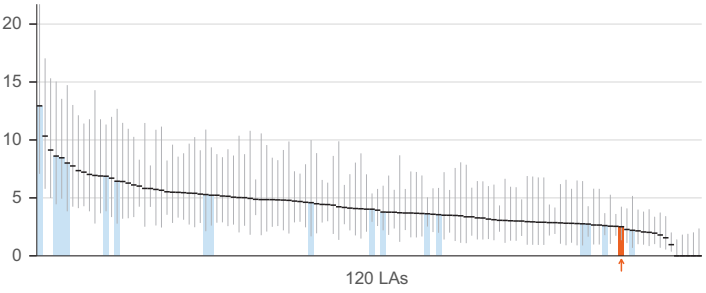
4.12i. Preventable sight loss - age related macular degeneration (AMD)



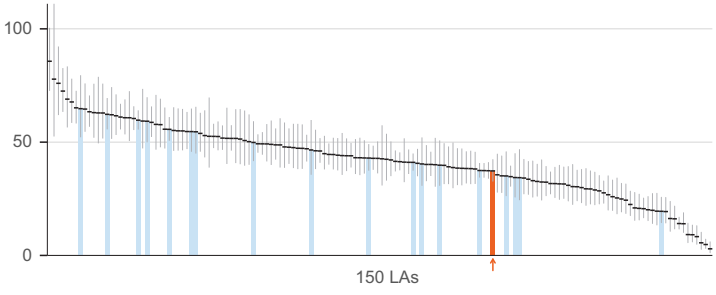
4.12ii. Preventable sight loss - glaucoma



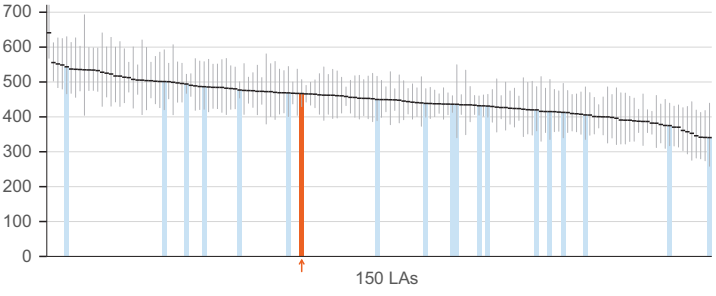
4.12iii. Preventable sight loss - diabetic eye disease



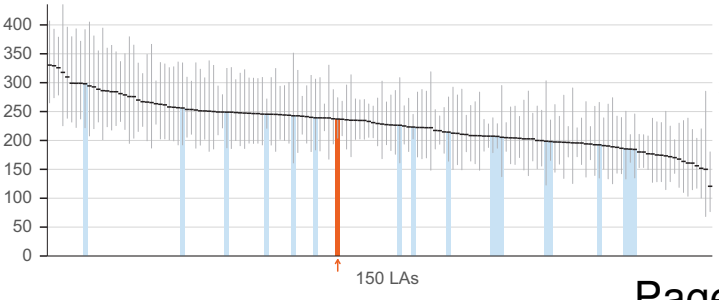
4.12iv. Preventable sight loss - sight loss certifications



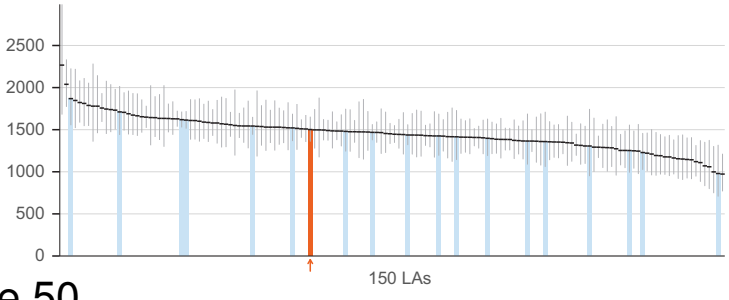
4.14i. Hip fractures in people aged 65 and over



4.14ii. Hip fractures in people aged 65 and over - aged 65-79



4.14iii. Hip fractures in people aged 65 and over - aged 80+

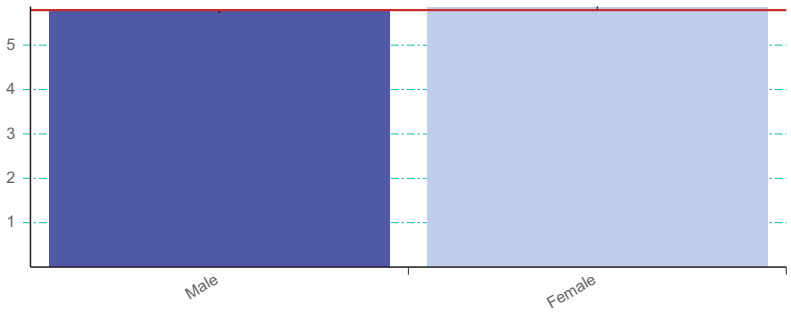


Inequalities

The Public Health Outcomes Framework focuses the whole system on achieving positive health outcomes for the population and reducing inequalities in health. The majority of indicators in this framework have the potential to impact on inequalities and we aspire to make it possible for all indicators to be disaggregated by equalities characteristics and by socioeconomic analysis wherever possible in order to support work locally to reduce in-area health inequalities where these persist. However, in this first publication, as well as breaking down some of the local authority level indicators by gender or age, we are also presenting data by equalities characteristics for a small number of indicators at national level only. These indicators are presented in this section.

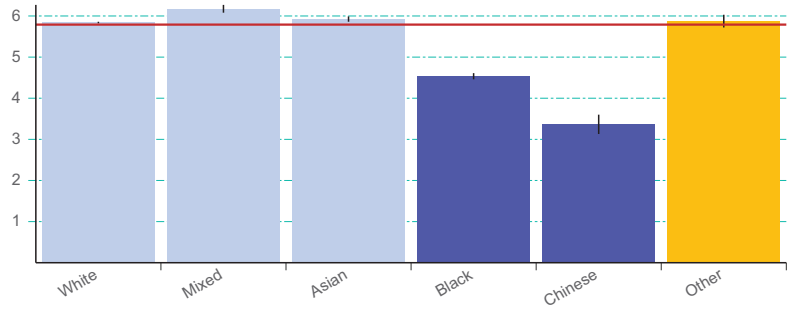
1.03 - Pupil absence - by gender England 2010/11

	Value	LCI	UCI
England	5.79	5.78	5.81
Male	5.75	5.72	5.77
Female	5.84	5.82	5.87



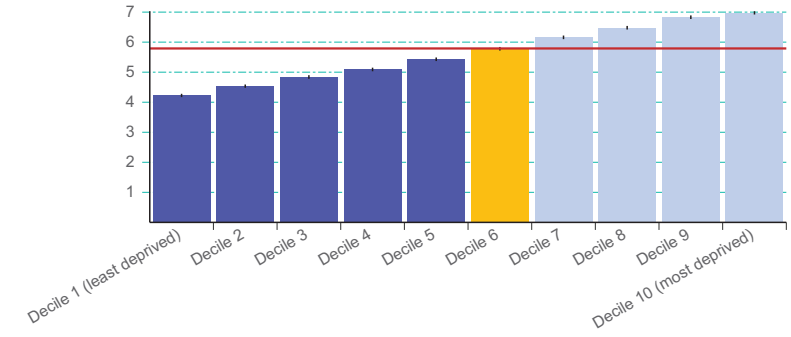
1.03 - Pupil absence - by ethnicity England 2010/11

	Value	LCI	UCI
England	5.79	5.78	5.81
White	5.84	5.82	5.86
Mixed	6.17	6.08	6.27
Asian	5.92	5.86	5.99
Black	4.54	4.46	4.61
Chinese	3.36	3.13	3.60
Other	5.88	5.72	6.03



1.03 - Pupil absence - by deprivation England 2010/11

	Value	LCI	UCI
England	5.79	5.78	5.81
Decile 1 (least deprived)	4.23	4.17	4.28
Decile 2	4.54	4.48	4.59
Decile 3	4.84	4.78	4.90
Decile 4	5.09	5.03	5.15
Decile 5	5.43	5.37	5.49
Decile 6	5.78	5.72	5.84
Decile 7	6.16	6.10	6.22
Decile 8	6.48	6.42	6.54
Decile 9	6.83	6.77	6.89
Decile 10 (most deprived)	6.98	6.92	7.03



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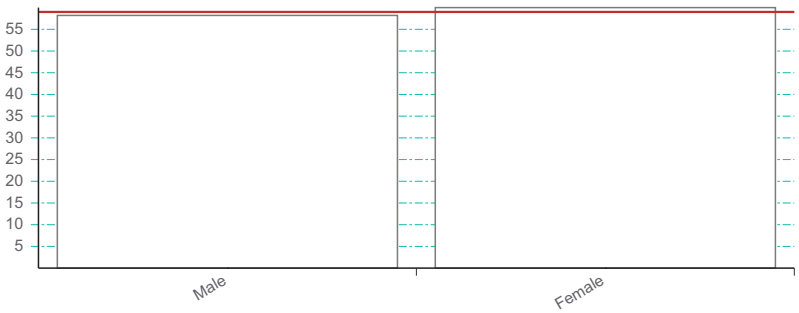
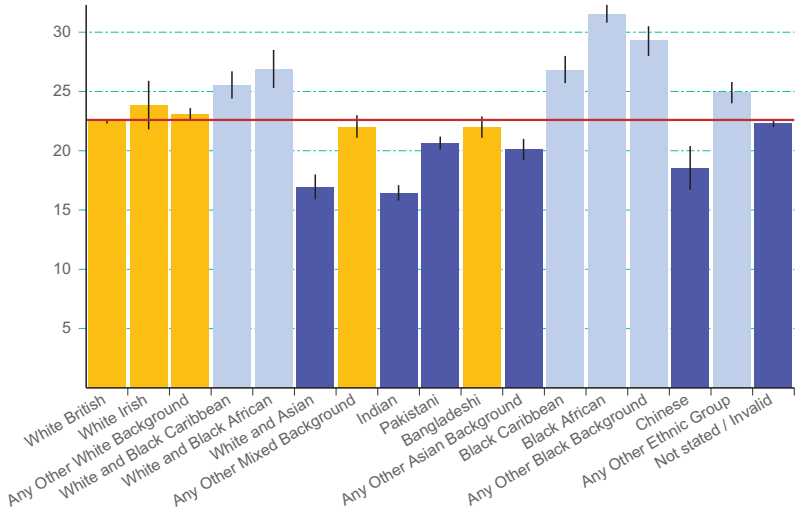
1.06i - Percentage of all adults with learning disabilities who are known to the council, who are recorded as living in their own home or with their family - by gender England 2010/11

	Value	LCI	UCI
England	59.00	-	-
Male	58.20	-	-
Female	60.00	-	-



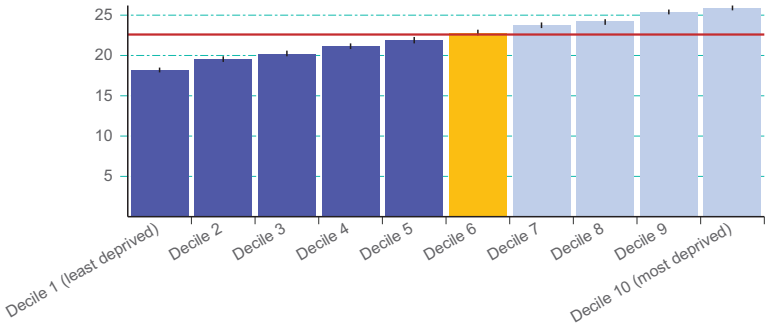
2.06i - Percentage of children aged 4-5 classified as overweight or obese - by ethnicity England 2010/11

	Value	LCI	UCI
England	22.60	22.50	22.70
White British	22.50	22.30	22.60
White Irish	23.80	21.80	25.90
Any Other White Background	23.10	22.60	23.60
White and Black Caribbean	25.50	24.40	26.70
White and Black African	26.90	25.30	28.50
White and Asian	16.90	15.90	18.00
Any Other Mixed Background	22.00	21.10	23.00
Indian	16.40	15.80	17.10
Pakistani	20.60	20.10	21.20
Bangladeshi	22.00	21.10	22.90
Any Other Asian Background	20.10	19.20	21.00
Black Caribbean	26.80	25.70	28.00
Black African	31.50	30.80	32.30
Any Other Black Background	29.30	28.00	30.50
Chinese	18.50	16.70	20.40
Any Other Ethnic Group	24.90	24.00	25.80
Not stated / Invalid	22.30	22.00	22.60



2.06i - Percentage of children aged 4-5 classified as overweight or obese - by deprivation England 2010/11

	Value	LCI	UCI
England	22.60	22.50	22.70
Decile 1 (least deprived)	18.20	17.90	18.50
Decile 2	19.50	19.20	19.90
Decile 3	20.20	19.90	20.60
Decile 4	21.10	20.80	21.50
Decile 5	21.90	21.50	22.30
Decile 6	22.80	22.50	23.20
Decile 7	23.70	23.40	24.10
Decile 8	24.20	23.80	24.50
Decile 9	25.40	25.10	25.70
Decile 10 (most deprived)	25.90	25.60	26.20



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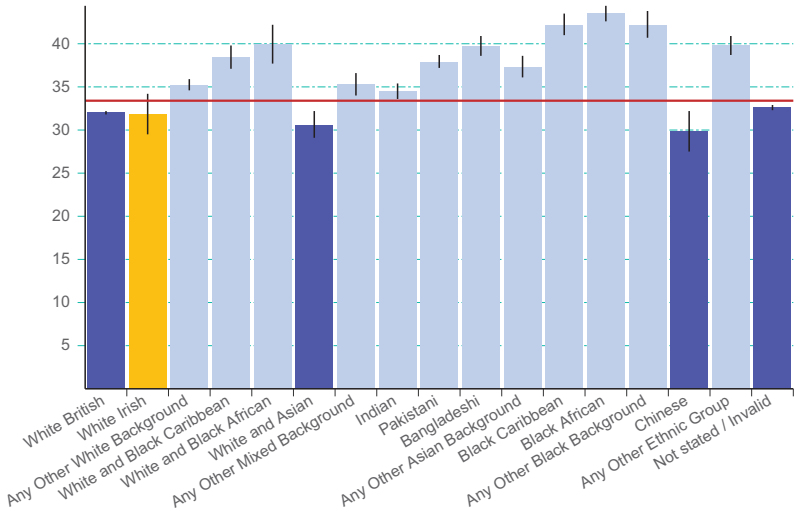
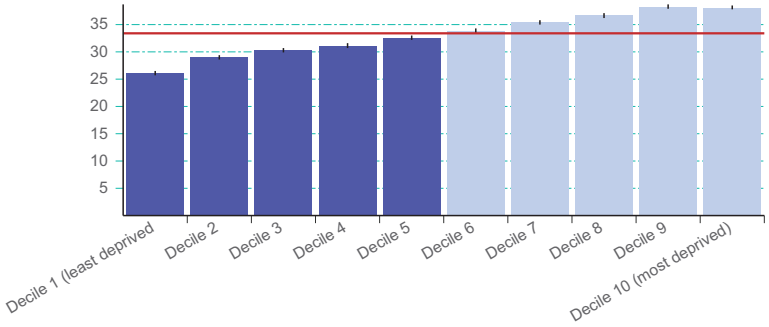
2.06ii - Percentage of children aged 10-11 classified as overweight or obese - by ethnicity England 2010/11

	Value	LCI	UCI
England	33.40	33.30	33.50
White British	32.00	31.80	32.20
White Irish	31.80	29.50	34.20
Any Other White Background	35.20	34.60	35.90
White and Black Caribbean	38.40	37.10	39.80
White and Black African	39.90	37.70	42.20
White and Asian	30.60	29.10	32.20
Any Other Mixed Background	35.30	34.00	36.60
Indian	34.50	33.60	35.40
Pakistani	37.90	37.20	38.70
Bangladeshi	39.70	38.60	40.90
Any Other Asian Background	37.30	36.10	38.60
Black Caribbean	42.20	41.00	43.50
Black African	43.50	42.60	44.40
Any Other Black Background	42.20	40.70	43.80
Chinese	29.80	27.50	32.20
Any Other Ethnic Group	39.80	38.70	40.90
Not stated / Invalid	32.60	32.30	32.90



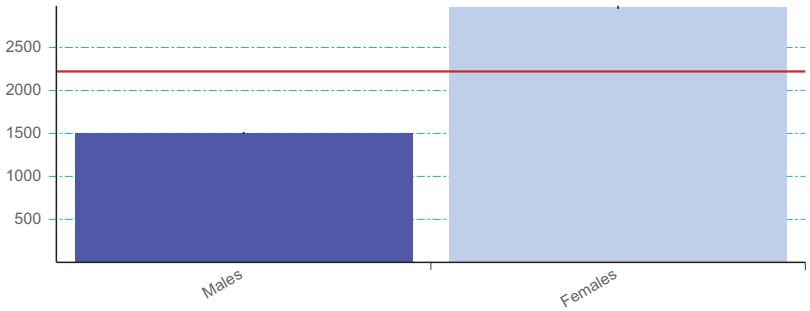
2.06ii - Percentage of children aged 10-11 classified as overweight or obese - by deprivation England 2010/11

	Value	LCI	UCI
England	33.40	33.30	33.50
Decile 1 (least deprived	26.10	25.70	26.50
Decile 2	29.00	28.60	29.40
Decile 3	30.30	29.90	30.70
Decile 4	31.10	30.70	31.60
Decile 5	32.60	32.20	33.00
Decile 6	33.90	33.40	34.30
Decile 7	35.40	35.00	35.80
Decile 8	36.70	36.20	37.10
Decile 9	38.30	37.90	38.70
Decile 10 (most deprived)	38.10	37.80	38.50



3.02 - Chlamydia diagnosis (15-24 year olds) - by gender England 2010

	Value	LCI	UCI
England	2,220	2,209	2,232
Males	1,504	1,491	1,517
Females	2,965	2,947	2,984



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Everyone Counts – Planning for Patients 2013/14
Briefing Paper

Background
This document is the 2013/14 planning and rule book for Clinical Commissioning Groups and NHS Commissioning Board Area Teams. It sets out how each group will be monitored, what improvements they are expected to make and how money should be spent. Below is the headline news of this document
Everyone counts: Planning for Patients 2013/14 | NHS Commissioning Board

Headline 1 – The importance of the NHS Constitution.
The NHS Constitution establishes the principles and values of the NHS in England. It sets out patient and staff rights and responsibilities. It protects the NHS and helps ensure we receive high-quality healthcare that is free for everyone. The constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service.
NHS Constitution | Department of Health

Headline 2 – The NHS Offer.
The document identifies five offers, these are outlined below

Offer	Description
Offer 1 – 7 days a week routine NHS care	All routine services should be available seven days a week. A report on how this will be achieved is due in Autumn 2013
Offer 2 –More transparency and choice	By releasing statistics on consultants performance, clinical audit and casemix comparisons, commissioners and patients will be able to make informed choices about how well local services are performing. Publication will start in Summer 2013 and will be built into 2014/15 contract.
Offer 3 – Listening to patients and their experiences	Commissioners will be expected to put in place real time patient and carer feedback mechanisms by 2015. This work will start this summer with the feedback of patients attending A&E depts. Being captured, moving to maternity services in October 2013. CCG plans will need to show that they have taken account of feedback and Health and Wellbeing boards will need to monitor the implementation of improvement.
Offer 4 – Better Data, which helps planning	A new data system will ensure commissioners have access to the latest technologies to local level data. The NHS contract will have minimum requirements for data built into the 2014/15 version. CCG will have to develop a strategy for implementing data improvements by 30th September 2013
Offer 5 – Higher Standards, better care	All CCG's will be required to implement the Winterbourne View report recommendations. There will also be a focus on improving practitioner competence by implementing "compassion in practice" and revalidation for medical practitioners.

Local Health and Wellbeing boards will be expected to oversee the implementation of this work, by ensuring that local priorities meet the needs of the population, agreeing local plans and then ensuring their implementation.

Clinical Commissioning Group Outcome Data sets have been published to help CCG's and Health and Wellbeing Boards to ensure that the right prioritises are picked. These can be found here.
Local Authority and Clinical Commissioning Groups Benchmarking Packs

Headline 3 – Delivering against the NHS Outcomes Framework
The NHS Outcomes Framework identifies five areas for improvement which all organisations will be measured against. These "domains" are listed overleaf

Domain	Description
Domain 1 - Preventing People from dying prematurely	This domain has identified four key factors which contribute to reducing eary deaths, these are • Early Diagnosis • Improving Management in community settings • Improving Care and treatment in acute settings • Preventing reoccurrence after an acute episode
Domain 2 - Enhancing quality of life for people with long term conditions	This domain aims to improve the patients experience by ensuring commissioners consider patient centred care and integrated services for people with long term conditions. This domain includes personal budgets, personal care plans and better co-ordination of care
Domain 3 - Helping people recover after episodes of ill health	This domain aims to reduce avoidable admissions by maximising effective treatments such as telemedicine, better communication between professionals and better discharge planning/co-ordination
Domain 4 - Ensuring People have a positive experience of care	The domain expects CCG's to develop systems for rapid comparable feedback which commissioners can act upon.
Domain 5 - Keeping people safe and protecting people from avoidable harm	This domain includes the need to reduce hospital acquired infections, there will be a national dashboard for commissioners to access their performance against national and regional peers

Headline 4 – Three local priorities
The CCG is expected to, with the help of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, to identify three local priority areas which they intend to address throughout 2013/14. The plan will be agreed by and monitored through the Health and Wellbeing Board.

Headline 5 – Other National Priorities to be rolled out
There are also a few national targets which CCG's will be monitored against these are as follows

- Reduction of waiting lists – zero tolerance of 52 week waits, 18 week waits continue to be a right in the NHS constitution
- More responsive Urgent and Emergency Care – fines for ambulance delays and zero tolerance of trolley waits over 12 hours
- Reducing cancellations
- 100% roll out of the IAPTS service (Improving Access to Psychological Therapies)

Timetable for Implementation

Date	Expected Action
25th January 2013	First Draft of CCG plan to be shared with the Area Team, this should include • Key elements of transformation change • Trajectories for NHS outcomes • 3 local priorities • Activity plan • Financial Information
8th February 2013	Feedback from Area team
29th March 2013	Further work on plans with Area team to ensure plans are robust
31st March 2013	Sign off of the plan locally
5th April 2013	Final CCG plans to be shared with Local Area Team
19th April 2013	Plans to be agreed by Board and areas of risk identified and planned for
10th May 2013	Plans to be approved by NHS CB Local Area Team Board
31st May 2013	Local Prospectus to be published to local population

Angela Baker
January 2013

Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting 21st February 2013

The following update covers the final LINk project reports delivered under the current contract and which will form part of the legacy for Local HealthWatch.

Maternity Services Review report

The report is now complete with the following concerns indicated as being the most prevalent:

1) **Breastfeeding**
   - Receiving conflicting information;
   - Strongly 'pushed' as the best option;
   - Initial promotion not followed up with the right level, or regularity, of support.

2) **Consistency of support**
   - Mothers seeing many different health visitors after the birth, which leads to conflicting information being given;
   - Lack of signposting onto other services means mothers can feel isolated and have to look for services themselves, potentially missing out on support;
   - This can result in an inability to develop a purposeful relationship with professionals.

The report was submitted on 4th February to Oxford University Hospitals NHS Trust and Commissioners with a request for a response to the recommendations

Mental Health Hearsay update

The report from the update event held on 6th December has been considered by the Mental Health Joint Management Group and will be taken to the Better Mental Health Programme Board on 28th February. Draft responses have been received from the Commissioners and Oxford Health.

Review of information provided for NHS Dental Patients in Oxfordshire

This project was set up to review access to information for Oxfordshire dental patients, in dental practices and on dental practice websites. The study design was developed in collaboration with the Primary Care Trust, based on a similar study undertaken by Berkshire LINk. Data collection & interviews were carried out by LINk volunteers & staff. The project lead and other key members have analysed the data and prepared this report on the findings for the PCT/OCCG. Overall recommendations for 'Good Practice' for display signage, printed and online materials are contained in Appendix 4.

OMEGA report into the system for referral and treatment of CFS/ME patients

The research findings have been circulated previously to the Committee. LINk has requested a response from Commissioners and Providers to the recommendations.

Transition to Local HealthWatch

A LINk round-up event will be taking place during March – invitations are in the process of being circulated. This will be an opportunity to review past LINk projects and provide a means to agree priority work to pass onto Local HealthWatch, based on the LINk Legacy. The Annual Report for 2012-13 will be presented at this event.

Adrian Chant (LINk Locality Manager)
01865 883488
Update 07/02/2013

Oxfordshire LINk Maternity Services Review

Postnatal Maternity Services in Oxfordshire August to December 2012

Sue Marshall
Development Officer
Oxfordshire LINk

Oxfordshire LINk

The Oxfordshire Local Involvement Network (LINk) was set up in April 2008 to give everyone an opportunity to say what they think about local health and social care services. The LINk is independent of the local council and the NHS.

The LINk listens to what local people say about their needs and about their experiences of services whether they are provided by the NHS, a local authority, charities, or a private company or voluntary organisation under contract to Social and Community Services. Social and Community Services is the part of the County Council which is responsible for adult social care.

The LINk wants to know what is working well and what is not so good and to give people an opportunity to monitor and check how services are planned and run. The LINk feeds back this information to the people in charge so that things can change for the better. LINk also has powers to ask the NHS and Social Services for information and to make recommendations.

Service providers listen to these comments and try to make changes to the services they provide

People in Oxfordshire receive health and social care services and share their opinions with Oxfordshire LINk

Oxfordshire LINk ask people their views and experiences of their services and pass on comments to the service provider

Maternity Services Review Introduction

Through engagement work carried out by Oxfordshire LINk, we received various comments relating to maternity services in Oxfordshire. On request, LINk presented a scoping document to Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) to judge the level of support for taking these comments forward and forming a project group. This was supported and work began to undertake more research in order to obtain a comprehensive, up to date picture of how people feel about their maternity services. As with all Oxfordshire LINk projects, the outcomes and recommendations are shared with the relevant service providers & commissioners with a request made for responses to the issues raised and, if appropriate, an action plan developed. The timescale was set for the majority of current LINk project work being completed by the end of December 2012.

What had LINk heard?

Comments received from previous engagement work:

What works well

- Midwives and Health Visitors are excellent (Bicester)
- The Maternity Ward at the JR was fantastic
- Maternity services are excellent at JR
- JR maternity care excellent – team very caring
- Maternity care is good
- Midwives were wonderful

Areas of concern

- Reduced Maternity service at the Horton
- Need consistency with midwife service – one or two midwives to see you through pregnancy, rather than lots of different ones.
- Midwives put new Mum's under pressure to breast feed
- More Midwives needed at the JR – there are staff shortages
- Health Visitors could be more helpful and supportive
- Felt pushed to breastfeed
- Left overnight after birth with no obs
- Sister in Leeds has 2 hour DVD's, special visits before birth! Why can't we have the same?
- Poor care at JR maternity
- JR Maternity – really good with the birth, but don't give any advice about looking after the baby, this is left to the Midwife. Community Midwives are under too much pressure to do everything and the service is stretched – you may not see a midwife for a week – 2 weeks after birth. Should have more training / information available in hospital before you leave with your new baby.
- Inconsistent advice post birth.
- Too much pressure on new Mums to breast feed
- Discharge after birth too soon
- Continuity of maternity care is not good – unusual to see the same person twice
- Post Natal depression was not taken seriously (x2)
- Lack of Midwives – only one for the whole area. No holiday cover.
- Takes ages to get an appointment (Thame)

Response received from Oxfordshire Primary Care Trust regarding comments received

Topic	Comments Received:	Response May 2012
a) Staffing:	• *Need consistency with midwife service – one or two midwives to see you through pregnancy, rather than lots of different ones.* • *Continuity of maternity care is not good – unusual to see the same person twice* • *More Midwives needed at the JR – there are staff shortages* • *Lack of Midwives – only one for the whole area. No holiday cover. Takes ages to get an appointment (Thame)* • *Health Visitors could be more helpful and supportive*	Staffing levels have improved since 2010/11and OUHT do not currently have any midwifery vacancies. OUHT recognise that continuity of care is an important issue to service users. A review of community caseloads has been undertaken and every effort is made to ensure continuity of carer wherever possible.
b) Breast Feeding:	• *Midwives put new Mum's under pressure to breast feed* • *Felt pushed to breastfeed* • *Too much pressure on new Mums to breast feed*	All midwives will are encouraged to support women in their chosen method of feeding. However we recognise that women, whilst given the choice, are actively encouraged to breast feed where possible, as there is strong evidence supporting the positive benefits of breast feeding for babies. The service recognises the need to ensure that an appropriate balance is struck, and that staff are sensitive to those women who may feel unduly pressurised.
c) Information	• *Sister in Leeds has 2 hour DVD's, special visits before birth! Why can't we have the same?* • *JR Maternity – really good with the birth, but don't give any advice about looking after the baby, this is left to the Midwife. Community Midwives are under too much pressure to do everything and the service is stretched – you may not see a midwife for a week – 2 weeks after birth. Should have more training / information available in hospital before you leave with your new baby.* • *Inconsistent advice post birth.*	Parent Education is currently being reviewed in order to meet the Department of Health recommendations in *'Birth and Beyond'.* These sessions will involve a multi-agency approach and will ensure that care of the baby is covered in both the ante-natal and post natal period. This will improve the level of education and information provided to mothers. Every effort is made by staff to ensure consistency in the advice that is provided.
d) Quality	• *Poor care at JR maternity* • *Left overnight after birth with no obs* • *Reduced Maternity service at the Horton* • *Discharge after birth too soon* • *Post Natal depression was not taken seriously (x2)*	All women are risk assessed by the service and an appropriate individual plan of care is put in place. This plan will include for example the required level and frequency of observation, and discharge planning needs. We are not unaware of any reduction in the maternity services at the Horton to which one comment refers.

Maternity services in Oxfordshire are grouped into three areas;

- **Antenatal Services** – services used during pregnancy including; ultrasound, pregnancy tests and screening, antenatal clinics, day assessment units, Silver Star service, community midwives.
- **Maternity Units** – services used during birth including; consultant led maternity units at the John Radcliffe and Horton hospitals, midwifery-led maternity units including Oxford Spires.
- **Postnatal Services** – services used after birth including; breastfeeding clinics, newborn screening programme, neonatal unit, Special Care baby unit (SCBU), birth afterthoughts, community health visitors.

Through consultation and discussion with the Joint Health Overview and Scrutiny Committee (HOSC), LINk agreed to focus research and project work on Postnatal services.

Oxfordshire LINk looked at ways to gather comments and views from the public, including questionnaires and research gathering via the following avenues:

- Facebook
- Twitter
- Oxfordshire LINk website
- Family support websites e.g; Netmums Oxfordshire
- Local press and media
- Existing LINk contacts
- Other support organisations including voluntary sector
- Children's Centres
- Mother and Baby groups & toddler groups

Organisations or groups with whom Oxfordshire LINk worked, or shared information, included:

- Oxford University Hospitals Trust
- Maternity Service Liaison Committee
- Oxfordshire Primary Care Trust
- Oxford Health
- Locality Clinical Commissioning Groups
- Voluntary Sector
- National Childbirth Trust
- Joint Health Overview & Scrutiny Committee
- Children's Services Scrutiny Committee

Example questionnaire used to gather views

Oxfordshire LINk Maternity Project Questionnaire

Do you have any comments to make about any area of your postnatal care (after the birth) in Oxfordshire?

Areas of postnatal care you might want to tell us about include:

- Your stay in hospital after the birth
- Breastfeeding Clinics
- The Birth Afterthoughts service
- Neonatal units
- The Newborn Hearing Screening Programme
- Support around your choice of feeding
- Home visits from Midwives
- Health Visitors
- Support after the home birth

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Please can you tell us the month and year you gave birth?.....

Which area of Oxfordshire do you live in?.....

Thank you for your contribution to this project

Comments Received

Positive Experiences

- The hearing programme is very good.
- Home visits from the midwives were also good, they were all very helpful.
- The midwife in the delivery suite was excellent, supportive, patient and very sensitive.
- I attended the JR breastfeeding and they were superbly supportive.
- The midwives who have visited us at home have been excellent.
- Breastfeeding clinic (at the JR) - excellent, thanks to Sally and her team
- Hearing Screening - lovely and efficient
- Breastfeeding clinics – excellent
- Hearing screening - excellent
- I came home straight after having my baby so didn't stay in hospital. However, I had some concerns after going home and therefore phoned the Spires Unit and they were very helpful and gave me advice which was reassuring.
- The Birth Afterthoughts service – after a very traumatic 2nd birth with lots of complications after the birth – this service made sense out of it all. My husband and I found this very helpful.
- Banbury SCBU – staff really kind
- The Newborn Hearing Screening programme – good
- Special Care Baby Unit and Intensive Care Baby unit are fantastic and so supportive.
- I am very pleased and satisfied about the Birth Afterthoughts services and in particular breastfeeding, health visitors and breastfeeding advisor Margaret are exceptionally helpful and give me great support, it is a work with a lot of respect, many thanks and keep helping mums!
- Stay in hospital very caring even after I went home. Had a little postnatal depression which was picked up and I was looked after with the correct support networks.
- Midwives were very helpful in hospital and once I returned home.
- My local Children's Centre is full of information and a place to come for a chat and a cup of coffee.
- Overall very happy with all sections (of postnatal care)
- The staff at the JR (John Radcliffe) post birth were great and very supportive.
- I have found our health visitor very approachable and knowledgeable.
- Once my baby was 4 weeks we started attending the Eynsham Children's Centre which I found to be excellent, the support for breastfeeding was excellent.
- Breast feeding clinics and children's centres in Oxfordshire are excellent - I felt very supported in this area.
- The midwives before and during the birth of my son were excellent.
- Hearing screening very helpful that done at hospital
- Midwives at home - excellent (Marie Blenheim team)

- I had help learning to bathe my baby and in the night it was reassuring to have someone there when he was struggling with fluid (from the birth) preventing him breathing. I personally found the stay overnight in hospital was the best choice for me - when you are a new mum the first night/day is the scariest!
- I had two difficult pregnancies and with both pregnancies I was under Silver Star service at JR but the care and expertise I had from Chipping Norton was EXCEPTIONAL. Midwives had an amazing positive impact during both births when I had to be transferred to the JR – 1st was undiagnosed breech and 2nd was 6 weeks premature birth. I transferred back to Chippy and the care I received was first rate. I could not have succeeded with breastfeeding (which I continued for 13 months) without the time, patience and expertise of the Chippy midwives. With my 2nd baby I had complications and was in JR and then Banbury when I did get home the midwives were great in looking after me until the health visitor took over.

Breastfeeding Comments

- While in hospital I asked the midwives for support with breast feeding but they didn't help me, the pain was unbearable and I was forced to stop breast feeding. The response I got from the midwives was it looks like she is latched on fine. In Oxfordshire breast feeding is pushed on you and I was made to feel very guilty about having to stop by one midwife. Who also told me my child would have a lower IQ if formula fed. My child is now 17 months old and is very advanced for her age. She was formula fed 3 days after being born.
- The breastfeeding support I received was HOPELESS - my baby did not latch on until, at ten days old, I eventually drove myself (and the baby) to Chipping Norton and spent the day there where the midwife suggested I use nipple shields. I went on to breastfeed until she was nearly 12 months despite suffering from mastitis over the New Year (undiagnosed by my two GPs and a Health Visitor and eventually diagnosed by an out of hours doctor).
- I was encouraged to stay in hospital following the birth of my baby as I had made specific mention in my notes that I wanted help with breastfeeding my baby. A number of different midwives visited me following the birth and helped me to breastfeed - all were very helpful and pushing the breast is best message! (one told me I couldn't leave until I did it!). However, I experienced difficulty (as I thought I may) and in the morning one midwife almost 'gave me permission' to stop pushing myself too hard... she herself had similar difficulties and had bottle-fed her baby. Although helpful when asked for assistance, the breast is best message is overdone and I appreciated the personal - what's best for you both approach in the end.
- Stay at hospital - horrid. Noisy, disturbed and frankly outrageously rubbish knowledge about breastfeeding and childcare.

- I have coeliac disease and the hospital couldn't guarantee cross contamination of the food so I struggled to eat for the 3 days I was in hospital after my child was born. My husband had to bring me some food in. This was important as I was trying to breast feed and needed the food.
- I would have appreciated more assistance with breastfeeding as I was only shown how to get my baby latched on whilst lying down which meant that within the first 48 hours I had major problems with a poor latch and despite going to the breastfeeding clinic twice, ended up giving up and bottle feeding which I didn't want to do. I found the breastfeeding clinic very good although it seemed a bit short staffed for the amount of mothers who were there needing help. The first time we had to wait several hours before there was anyone free to see us properly.
- Feeding - I still cannot believe that health professionals know less about breastfeeding than amateurs with an interest
- With first child – difficulty and breastfeeding got wrong info from midwife (home visit) More confident with second and third child

<u>Support Comments</u>

- I haven't had as positive experience with health visitors. The few we have seen have told us conflicting things so it is confusing.
- The midwife we dealt with in the assessment suite at the hospital was rude and abrupt.
- The GP we saw for the 24 hour check post delivery was not supportive and I found her insensitive.
- I wanted to have my baby at Chipping Norton but was told my BMI was too high which meant if I developed complications during the birth and needed to be transferred they might have trouble lifting me out of the birthing pool. Which was RIDICULOUS as I weigh just over 10stone which is MUCH LESS than taller women with a lower BMI!!! I went on to have a quick and easy homebirth without a midwife or paramedic in attendance. I was then transferred to the John Radcliffe as I had a retained placenta. I think this was because it took a midwife SO LONG to come to the house that the injection to deliver the placenta was too late.
- I never saw the same midwife or Health Visitor twice - one Health Visitor refused to come and visit me at home because she was frightened of cats and dogs (both very placid and friendly) even though I was a single parent and lived in a remote rural area.
- You are left alone with a new baby for long periods of time and I needed my husband to stay with me and that is not allowed.
- I found the home visits from midwives to be fine, however I was asked to go to Witney Hospital after a few days to attend the drop-in there. This is fine but after just having a baby it might have been less stressful to continue to have the midwives visit at home.
- It took longer than I would have liked to be discharged the next day as the paediatrician was very busy. The health visitors were very helpful and reassuring, once

again we had a very good health visitor who helped us feel confident as parents to be led by what our baby needed/wanted. I was surprised by how many health visits there are in the beginning - no one tells you this pre-birth! I was fortunate to be able to see our local doctors for follow up checks. All in all we had the right amount of support when we needed it and I had a very positive experience.

- Health visitors - again a shocking lack of knowledge about feeding, weaning, sleeping arrangements etc. I still have not worked out what the point of the visits was apart from a box ticking exercise
- One issue we did not receive advice on though was how to prevent flat head syndrome, until our baby had it quite badly and I find it frustrating that new parents are not advised on how to prevent this from the beginning. It only seems to be after the event that advice is given. It should be on the various checklists from the very start so that the problem can be prevented in the first place.
- My only other comment is that we saw a different midwife on each of the home visits which as a new mother makes it harder to talk to them as there is no continuity of relationship.
- I felt that the postnatal care was rushed and I didn't get the support I would have wanted. My final appointment was at the JR rather than in my home, which wasn't ideal. I had to book my son for his first review within 72 hours of his birth. However, I wasn't told this until 24 hours after his birth and as it was coming up to the weekend I had to rush to get a doctors appointment the next day. I really didn't feel up to this at the time and thought it could have been handled better. Is there any reason this couldn't be done in hospital after the birth?
- I just wanted to make a point regarding my birth of 4th baby at JR Hospital which ran by the midwives. First of all when I called the reception and spoke to the midwife during my labour pain they didn’t believe me. I was in so much pain and 9cm dilated by the time I was checked in. Also I hardly seen the midwives after birth. Just a few chats and information. Also I was with the baby almost 5-6 hours without baby cot and pillow to sleep on. Midwives kept coming in and out of the labour room for some reason and I was ready to go home asap. I never had such uncomfortness for my other 3 children though 2 born in London and 1 in JR Hospital. Very sorry to make this complaint but I feel that I should be heard and childbirth should be with good memories.
- Waters broke before birth, dry birth, not right information
- Children X3 at Horton, 1 induction 2 sections. Quality of stay varied hugely depending on staffing levels.
- Birth Afterthoughts – used after 1st child, very good but difficult to get through to and not signposted
- Health visiting – very valuable service but feels as though staff levels are low
- Hospital – very busy and noisy, no sleep

Project Evaluation and Recommendations

LINk also received several comments and stories that we have not received permission to print in detail but which have been counted towards the evaluation. There are many positive comments and we hope these are encouraging to the service providers.

From our research, the following concerns appear to be the most prevalent:

1) **Breastfeeding**
   - Receiving conflicting information,
   - Strongly 'pushed' as the best option
   - Initial promotion not followed up with the right level, or regularity, of support

2) **Consistency of support**
   - Mothers seeing many different health visitors after the birth, which leads to conflicting information being given
   - Lack of signposting onto other services means mothers can feel isolated and have to look for services themselves, potentially missing out on support
   - This can result in an inability to develop a purposeful relationship with professionals.

Oxfordshire LINk looks forward to receiving responses to the recommendations above from the service providers and commissioners in charge of Maternity Services in Oxfordshire.

Future Commissioning of Maternity Services

LINk is aware of the proposal to change the way in which Oxfordshire Clinical Commissioning Group will purchase local Maternity Services from April 2013, through 'Outcome Based Commissioning' (payments linked to work done). The following priorities are derived from key themes emerging from local and national work. These can be summarised as:

- Choice of where and how to receive Maternity Services
- Continuity of care, especially one-to-one care in labour and birth
- Early access to services and reducing avoidable admissions to neonatal units
- Reducing differences in outcomes between communities and groups (e.g. breastfeeding)

In September 2012, the Joint Commissioning Team (pooled resources between the Local Authority and NHS) started early discussions with local users and representatives on what outcomes would be prioritise. This has provided the following priority areas for women in Oxfordshire:

- Breastfeeding
- Maternal mental health
- Continuity of care (especially in antenatal period)
- One-to-one care in labour
- Normal birth
- No unexpected admissions at term (40 weeks)

These areas fall broadly in line with current LINk findings. This review and recommendations will be supplied to Oxfordshire's commissioners to further inform their decision making.

Midwife-Led Units:

During the period of this review, LINk received requests to look into concerns about temporary closures to Wantage and Chipping Norton Maternity Units. The HOSC and LINk have been assured that both units will reopen. The maternity unit at Wantage reopened for births on the 26th November 2012. Chipping Norton will reopen following a review of the service. Further details of the responses from Oxford University Hospitals NHS Trust can be found in the relevant Scrutiny papers on Oxfordshire County Council's website

Local HealthWatch

A new system for Patient and Public Engagement will be introduced from 1st April 2013, under contract with OCC. We will ensure that this report forms part of the legacy which LINk wishes to pass onto the new organisation and we will recommend that actions arising from this review are prioritised in the initial work programme that HealthWatch will deliver. Further information about Local HealthWatch & HealthWatch England can be obtained directly from OCC

Oxfordshire LINk would like to thank everyone involved in this service review for their comments and their time.

Glossary of terms used

HOSC	Oxfordshire Joint Health Overview and Scrutiny Committee
JSNA	Joint Strategic Needs Assessment
SCS	Social and Community Services, Oxfordshire County Council
JR	John Radcliffe Hospital, Oxford
PCT	Primary Care Trust (until April 2013)
OCCG	Oxfordshire Clinical Commissioning Group (from April 2013)
OUHT	Oxford University Hospitals NHS Trust

Review of Information provided for NHS Dental patients in Oxfordshire

Report of a survey conducted by LINk members and volunteers between October - December 2012

Report by Marion Judd, Oxfordshire LINk

Date of report: January 2013

Introduction

This report presents the results of a survey carried out across Oxfordshire to ascertain the extent to which Dental Practices contracted to provide NHS services are making available all appropriate and necessary information for their NHS patients. This survey replicates one developed by the Berkshire LINk. In Oxfordshire, the survey has been implemented by Oxfordshire LINk in collaboration with NHS Oxfordshire, which, with Berkshire, will supply commissioners with data covering both counties. Data was collected from practice leaflets, websites and site visits to 62 (77.5%) out of the 80 Dental Practices providing NHS services in Oxfordshire with 14 of the 62 Practices providing NHS services to children only (one of these provide services for children plus exempt patients only).

Providing easily accessible information for NHS patients can potentially assist dental practices in marketing their services and is essential for NHS patients to help them make informed decisions about their dental care. Therefore, based on the Oxfordshire results, the report includes recommendations for good practice relating to important information for NHS patients, and how best it can be made easily accessible at practice premises, in practice leaflets and on practice websites of those dental practices who are contracted to offer NHS treatment by Oxfordshire PCT/Clinical Commissioning Group.

Method

This project was approved by Oxfordshire LINk's Priorities and Finance Group in July 2012. Preparation for starting the survey included development of a project plan followed by a recruitment drive for volunteers with preparation of briefing materials. An introductory letter was sent to all potential participating dental practices to brief them

about the project and about the LINk, and to inform them that they would be contacted by an authorised LINk volunteer to arrange a visit. Volunteers were recruited from existing LINk participants and the wider public through use of media and public engagement initiatives, though other voluntary organisations and by word of mouth. A pilot of the survey was first carried out at dental practices in Wantage and Didcot. Once sufficient volunteers had been identified and briefed, data collection took place between November and December 2012. Analysis of data collected from practice visits, practice information leaflets and practice websites is presented below.

Results

This section presents a summary of our findings. For detailed results, see Appendices 1 - 3.

1. Information displayed outside Dental Practices:

- 93.5% of all practices visited displayed clear external signage stating the name of the practice.
- Only 27% displayed the NHS logo externally. None of the practices with children-only contracts displayed the NHS logo.
- 76% of practices displayed the practice opening hours externally
- Only 24% displayed disabled access signage although a further 16 practices were noted by volunteers to have full or partial access for disabled people. A few practices were unable to provide disabled access due to the nature of their buildings.

Recommendations:

We recommend that all dental practices contracted to provide NHS services should display externally the NHS logo and indicate whether the NHS service they provide is for all patients or not (e.g. children only). This should always be placed in a position where it can be seen easily. Furthermore, it would be desirable if all indicated externally whether or not they had disabled access, and to state whether this excluded or included wheelchair users.

2. Information available in waiting/reception areas:

- 64% of practices displayed a schedule of services
- 72% of practices displayed a list of charges
- 61% of practices displayed dental practice leaflets
- Where there was no leaflet on display because it was in preparation or being updated, 7 practices provided a copy of their new draft or old leaflet

Recommendations:

We recommend that all dental practices contracted to provide NHS services should display a schedule of services and list of NHS charges in their waiting/reception areas that are clearly visible and in a sufficiently large font to facilitate easy reading. In the case of children-only

contracts this is not applicable but all practice leaflets on display should contain relevant information about the NHS services provided plus copies of the NHS leaflet "NHS Dental Services in England" displayed.

3. Questions asked of Reception Staff and/or Practice Managers:

- 77% of practices indicated they were accepting new patients. A further 8 said their lists were currently full
- 92% indicated they were accepting emergency appointments
- Procedures for joining the Practice: we were informed that patients are generally required to phone or visit and fill in medical and application forms in order to join practices with an NHS contract. A few Practices also allow new patients to join via e-mail and some have the required forms downloadable from their websites.
- 4-8 weeks was the maximum time patients needed to wait to get a first appointment although most were given an appointment within 2 weeks.
- Receptionists at 41 practices cited the correct charges for all three charge bands. A further 4 were inaccurate or the receptionist did not know and 14 practices saw exempt patients only.
- Most receptionists understood exemption rules for children, adults on income support and young people of 19 in full time education although not all mentioned the need to verify exempt status through sight of the relevant form.

<u>Procedure for arranging interpreters</u>

We found understanding of how to access interpreting services to be mixed.

- Only 17 receptionists were aware they could contact the PCT or NHS for interpreting services; one also cited social services.
- 12 receptionists indicated family or friends were normally expected to interpret for the patient.
- 7 said they had non-specific numbers to phone to access interpreters.
- 11 did not know how to access an interpreter and 3 said the need had never arisen.

<u>Key themes drawn from volunteers' comments</u>

Volunteers reported how friendly and helpful they had found reception staff and practice managers at many of the practices they visited or contacted by phone. However, in some instances volunteers did experience difficulties in making arrangements to visit practices and

contact from PCT Commissioners was required in order to facilitate a small number of visits through reminding Practices of their obligations for Patient and Public Engagement under NHS contracts. Some volunteers and LINk staff found it took time and perseverance to either make an appointment or to get through to speak with the practice manager. Also, certain children-only practices were found to be hesitant to take part in the survey. Only one volunteer commented on being met with antagonism on visiting a practice.

Instances were noted in which practices displayed an excellent range of information for NHS patients. This was not always the case however, particularly in those practices with children-only contracts. Information provided via TV displays in waiting rooms was also seen to offer opportunities for patients to gain all the information they needed providing they were not partially sighted, blind or not literate and provided they remained in the waiting room long enough to see the whole programme. TV displays were also a good source of information about preventive self-management, disease prevention and the need to have mouth, teeth and gums monitored for serious conditions.

Volunteers noted how, in some instances, practices appeared to place a greater emphasis on private treatment provision with NHS information tending to be marginalised or absent.

One particular practice providing services to adults had no NHS information on display either externally or internally, no disabled access information outside, no practice leaflets and no knowledge of the PCT's interpreting service, although one other language was spoken by staff in-house.

Access arrangements:

Without disabled access signage displayed externally or on practice websites, potential patients could be disadvantaged. For example, one practice situated on the first floor could be accessed by chairlift from the ground floor, after negotiating a step, but patients would then encounter more steps at the top of the main stairs to access waiting room, reception and surgeries. Therefore wheelchair users could not have accessed this practice and this information could be usefully signed externally.

External signage indicating "Taking on new (NHS) patients" was a positive finding in a practice where NHS service information in all forms was clearly displayed both externally and internally.

Volunteers commented on the interface between private and NHS treatment, and how this was presented to patients. One volunteer commented on the 'hard sell' for cosmetic dentistry on the practice phone prior to reaching a receptionist and felt NHS patients were being treated as 'poor relations'. Another practice gave all patients, both NHS and private, a costed care plan before treatment started and yet another, if there were no NHS vacancies, would take on new patients as private patients, moving them to their NHS list when a vacancy arose.

Recommendations:

For any future surveys of dental practices, it is suggested that practices are contacted initially by the commissioning body prior to any approach being made by HealthWatch volunteers.

We recommend that information about disabled access is clearly visible externally and it should be stated if there is no, or limited, disabled access and whether or not the practice is fully wheelchair accessible.

4. Review of Practice Leaflets:

29 practice leaflets were collected for review. Three were unavailable because they were being updated or re-printed and a further 30 were not obtained.

Contractor status is rarely mentioned at all in practice leaflets although it can be deduced to be either the first name of any list of dental practitioners, or where the designation “principle dentist” is stated. Also, where there are more than 2 dental practitioners listed in practice leaflets no practice makes it clear whether all or only some dentists provide NHS services under the contract.

There are problems with the content of information given about disabled access as leaflets do not always make clear whether there is no disabled access at all, or whether there is full or partial disabled access. It is useful to find information about parking in many practice leaflets.

All practice leaflets need to update the NHS number and more practices need to include information about services available under the contract. The rights and responsibilities of the patient, the rights of the contractor to cease providing services and access to patient information would benefit from a standard format, perhaps suggested by the commissioners, as each practice is currently free to re-invent the wheel with respect to this information, not always with adequate results. A standard format for (PCT) contact details would also help practices to provide this information in full.

Key themes drawn from volunteers’ comments

Among the leaflets audited there were some very good and informative leaflets that contained all or almost all the information required by NHS patients. It was noted that separating NHS information from private treatment information within a leaflet made it easier for NHS patients to find the information they needed, or information that the practice needed them to be aware of. It was good to find that information was given about languages spoken in house in one practice leaflet and this information being contained in practice leaflets could usefully be adopted by other practices. In some instances, more attention needs to be paid to font size and colours of print to assist patients with visual impairment to read leaflets.

Recommendations:

Commissioners could usefully provide a standard format for required information content of practice leaflets with the expectation that contractors include this content verbatim in their practice leaflets.

Practices could also be advised on the need to consider font size and colour to ensure all patients can read their practice leaflets easily.

Information about disabled access could be improved in terms of its absence from some leaflets.

5. Review of Practice Websites

42 Dental Practices providing services to NHS Patients have their own practice websites; the remaining 20 have variable amounts of practice information on the NHS Choices website which gives them the opportunity to include all information NHS patients need, apart from downloadable practice leaflets. For this reason, we have included a review of the NHS Choices websites of those practices without their own website. It is up to each practice to determine how informative their NHS Choices website pages are for their patients.

Useful features found included provision of the practice e-mail address, a link to NHS Direct, a link to the General Dental Council and the PCT, links to the British Dental Health Foundation and Patients Association, provision of an online form to allow patients to e-mail the practice, a facility to book appointments online, out of hours contact details, information on disabled access, testimonials and comments from patients, parking information and map of location, practice contact details repeated on each webpage, preventative treatment and oral health information and a résumé of each dentist.

On the whole, general information for NHS patients on both practice and NHS websites is extremely inconsistent and inadequate between practices in respect of the optimum number of information items that would constitute best practice. There are only a very few really excellent and informative websites and some websites could be difficult to negotiate. Many were noted to be primarily focussed on provision of private treatments, with references to NHS services incidental, if there at all, and in some instances not easy to find. Also, some were presented in very small print and not all patients could be expected to know how to view this in a larger format if needed. Detailed results of the website review can be found in Appendix 3.

Comments:

All dental practices with NHS contracts, whether or not they have their own websites, have their own web pages on the NHS Choices website and it is up to them to enter information for patients. For practices without their own website, NHS Choices provides web pages with the potential to contain all the information their NHS patients need. However, not all practices with an NHS contract using NHS Choices web pages indicated that they provided NHS treatment, or other information for NHS patients.

Recommendations:

Practices' own websites would benefit from displaying a standard package of information for NHS and other patients. This should include all items meeting proposed standards of good practice in practice leaflets (See Appendix 4).

Promotion of private dental treatments and procedures takes precedence on many practice websites and we therefore recommend that if the practice is contracted to provide NHS treatment this should be displayed on its own separate webpage that is readily accessible for NHS patients, as currently NHS information may be well hidden. We also recommend that practice website home pages should present name of practice, contact details, location map, and opening times as standard, also indicating whether they provide NHS treatment, to what category of patients, whether they have vacancies and how to make an appointment.

Standards for good practice could usefully include some of the additional features identified above.

In conclusion

We are very grateful to all those volunteers whose efforts have contributed so much to the content of this report. We also thank all the friendly and helpful Dental Practice Managers and reception staff members who willingly gave time and information to our volunteers.

Although many of the dental practices visited in the course of this survey provide excellent and easily accessible information for their NHS patients, in general information provision is inconsistent and incomplete as no standards for consistent good practice appear to operate as part of the NHS contract. There remain many gaps in good practice in provision of information for patients that need to be remedied. In website design, practices need to consider carefully whom their target groups are likely to be, remembering that these are likely to be persons of all ages, socioeconomic groups, literacy, computer literacy and (dis)abilty. More consideration needs to be taken of individuals with visual impairments who may need larger fonts and colours that make print easier to read. More downloadable information should also be considered as a way of minimising the number of web pages and tabs people can have to trawl though to find information they need. Also, we believe NHS patients should be able to see information about charge bands and services under the NHS on one page and all home pages should ideally give the name, contact detail and opening hours of each practice that currently is not always the case. In addition, if there is more than one dentist in a practice, it should be clearly stated which of the dentists provides NHS services, as not all may do so.

We have made a number of recommendations for good practice with regard to external signage, internal information display, practice leaflets and practice websites. It is hoped that dental practices might be willing to consider some of our recommendations that seek to improve, where necessary, access to relevant information for all their NHS patients, and through this, to optimise marketing of their NHS services.

The data collected through this survey would allow the LINk (or Healthwatch in the future) to develop guidelines for good practice regarding the content and presentation of Dental Practice leaflets and website design to meet the needs of NHS patients. Print size, information about disabled access and clearly presented information accessible without wading though multiple pages would benefit the usability of some sites. Also certain Practices using the NHS Choices website only could improve the quality of information and ensure it is regularly updated so that NHS patients can access all the information they need.

In future, should the new HealthWatch organisation decide to use lay volunteers to collect data from dental or other NHS facilities, we suggest that any similar project is preceded by a written introduction from the Commissioning body in order to emphasise the legitimacy of any similar joint project work. Also, because we found that dental practices in general have no knowledge or understanding of the LINk and its public engagement role, we recommend that HealthWatch actively raises its profile with all NHS providers in the future.

We also recommend that members of Oxfordshire-based Disability Groups should consider auditing their access to the dental practices they attend in order to obtain disabled users' own views about whether facilities advertised or otherwise as disability friendly are suitable for their needs and this could provide an even more detailed understanding of disabled people's access needs.

Appendix 1 - Data gathered through visits/phone calls to dental practices

1. Information displayed outside and inside 62 Dental Practices

External signage

	Yes	No	Comments
Clear external signing stating the name of the practice	58	4	Some practices display additional information including names of practitioners, website address and phone number
NHS logo displayed	17	45	One Practice without an NHS logo indicated they saw children and exempt patients under the NHS. Another without the logo displayed an emergency number. All other children-only practices omitted to display the NHS logo.
Practice opening hours	47	15	
Disabled access signed	11	35	16 Practices have no signage but volunteers noted they do have access for disabled people.

Information available in waiting/reception areas:

	Yes	No	Comments
Schedule of services on display (n = 56)	36	20	(not applicable for children-only practices). This information was noted to be displayed on walls but was not always easily seen. When shown on a TV notice board, the information could easily be missed if patient was only in waiting room for a short time.
List of charges on display (n = 58)	42	16	Not applicable for children-only practices.
Dental practice leaflets on display in the waiting area (n = 59)	36	16	Not all practice leaflets contain information about NHS services and are primarily focussed on private treatment. Some practice leaflets are being updated or reprinted, therefore were not available at the time.
If not, leaflet made available on request	7		New drafts or old leaflets made available

2. Information given by Reception Staff/Practice Managers

	Yes	No	Comments
Accepting new NHS patients?	48	14	8 practices indicated they were at full capacity
Accepting Emergency appointments?	57	5	6 practices indicated they were accepting children and/or exempt patients only

Procedures for joining the Practice: Patients are generally required to phone or visit and fill in medical and application forms to join an NHS Dental Practice. A few Practices allow new patients to join via e-mail and some have the required forms downloadable from their websites.

Length of time to obtain 1st appointment (n=61):

Within 1 week	1-2 weeks	2-3 weeks	4-8 weeks	6 months	Not accepting new patients	Other
20	24	3	4	1	1	8

Payment: NHS charge Bands

Receptionists at 41 Practices cited the correct charges for all three charge bands.

Of the remaining 21 practices, 4 responses were either inaccurate or the receptionist did not know the answers. We do not have data for 4 practices and for the remaining 14, their patients (either children or exempt adults) are exempt from charges.

NHS Dental treatment on Income Support

Receptionists at almost all Practices providing NHS dental treatment for adults understood there was no charge for people on income support, but not all specified that they needed to verify exempt status through having site of the relevant exemption form.

Payment for dental treatment at 19 years if in full time education

Most reception staff understood that with an appropriate exemption certificate, young people at 19 years in full time education would be exempt from charges, otherwise they would have to pay. Only 3 gave incorrect answers and 1 was not sure.

Procedure for arranging interpreters

Understanding of how to access interpreting services is mixed. Only 17 receptionists were aware they could contact the PCT or NHS for interpreting services; one also cited social services.

12 receptionists indicated family or friends were normally expected to interpret for the patient; 7 said they had non-specific numbers to phone to access interpreters and 11 did not know how to access an interpreter and 3 said the need had never arisen.

Oxfordshire LINk

Appendix 2

Review of Practice Leaflets

(n = 29)	Yes	No	Comments
Name of contractor	28	0	But in all but one case, contractor status was not mentioned. Contractor status has mainly been deduced to be the first named dentist on a list of dentists or the 'principle dentist' designation.
Name of each person providing NHS services	23	5	But in instances where a full list of practicing dentists is given, none indicated whether all or only some practitioners provided NHS services.
Professional qualifications of each person	24	4	
Teaching/training of persons who provide dental services or who intend to do so?	5	22	It is unclear whether the 22 do not provide any training, or do provide training but omit to state it.
Address of each of the practice premises	29	0	
Contractors telephone number	28	1	
Contractors Fax number	9	20	20 either not given or have no Fax
Does the contractor provide an e-mail address?	14	15	
Does the practice have a website?	29	0	All have websites, either their own or NHS Choices as their primary website.
Suitable access for disabled patients or information on alternative arrangements for providing services to such patients?	18	11	Disabled information given is not always detailed enough to inform disabled people whether the access suits their own particular needs.
How to request services as a patient	20	9	Of the 20 leaflets, 5 gave information about access to emergency services only
The rights of a patient to express a preference of practitioner, and the means of expressing such a preference	11	18	This was only made explicit in 11 leaflets.
The services available under the contract	19	10	19 included information about services available under the contract either in the Practice leaflet or through provision of the NHS leaflet. The remainder contained information about private treatment only. In one company leaflet the NHS charge bans costs were out of date.
The normal surgery days and hours of the practice	26	3	
Information on the practice answer phone explaining how patients can access dental	19	10	

services out of hours including how to access emergency treatment and the number of the dental helpline			
The telephone number (currently 08454647) of NHS Direct and details of NHS Direct online	19	10	All 19 leaflets contained the old NHS number.
How patients may make a complaint or comment on the provision of service.	19	10	
The rights and responsibilities of the patient, including keeping appointments.	21	8	Although 21 leaflets contained parts of this information, few covered the full rights and responsibilities of patients in a clear an comprehensive way..
The rights of the contractor to cease providing services to any patient who does not attend and fails to cancel with 24 hours notice two booked appointments in any 12 month rolling period.	20	9	These rights were not always fully explained.
Details of who has access to patient information (including information from which the identity of the individual can be ascertained) and the patient's rights in relation to disclosure of such information.	18	11	This was not always explained fully and omitted often.
The name, postal, website and telephone number of the PCT and from whom details of primary dental services in the area may be obtained.	14	15	Those who displayed details of how to contact the PCT did not necessarily provide full contact details

Appendix 3

Review of Practice Websites

	Yes	No	Comments
Name of contractor?	62	0	However, in most websites contractor status is not specified but can be inferred; e.g. first name on the list of dentists. Some mention 'principle dentist' and only one specified contractual status
Name of each person providing NHS services?	44	18	List of staff shown but unclear whether all clinical staff members provide NHS services. Can be implied where few dentists
Professional qualifications of each person providing NHS services included?	39	16	**The remaining 7 were unclear**; e.g. GDC registration numbers only, or referral to graduate status without details of qualifications.
Address of practice premises?	62	0	
Contractors telephone number?	61	1	
Contractors Fax number?	15	47	Not all practices appear to have a Fax. One gave 2 phone numbers but did not specify one as a Fax number. Twelve provided e-mail addresses or a facility to e-mail via their website.
Downloadable Practice Leaflet?	0	62	No downloadable Practice leaflets found with all necessary information for NHS patients but: 1 website had 11 downloadable information sheets 1 had 31 downloadable advice leaflets, not necessarily relevant to NHS patients 1 had downloadable leaflets on prevention and treatments 2 had downloadable registration and medical history forms 1 had a downloadable guide to NHS treatment fees From 1 website all information could be copied, pasted and printed as required if patient was computer literate
Services available under the contract?	40	22	NHS services were generally very poorly presented, largely incomplete and inadequate. One website displayed the logo only, another only a contact number for complaints. On other sites, reference to the NHS was difficult to find. We were informed that one website was being updated to include NHS information.
Normal surgery days and hours?	54	8	1 website contained inaccurate information and another was confusing and difficult to access for some patients. On some websites finding this information involved searching through multiple web pages.

Appendix 4:

Suggested Good Practice guidelines for content of dental practice external signage, internal information provision, practice leaflets and websites

Although we identified a number of practices whose information provision and presentation of information was excellent, evidence from our survey shows that not all Oxfordshire dental practices either provide, or present, adequate information for their NHS patients either, externally, internally, in practice leaflets or in practice websites.

When preparing and displaying written material for NHS patients, Dental Practices should be mindful of the needs of disabled patients, patients who may not be computer literate and patients whose visual acuity may be less than perfect. In preparing written information, the use of font sizes that can be easily seen is an important consideration.

1. External signage:

We recommend that:

1.1 At the minimum, name of practice, opening hours, contact number and emergency contact number should be displayed outside practices in a position where they can be easily seen. Additionally, e-mail and website address should be considered.

1.2 Where Practices are contracted to provide NHS dental care, this should be clearly stated externally, at a minimum through displaying the NHS logo. In addition, indicating which groups of individuals can be seen under the contract could also be beneficial for potential new patients.

1.3 Disability access should be clearly signed externally. If this excludes wheelchair users this should be stated. For practices with no disability access, ideally this should also be indicated externally.

2. Information for NHS patients for display in waiting / reception areas:

We recommend that:

2.1. A schedule of NHS services with a list of charges should be displayed in a prominent position where it can be easily seen, and with print large enough to be easily read. In practices where this information is presented exclusively on TV notice boards, we recommend the information is also duplicated in written format as patients may not have time, or adequate vision, to see all the information on the screen.

2.2. Dental Practice Leaflets that include all the information NHS patients need should be placed where they can easily be seen. In the case of children-only contracts, the NHS leaflet “NHS Dental Services in England” should either be displayed or routinely offered to parents on their first visit.

3. Dental Practice leaflets

We recommend that:

3.1 In order to address the current inconsistencies, we recommend that Commissioners provide dental contractors with a standard information package for NHS patients to be included verbatim in dental practice leaflets.

3.2 The current NHS number and full contact details for Dental Commissioning should always be included in practice leaflets.

3.3 Font size should be sufficiently large to facilitate easy reading.

3.4 Disabled access details should be included.

3.5 In practices with more than two dentists, practice leaflets should indicate which dental practitioners provide NHS services

3.6 NHS patient-specific information should be presented all together in one bloc within leaflets.

3.7 Details should be given of any languages other than English spoken in house

3.8 Leaflets should contain full information about disabled access detailing whether or not it is wheelchair friendly

4. Dental Practice websites

We recommend that:

4.1 In order to address the current inconsistencies, we recommend that Commissioners provide dental contractors with a standard information package for NHS patients to be included verbatim on dental practice websites.

4.2 Those practices who use NHS Choices website exclusively ensure that all the information NHS patients need is displayed on their web pages and that this information is reviewed regularly to ensure it remains current.

4.3 The home page of dental practice websites display name of practice, address of practice, phone and e-mail address of practice, opening times, emergency contact details and a link to a location map as standard. The home page should also state that they provide NHS services, to which category of patients, whether they have vacancies and how to make an appointment.

4.4 Dental practices with their own websites ensure that a standard package of information for NHS patients is included on its own web page, separately from private practice information, to make it easily accessible for patients.

4.5 Websites (excluding NHS Choices) provide downloadable practice leaflets plus oral health promotion and disease prevention material

4.6 Websites clearly detail their charges for private treatments not available on the NHS, including treatment from a hygienist.

We also recommend that NHS patients should have access to information detailing the professional qualifications of dental and other practitioners. Those websites that already provide a brief résumé of each professional member of staff and information about their special interests imply a friendly approach toward their patients.

Appendix 5: Volunteers who took part in the survey

Thanks go to all those individuals who volunteered to visit the Dental Practices. They are:

Sue Butterworth
Margaret Eaglestone
Elizabeth Henty
Marion Judd
Mary Judge
Pauline McCormack-White
Anton Nath
Jean Nunn-Price
Nicole O'Donnell
Irene Rae
Wendy Stillgoe
Julie Taylor
Ann Tomline

Mental Health Hearsay! update event

Report on Mental Health Hearsay! update event held 6th December 2012 at The Old Fire Station, Oxford.

Report by Oxfordshire Local Involvement Network

Date of this report – 18/1/13

Introduction

Mental Health Hearsay! – overview

In 2011, Oxfordshire LINk was asked by Oxfordshire County Council and Oxfordshire Primary Care Trust to organise a Mental Health Hearsay! event based on the Hearsay! model of engagement delivered previously for Social and Community Services and the Nuffield Orthopaedic Centre NHS Trust. The first event on the 12th January 2012 was held in place of the previous Mental Health Sounding Board. The aim of the day was to enable people who currently use Mental Health Services, or who have used them in the last three years, their Carers and family members, to meet with those who commission and deliver these services. Representatives from Oxfordshire County Council, Oxfordshire PCT, Care Quality Commission, together with community and voluntary sector representatives attended the event to hear what people had to say.

After the event, LINk produced a report prioritising the actions to present to service providers and commissioners. An action plan was produced jointly with Oxford Health and Oxfordshire Clinical Commissioning Group explaining how improvements will be made to the services. The subsequent update event held on the 6th December 2012 reviewed actions taken during the year in response to the first Mental Health Hearsay! and engaged with service users and service providers in further consultation. The event was independently facilitated by Jeremy Spafford who has previously facilitated Mental Health Sounding Boards, and other Hearsay! engagement events. After an update from Oxfordshire Health NHS Foundation Trust and Oxfordshire Clinical Commissioning Group, Jeremy asked attendees seated at six tables to feedback on mental health services across Oxfordshire and Buckinghamshire. He then selected six themes which emerged from the discussion and asked each table to respond with possible solutions to each of the themes.

Update from Oxford Health & Oxfordshire Clinical Commissioning Group

Juliet Long, Service Development Manager, Oxfordshire Clinical Commissioning Group (OCCG)

Responses to previous Hearsay actions:

Better Mental Health in Oxfordshire commissioning programme:

2012/2013

- Carers' needs are a commissioning priority during 2012/13 and we are refreshing our Carers' strategy which will have the needs of mental health carers included. We are also re-commissioning the Mental Health Carers Support service in line with the strategy priorities.
- OCCG recognise good information is essential and have therefore commissioned Oxfordshire Mind information service to publish the new MIND Guide which was released in October 2012.
- As part of public health and wellbeing developments OCCG commissioned Oxfordshire Mind wellbeing service, who are involved in providing mental health first aid training and public health campaigns.

2013/14 :

- 'Support to Independent Living' work stream will remain a priority to support the needs of service users to enable them to move towards independent living.
- Integration of physical and mental health is a priority, which includes improving physical outcomes for people with mental health problems, mental health needs of people with physical long term health conditions and psychological needs of people with severe mental illness.
- Improving service user and carer involvement systematically and not just when services are redesigned or part of a project.
- Finding effective ways to map service user and carer involvement into Healthwatch.

Jackie Thomas, Head of Community Adult Mental Health Services, Oxford Health

1. **Information for Patients and Carers**
   The Trust has listened to feedback from the people who use our service about the information available to them and have initiated a number of pieces of work to address these.

The Modern Matrons have just completed a project and all inpatient wards now have a 'welcome pack' for all new admissions. This includes meaningful, personal information for both the patient and their carer. There is also similar detailed and personal information for all patients when they are discharged from an inpatient ward, with information about their on-going care.

The division are working on a similar project across our community teams, whereby all patients receive a folder with useful information, ranging from the aims and outcomes of their team, through to contact details, through how to access additional support. We are in the final stages of this project and hope to be ready to roll this out by the end of the year across the whole division.

2. **Access and Support by the Community Acute Service**

The Trust continues to look to improve the service we provide to our patients. Following feedback from patients and referrers we reviewed how telephone calls to the Community Acute Service (CAS) are managed during the out of hours period to ensure that, as call volumes increase, patients are able to access the service when they need it.

CAS is there to provide an urgent response to existing or new patients who are experiencing a mental health crisis such as thoughts of self-harm or suicide and so it is important that they are available to those who need help quickly.

In order to improve response times for those patients who require care from CAS, since 1st August 2012 telephone calls out of hours are managed now through our dedicated Out of Hours Co-ordination Centre who will transfer calls from patients needing urgent care to a member of the CAS Team. It will also signpost other patients with more general and non-urgent enquiries to the appropriate place.

Since these changes, the Trust has received positive feedback from patients, GPs and commissioners about the improved accessibility to the service and our CAS staff are able to dedicate all their time to those patients experiencing a mental health crisis.

3. **Ensuring that the information on the website is correct and up to date**

The content of the website is managed through the communications team. Teams and services will update us of changes and we are always very responsive to make these within 2 working days. We are in the process of doing a large piece of work to create a brand new service directory, which will be much more user friendly and service information should be much more accessible. We are hoping to be able to launch this in the New Year.

4. **Therapeutic Activity on the Wards**
   All inpatient wards across both adult and older adult services have a WTE Activity Worker, in addition to the nursing establishment on the ward. All wards will have a range of activities on them, which can be adapted to meet individual patient needs.

5. **Involvement activities**
   The new CEO, Stuart Bell, has been listening to feedback from patients, service users and carers and has asked for a piece of work to take place to review the way in which the Trust approaches involvement and to look at establishing appropriate opportunities for people to engage in the work of the Trust. This includes a review of the resource and support in place and linking with patients, service users and carers to understand how they would like us to engage with them. This will be taking place over the next three months and we hope by the April 2013 to have put a support model in place to enable the feedback to be taken forward and good involvement practice to be shared across the Trust.

Key themes arising from the discussions

1. GP & Medication Reviews
2. Support for Carers and Confidentiality
3. Information – Isolation – Internet
4. Working across services
5. Care pathways and Care co-ordination
6. Crisis response and staff attitudes

1. GP and Medication Reviews

Service users would like GPs to consider what else is going on in the patient's life at the time of medication, investigate what other medication the patient may be taking, explore alternative options such as talking therapy, and inform the patient of the possible side effects of medication. More aftercare is needed with a suggestion of drop-in centres. Communication must be confidential – add CONFIDENTIAL to post. Professionals must take responsibility for misdiagnosis. There was a suggestion that GPs could receive regular CPD on mental health in order to work more effectively with patients.

2. Support for Carers and Confidentiality

More support and involvement is needed for carers, with clear and consistent guidance including information on confidentiality policies. Carers want to be more involved in the care of their partner, friend or relative when in hospital. Oxford Health is currently working to provide carers with an information pack and has agreed to consult with carers.

3. Information – Isolation – Internet

Not all service users have access to the internet or are able to use the internet. There was a request for a range of information channels including on-line and hard copies as well as direct information from the GP. A 24 hour telephone service or a face-to-face drop in service could be effective in managing enquiries. Transport was also considered with access to transport to be included as part of a service user recovery plan to address isolation and return to employment. A bus pass, car share scheme or volunteer support to support mental health service users were put forward as possible solutions. There was a suggestion to link up to the community transport review, and ask Better Mental Health in Oxfordshire to collate information to explore the bigger picture.

4. Working across services

Better integration of physical and mental health care, and in-patient and community services, are needed. Service users and service providers considered partnership working to support working across the services to meet the needs of the service user. Service user led organisations could play a key role in making a difference to services by meeting together and sharing knowledge. A forum could be set up with representatives from across the whole

of Oxfordshire to encourage partnerships and information sharing with funding available across organisations to support research and provide training.

5. Care pathways and Care co-ordination

Early and accurate diagnosis, referral to the right specialist, and more service user and carer involvement with better communication is needed. Again, the internet is not accessible to everyone and so a telephone service or drop-in centre was suggested. A person and carer centred information pack would be helpful. Oxford Health feedback indicated that services users reported feeling more satisfied with the recent information pack (blue folder) which has been introduced. A consultation with carers will be launched soon to support publication of an information pack for carers. Jackie Thomas also suggested memory clinics at Oxford University Hospitals HNS Trust and Oxford Health could work together across the health economy for better diagnosis.

6. Crisis Response and staff attitudes

Crisis response is available for those registered with the Community Mental Health Team (CMHT), who may be in danger of harming themselves or others. Calls from people not registered with the CMHT have to wait a long time to be answered. Those who are in crisis need a faster response to stay safe. Those who are not in crisis need to know who to contact. This also applied to the 111 number where callers wait to receive a call back from a GP which could be too long in difficult circumstances. There was a suggestion to explain the process on the Oxford Health website and include information on signposting which would enable the CMHT to concentrate on urgent calls and provide information and support to those who need it. There was also a suggestion to enable CMHT service users to self-refer after six months of discharge.

A high percentage of complaints to Oxford Health are about staff attitudes. Oxford Health confirmed that this is being addressed with customer service training for all ward based staff. There was a suggestion to address particular wards with a culture of poor attitude.

ANNEX: Developing Mental Health services in Oxfordshire and Buckinghamshire – detailed comments.

This section shows responses captured on the flip charts describing possible solutions to the six emerging themes on the day.

GP and medication reviews
Continuous Professional Development for GPs on mental health
GP to consider carers as equal partners during a medication review
GP to consider what else is going on in a service users life at the time of the review
GP to investigate what other medication the service user is taking
GP to explore more options with service user like talking therapy
GP to inform service user of possible side effects of medication
More aftercare is needed
Drop in centres
Professionals
Support for carers and confidentiality
Carers need to know the policies on confidentiality
Carers want to be involved when service user is in hospital
Carers want clear guidance and consistent information
Carers want more support
Information- Isolation - Internet
Range of information channels needed – GP, internet, hard copies
24 hour help line
A 111 number for mental health
Bus passes for mental health service users
Car share scheme
Volunteer support with transport
Link up with community transport review and ask BMHO to collate evidence to explore the bigger picture
Working across services
Integrate physical and mental health care services
Integrate in-patient and community services
Partnership working
Work across services to meet service user needs rather than focus on condition
Service user led organisations could play a key role in making a difference to services through meeting together and sharing knowledge. A forum could be set up with representatives from across Oxfordshire to encourage partnerships, with funding available

across organisations
Less competition
Awareness and respect of age and culture
Better co-ordination of health and social care services through partnership working
Increase awareness and understanding of processes in place and how service users can feed into them
Is physical health included in Oxfordshire's health and wellbeing strategy priorities
Funding for research across agencies
Public sector to share data with community and voluntary sector
More training needed
Care pathways and Care co-ordination
Early diagnosis needed
Appropriate referral to the right specialist
Awareness of cultural diversity to improve accuracy of diagnosis
Memory clinics at OUH and OH operate independently, can they work together across the health economy for better diagnosis
• Better communication: • Not everyone has internet access • Service users don't want to speak to an answerphone • Quick response to enquiries • Drop-in centre for information and advice, support with form filling • Data protection – put CONFIDENTIAL on all correspondence, RETURN TO SENDER on post so that service providers can amend incorrect address • Person centred welcome packs with information and advice
• Service user and carer want more involvement in care plan
Crisis Response and staff attitudes
Crisis response
20% of calls were not in crisis
Crisis response is for those who are already registered with their local Community Mental Health Team, sign post others where appropriate.
Calls that don't meet the criteria and need to go via their GP are put on hold for a long time waiting to speak to the Crisis Team and may self-harm or harm others before help is given. Explain the process on the Oxford Health website with information on criteria to register with the CMHT and sign posting.
999 – manages accidents 111 – GP will ring back but this could be too long a wait for some
Can service users self-refer back to the CMHT within 6 months of discharge
Staff attitudes
High percentage of complaints to OH are about staff attitudes
Address particular wards that have a culture of poor attitude

Feedback

Comments about the Hearsay! event

Comments are collated from evaluation forms provided for attendees at the end of the event.

Were you able to say what you wanted? Did you feel listened to?

- Good relaxed atmosphere enabled me to express my thoughts freely.
- Gained useful insights from other people's experiences and knowledge.
- I enjoy most the opportunity to meet people from different backgrounds with different experiences. It was great to share and to hear what other people had to say.
- No problems with anything I wanted to say.
- Great opportunity to discuss issues.
- Very fair and attention given to everyone who wished to voice their feelings, well done!

Do you think anything will change as a result of this meeting?

- I am sure some things (will change) as there seems to be a desire to offer the best to service users and carers within the obvious practical constraints.
- I would like real evidence of what will change as a result of this event.
- Probably, possibly, hopefully!
- Hope so, I think in the past comments and suggestions tend to fall into a black hole.
- Only having meetings once a year means that so much change has taken place in the preceding 12 months that some of the topics discussed have moved on to such a point that changes are always tangible.
- Hopefully, new changes begun since August were discussed and explained by professional staff.
- Look forward to viewing feedback from this meeting.
- Hopefully, but unlikely with the massive re-organisation (chaos!) underway.
- I believe this meeting does help people to make changes within the system.

Did you like the venue?

- Non-medical creative venue.
- Venue too small.
- Cold (several people said that the venue was cold)
- Very welcoming venue, caring and courteous staff, and lovely coffee and cake.
- A very interesting meeting, particularly with such a number of people from various organisations exploring their part in mental health.
- Yes, very comfortable.

Was the meeting well run?

- Facilitation was very skilled and supported everyone to have their say.
- Not enough time to say what I wanted.
- Well organised but felt that more time should be allocated to the discussions. Open discussion felt a bit rushed and feedback was not able to be explained.
- I feel that these are big issues and we needed more time to discuss solutions.

- Meeting was well co-ordinated with excellent leadership from Jeremy Spafford. Ditto input from specialist staff attending.

Further comments on experience of mental health in Oxfordshire

- Care of elderly for better quality of life. More pension for incontinence such as washing powder, make-up and hair dressing. It's all about looking and feeling good.

- My aim was to improve my knowledge and skills of Mental Health problems. Thank you for this excellent opportunity.

- Better communication of knowledge, cross-fertilisation of knowledge for those with complex needs, for example, organisations which deal with mental health or physical disability. An example – a young man with cerebral palsy, hemiplegic, and epileptic, also has behavioural problems. There was extreme difficulty in finding him accommodation and a transition to study or work after school that would manage these conditions. Mental health services could not handle physical impairment and vice versa.

- Need to consider counselling services for military personnel.

- Child and adolescent mental health provision is very poor in Oxfordshire as evidenced by Head teachers and Directors of Family and Children's Centres.

- My mother volunteered with MIND. She developed Alzheimer's in her mid-80s. I was her Carer. Some services such as Day Break and the Memory Clinic were excellent, but respite care took too long to implement.

- I would like to see more improvements to transport issues for people with disabilities.

Next steps

Any amendments required to existing Action Plan, to take forward in 2013, to be agreed by OH & OCCG following the Mental Health Joint Management Group meeting on 24th January & The Better Mental Health Programme Board on 28th February.

Report to OJHOSC meeting on 21st February